Ontario's HSOs have not failed!

So "Ontario's HSO [Health Service Organization] program failed — at great expense — to achieve its objectives." This unreferenced statement in Dr. David Mowat's article "Primary care reform: Is it time for population-based funding?" (*Can Med Assoc J* 1997;157 [1]:43-4) is unfair, given that the HSO program has never been properly evaluated (except for a comparison of rates of admission to hospital, which showed no apppreciable differences between HSOs and fee-for-service practices).

Within the current contract, the costs for the medical primary care services provided by the multidisciplinary HSO teams are *below* the province's average per capita cost. Patients do not get assembly-line care, despite some perverse incentives in the current programs.[1]

Ontario's HSOs failed? By what measures and what studies?

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Reference

1. Gibson GA. Capitated practices. Do they work? [editorial]. *Can Fam Physician* 1996;42:589-92.

It is uncertain whether the Ontario Ministry of Health articulated its objectives and methods of assessment when establishing the HSO program in the early 1970s, but it is clear that many view with scepticism the role of HSOs in Canada's evolving health care network.

A perception exists that HSOs are more costly than the fee-for-service model. HSO funding arises from 2 sources: capitation (a preset monthly amount based on numbers of patients in various age and sex categories) and program funding (a negotiated sum that does not constitute physician income and which enables the HSO to administer "enhanced care" by ancillary medical staff). On the basis of data submitted by the ministry to the OMA in 1996, it has been calculated that per capita capitation costs of the HSO program are slightly lower than the corresponding fee-for-service averages. When program funding costs are added, per capita costs are slightly higher for the HSOs. However, the enhanced care programs reduce use of hospital-based services, which are traditionally funded by global hospital budgets.

Having worked within an HSO for over 10 years, I have come to appreciate that the benefits are intertwined with challenges. The dissociation between remuneration and "office visit" has enabled me to practise in a way that I believe is appreciated by patients, while affording me greater flexibility. My willingness to use the telephone (and even email) to communicate with patients would be difficult to duplicate in a "reformed fee-for-service" milieu. Even if the ministry links fees to telecommunication-based "visits," the frequency, brevity and variety (in terms of time and location) of physician-initiated patient contact will make remuneration for this contact cumbersome. Likewise, the ability to rely on allied health care professionals during patient visits has enabled our office to use physicians' skills to better advantage.

Although I remain a strong advocate of physician choice in compensation, I have difficulty understanding why, as Ontario searches to evaluate new ways to deliver high-quality primary health care efficiently, the HSO program has not received the attention it deserves.

David Wallik, MD
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[The author responds:]

Drs. Gibson and Wallik raise legitimate points which, because of space limitations, I was not able to address in my editorial.

One criticism of the HSO program as originally established was a lack of clear expectations.[1] Nevertheless, the program *was* expected to promote some specific changes in the provision of primary care, such as the placement of greater emphasis on clinical prevention and health promotion. A 1988 study[2] surveyed disease prevention and health promotion activities in HSOs, community health centres (CHCs) and fee-for service practices. At that time, HSO practice did not differ significantly from fee-for-service practices in terms of knowledge of or compliance with selected recommendations of the Canadian Task Force on the Periodic Health Examination. The increased use of nonphysician personnel was another aim. In general, the use of nonphysician health professionals has been modest.[2]

The important goal of reducing the rate of hospital admissions has received little study, but it is apparent, as Gibson states, that there are no significant differences between HSOs and fee-for-service practices, after physician and patient characteristics are taken into account.[3]

Difficulties with policies concerning the capitation rate, negotiation, arrangements for specialties and the Ambulatory Care Incentive Program

had, by 1991, resulted in extraordinarily high costs. Contract changes instituted in 1993 have addressed many of these issues and have reduced the per capita cost for primary medical care to an amount only marginally greater than that for fee-for-service patients. I am unable, however, to verify Gibson's assertion[4] that, within the current contract, capitation rates are based on the provincial average per capita costs.

Wallik mentions the scepticism associated with the HSO program; this may result from problems, especially with costs, that the program experienced before reforms were introduced in 1993. It would be unfortunate, as I attempted to point out in the original article, if this were interpreted either as evidence against capitation funding in general or as implying that there is no role for the CHC system in primary care reform.

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2. Abelson J, Lomas J. Do health service organizations and community health centres have higher disease prevention and health promotion levels than fee-for-service practices? *Can Med Assoc J* 1990;142:575-81.
3. Birch S, Lomas J, Harley J, Lomas L, Stratford-Devai F. *Effect of a financial incentive to reduce hospital utilization in capitated primary care practice.* Hamilton (ON): Centre for Health Economics and Policy Analysis; 1994.
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CPGs: To reach the unreachable goal?

The articles "The effects of clinical practice guidelines on patient outcomes in primary care: a systematic review," by Dr. Graham Worrall and associates (*Can Med Assoc J* 1997;156[12]:1705-12), and "Canadian physicians' attitudes about and preferences regarding clinical practice guidelines," by Dr. Robert S.A. Hayward and colleagues (*Can Med Assoc J* 1997;156[12]:1715-23), and the accompanying editorial "Clinical practice guidelines on trial," by Dr. Hayward (*Can Med Assoc J* 1997;156[12]:1725-7), are valuable additions to the literature on the topic of clinical practice guidelines.

However, I am concerned with the concept that change in patient outcomes is the only measure of success or failure of guidelines. In my view, a guideline that can reduce the resources needed to care for a patient, without changing the patient outcome, releases resources to be used elsewhere and can hardly be seen as a failure. We should set high standards, but let us not make them unattainable or unrealistic.

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Received via email

Addressing needle-stick concerns

One solution to the problem of patients not consenting to testing for diseases communicable to a health care provider, described in the letter "Needle-stick concerns," by Dr. Jeffrey R. Sloan (*Can Med Assoc J* 1997;156[9]:1267) is to get consent for such testing in advance. Every consent form used in an institution should contain a section stating that if a health care provider is exposed to the patient's blood or body fluids, consent is given for appropriate testing of the patient for communicable disease.

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The US attack on Cuba's health

The remedy for Cuba's problems is simple — free elections, not the pro-totalitarian propaganda presented in "The US attack on Cuba's health" (*Can Med Assoc J* 1997;157[3]:281-4), by Dr. Anthony F. Kirkpatrick.

The only "attack" on the health of Cubans comes from its totalitarian regime, which is incapable of producing wealth. Only the US maintains a trade embargo on this dictatorship, which can purchase whatever it wants elsewhere — if only it had something to trade in exchange.

Fidel Castro and his communist hierarchy are well provided for in their own exclusive health facilities, even as the population suffers.

Akselis Lielmanis, MB
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Although an anti-US mode is almost mandatory in Canadian journalism, it is unacceptable that our journal should be used by an American dissident to expound his political distortions against his own country. He has done the same thing in the United Kingdom and elsewhere. To make matters worse, you have obviously not peer reviewed his contentions properly.

Please tell me which dread epidemic caused 50 000 people to suffer from "optic neuropathy, deafness, loss of sensation and pain in the extremities and a spinal cord disorder that impaired walking and bladder control" as a result of the Cuban Democracy Act, within 5 months of the act being passed by Congress. What is the diagnosis and how is it so rapidly attributable to US calumny? Who is blockading supplies from Cuba's friends in China and Europe? Why should the US provide succour to a country that voluntarily lent its territory as a platform for nuclear Armageddon?