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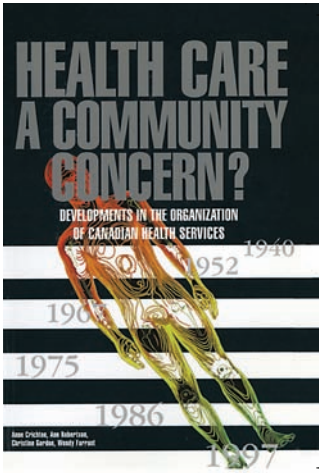

HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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CHAPTER 11

Medical Practice Organization: Alternative Medical Care Delivery Models

This chapter is divided into two sections: discussions of Community Health Centres and other alternative delivery models.

Concurrent with the planning to introduce Medical Care Insurance in 1966, there was some interest in the prospects of restructuring medical care organization. The Canadian Medical Association (CMA 1967) gave its support to the group practice model. How this concept was developed was discussed in Chapter 9. It was not developed far because computerization of billing enabled many doctors to choose loose forms of individualistic practice organization with commitment to sharing overhead and backup services while maintaining their own patient lists.

The Community Health Centre Model of Practice/Centres locaux des services communautaires

Some practitioners and community members questioned all individualistic forms of practice organization whether solo or partnership practice.[1] They thought this form of organization did not have a place for consumer inputs other than through individual doctor-patient discussions, nor did it have any

1 For example the Saskatchewan Community Clinic physicians, the Community Health Services Association of Saskatchewan and the Canwood Association (Crichton and Anderson 1973) as well as the United Steelworkers of America, the Sault Ste. Marie and District Group Health Association and St. Catharines' Group Health Centres (Lomas 1985) *inter alia*.

incentives built into it for delegation to other health professionals (because the doctors were still paid by fee-for-service — with minor exceptions), nor were there any financial incentives to encourage disease prevention or health promotion approaches or to discourage the use of hospital referrals.

These reformers became interested in the concept of a "community health centre (CHC)" which is a form of group practice. It relies on teamwork among professionals — doctors and others — focuses on prevention of illness and promotion of health and works with a community board.

Canadians began to look across their borders for new models of practice organization which might not only be more economical but also provide better service to patients. Different provinces tended to be influenced by different models. The response from provincial governments reflected the ideologies of political parties in power as these reformers challenged the established medical profession for room to develop these alternatives.

The Ontario Experience with CHCs

Three United States Health Maintenance Organization (HMO) models were of special interest to Ontarians — the Kaiser-Permanente Medical Care program (Somers 1971; Saward, Blank and Greenlick 1967) the Health Insurance Plan of Greater New York (Dailey 1959) and Group Health, Puget Sound (Bloomberg 1969). Capitation payments are required to define an organization's population and budgetary resources and all staff are likely to be salaried, though bonuses may be paid for obvious cost savings. Health Maintenance Organization models save costs by keeping more patients out of hospital beds than traditional practitioners do.

Another HMO model which influenced Canadians in Ontario was that of the Group Health Association of America (GHAA). Lomas (1985) explained that the GHAA was established by the amalgamation of the Group Health Federation of America with the American Labor Health Association. The GHAA was based on four principles: "prepayment of the cost of medical care, group practice of medicine, comprehensive health care of a high quality under the direction of qualified professional personnel, control of policy and administrative functions by, or in the interest of, consumers of health services."

In all of these models, hospitals were part of the group practice organization and physicians were given incentives to keep their patients from using hospital beds unnecessarily.

Although health planners were interested in HMOs generally, this GHAA model was particularly influential on Ontario's thinking. Lomas has described how the trade unions in Ontario were concerned to protect their members' health in the postwar years before Medicare came in. Miners in

Sudbury, Kirkland Lake and Thunder Bay, autoworkers in St. Catharines and steelworkers in Sault Ste. Marie sponsored the establishment of family practice clinics for their members. Funds were raised from capitation payments and salaried doctors were hired. The miners' clinics did not survive when the hostile, traditionally oriented medical profession decided to close them down (Lomas 1985, 25) but the autoworkers and steelworkers and their supportive physicians resisted traditionally oriented medical opposition to their pioneering efforts to change the organization of services.

> In these early years the health centre doctors [at Sault Ste. Marie] found themselves almost universally excluded from the local medical society, from hospital committees ... from almost any referrals from downtown physicians, from social, cultural and recreational organizations in the city and generally from any decision making regarding local medical matters. On an official level everything possible was done to make the health centre doctors feel like second class citizens. (Lomas 1985, 72–73)

Opened in 1963, the Sault Ste. Marie Group Health Centre decided to ask for an independent study of its activities in 1966. Hastings et al. (1973) compared the work of that health centre with that of doctors in other forms of practice and found that "the Sault's consumer-sponsored prepaid group practice did indeed reduce the demands on the local hospital facilities, partly by greater use of their own diagnostic facilities."[2] The study concluded, "although the group practice had no financial incentive to economize on inpatient care, its rate of hospital utilization was lower by about a quarter ... it appeared that the group practice placed somewhat greater emphasis on health protection as against the investigation and treatment of disease, but utilization of both laboratory and radiologic services was certainly higher in the population served by the group practice" (Lomas 1985, 71).

With the passing of the federal Medical Care Act, 1966, and its provincial implementation in 1968, the situation for the Sault Ste. Marie and St. Catharines' Group Health Centres changed. They were no longer independent financial entities. They needed to negotiate how they could fit into the new provincial funding system. As well, the provincial government had to decide what attitudes to take and policies to develop regarding all alternative forms of primary care organization in order to see where the group health centres could be fitted in. Bayne (1988) has traced the development of policy in the 1970s in statements of the Ontario Health Council (an advisory body) and the Health Planning Task Force (Ontario 1974), both of which took an

2 It will be recalled that public hospital insurance had been legislated in 1957, so in Canada, hospitals were not part of a group practice organization.

evolutionary approach to the emergence of new models.[3] But these bodies were not the implementers of policy. Specific decisions had to be made by government for the existing centres. A Program Development and Implementation Group (PDIG) was set up to work out a resolution. Since the minister did not want to crush any new initiatives for structuring alternative organizations, the PDIG was instructed not to consider consumer sponsorship or community involvement issues as the major principle in restructuring. Instead it was to focus on alternative methods of payment to anybody proposing a different way of delivering primary care. One official was reported as saying: "Government is not in the business of providing services, it's in the business of paying for services" (Lomas 1985, 150). Vayda (1977) and Lomas (1985) have described how the Sault Ste. Marie centre struggled with officials for nearly twelve years before they were able to reach agreement on a relatively satisfactory framework of funding. The Health Service Organization (HSO) funding formula which was finally agreed upon, said Lomas, "was far from perfect, restricting, as it did, the possibilities for the development of new truly 'community' health centres ... the HSO program was still clearly subordinate to the fee-for-service system" (pp. 122–23).

Bayne (1988) has explained the HSO/CHC funding agreements which had been reached by trial and error over the years. There were, she said, six different models of organization:

> Ontario health centres are differentiated along two dimensions, (1) funding: capitation or budget and (2) sponsorship: physician, university/hospital, community, giving rise to six different types. Centres financed on a capitation basis receive funding according to the number, age and gender of the people who have enrolled and agree to use the centre. The amount the centre receives per enrollee is calculated on the basis of average costs for care for individuals with similar characteristics. Enrollees are at liberty to use services outside the capitation funded centre but payments to the centre are withheld for the month in which they do so. (p. 10)

This was the first set of rules worked out for payment of all centres whether community health centres or private practices funded by capitation rather than fee-for-service.

But Lomas (1985) said that these conditions of funding, the so-called capitation negation rules, were so tough on the city-based community health centres (CHCs) (which had to cope with much local competition) that many went under.

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3 The Health Planning Task Force built on the recommendations of the national investigation of CHCs (Canada 1972, 1973b) conducted in 1971–72, to be discussed below.

Bayne (1988) described the second form of funding which was then introduced:

> Centres financed on a budget basis receive an annual global budget to cover anticipated costs of a range of services. Supplementary funds may be sought from other sources. This funding method is better suited to the Community Health Centres' perceived role of providing health promotion, education and preventive services to the broader community, not simply to those enrolled as clients.
>
> Both capitation and budget funded centres are eligible for ambulatory care incentive payments (ACIP) if hospitalization rates of their clients are lower than average. (p. 159)

The terminology began to change. Health Service Organizations were capitation-funded group practices, CHCs were funded on a global budget.

After years of solitary struggle (because none of the centres found the conditions of funding were supportive and they had no room for outside activities), in 1981 the nineteen HSOs and thirteen CHCs still in existence decided to form an Association of Ontario Health Centres to maintain communication with one another. And in 1982, the new Minister of Health, Larry Grossman, met with the association to discuss his interest in CHCs.

A health planning task force (Ontario 1982) was set up to review HSOs and CHCs and to make recommendations on role, scope and funding: "the health centre was perceived by the Task Force to be an organizational arrangement which satisfied multiple objectives. ... Within a climate of cost consciousness, the health centre was a particularly appealing service model" (p. 56).[4] Nevertheless the need for a pluralistic approach to health care delivery was emphasized.

Following the task force report, a new branch of the ministry was set up to develop CHC policy but it was made clear that CHCs were expected to serve only high risk areas. And guidelines on global funding indicated that CHCs need only have "consumer input," not necessarily consumer boards. Bayne summed up the position in 1988: "The small number of health centres which exist in Ontario employ fewer than one percent of the general practitioner population and provide service to only 3 percent of the population."[5]

In another paper (Bayne 1988) argued that, in Ontario, the CHC concept had not caught on. HSOs (i.e., group practices remunerated on a capitation

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4 In a study of CHCs and hospital costs in Ontario, Barer (1981) had shown that CHCs were more economical than other service organizations.

5 Daly (1989) has discussed the marginalization of CHCs, using the decision to set up a CHC for native people in Toronto as an example.

basis) were growing in numbers but CHCs seemed to have reached stable numbers. The CHC paradigm had not been accepted in the province.

Further development of the HSO idea is discussed later in the chapter. The next section continues to explore the CHC idea.

The Saskatchewan Community Clinics' Experience

In 1962 a Community Health Services Association[6] was formed in Saskatchewan just before the Cooperative Commonwealth Federation (CCF) government enacted the provincial Medical Care Insurance Act. This provincial cooperative association sponsored the development of local associations wishing to set up clinics with consumer boards. By March 1973, thirty-seven of these local associations had been established, although only nine had been able to find clinic premises and doctors to staff them (Feingold and Tauberhaus 1968). By the end of the decade this had been reduced to five practices, of which only three could be considered to be conforming to the community clinic model (Crichton and Anderson 1973). These three were city-based clinics in Prince Albert, Saskatoon and Regina — clinics which worked closely together to define the meaning, and work out the feasibility, of CHC development.

The Saskatchewan community clinics were influenced by British models of practice. In the 1930s a CHC model had been developed in Peckham, South London and, although it had closed in the war, it was regarded as an ideal demonstration of a multi-facility health and social service centre (Pearse and Crocker 1945). Later in the 1960s the British National Health Service (NHS) moved to integrate general practice with public health nursing and social work services in local health centres. Another strong influence on British family practitioners was the work of Balint (1957) who was teaching "whole patient medicine."

Like the Sault Ste. Marie centre, the community clinics were embattled organizations determined to make their case against the strong opposition of the traditional medical profession (Tollefson 1963). There had been a doctors' strike over the introduction of the provincial medical care insurance plan. Settlement was finally reached between government and the organized medical profession in the Saskatoon Agreement, 1962 (Badgley and Wolfe 1967). The establishment of the community clinics (CCs) as alternatives to traditional practice at this time was so greatly resented by the established profession that they made sure that the agreement specified that there should be no payment method other than fee-for-service and that the community

6 There is a long history of cooperative community involvement in health planning in the province.

clinic boards' role must be limited to that of landlord in the rental of premises and equipment. As well, most established doctors refused to speak to the clinic physicians using the same hospitals, and tried to influence the hospital boards to deny privileges to newcomers joining CC staffs. Consequently, the boycotted doctors decided to appeal to the world at large to justify their stance. Wolfe and Badgley (1972), sympathizers, published a review of their work to show that they had a different philosophy which could only be realized through a form of organization other than traditional practice. Their approach was to "whole patient medicine" which emphasized physical, emotional and social care, in the context of family. The clinics' staff thought they could best provide this care by teamwork — general practitioners and specialists working closely together, backed up by allied health professionals — and working through consumer boards to educate their clients on good health practices. They published studies of teamwork (e.g., Wolfe and Teed 1967; Ghan and Road 1970; Mossing 1966) but were limited in developing their relationships with their consumer boards and vice versa.

Then they sought to put forward another justification of their work, their cost effectiveness. In 1969 the federal government responded to their request for an economic study, appointing D.O. Anderson, an epidemiologist, to review their patterns of practice as compared with other medical groups in the province. Although Anderson and Crichton (1973) found cost effectiveness difficult to prove, there were clear differences in practice organization which could be explained to the government (Crichton and Anderson 1973). Officials were then persuaded to change the method of funding to a line budgeting agreement which made it easier to finance the allied health professional staff.

A study by McPhee (1973) of hospital utilization by the clinics created some controversy. It was dismissed by CMA critics as "showing greater expenditure" (Korkok 1973a,b; Baltzan 1973a,b; Brandejs 1973a,b) although the government drew the opposite conclusions.

In 1973 the Canadian Medical Association (CMA) launched several other attacks on the clinics (Korkok 1973b; McTaggart 1973).[7] And in 1975 when the doctors at the Regina clinic walked out and set up a private fee-for-service practice nearby, many of the opposition doctors were not surprised at the defection. However, Young (1975) had reported that similar behaviour had occurred elsewhere when disagreements with community boards had become too much to bear. In time new doctors were found to restart the clinic. There are now four CCs in the province: another has been opened in Wynyard.

7 These attacks followed the national study on CHCs (to be discussed below).

In 1983 a further study of cost effectiveness showed that CCs made clear savings (Saskatchewan 1983), although the results of this study were not made public for six years for political reasons.

Texeira (1987) has drawn attention to the existence of eleven rural so-called CHCs in Saskatchewan. These will be discussed again in the chapter on rural health care (Chapter 14). Their approach differs ideologically from that of the community clinics. These community health centres are a redevelopment of rural hospitals. Texeira explained that any hospital board could open a centre staffed by a resident nurse on twenty-four-hour call and recruit part-time staff for laboratory, x-ray and maintenance services. Social services could also choose to use the facilities. Saskatchewan had been trying to close rural hospitals since 1970 or even earlier, and this was one way of cutting back the costs of maintaining an inpatient acute care facility.

Quebec's Centres locaux des services communautaires (CLSC)

The development of Quebec's CLSCs can only be understood when considered as one aspect of social restructuring brought about by the Quiet Revolution. The CLSCs were to be the point of entry to primary and community care. They were proposed by the Castonguay-Nepveu Commission (Quebec 1970–72) which reviewed Quebec's health and social services and recommended change.[8] Lésémann (1984) has argued that they were an amalgam of two models, that is, local health centres and community service centres (multiservice health and social service centres):

> The local health centre was the product of a theoretical model [which] ... reflected changes in the philosophy of health care aimed at overcoming the dominant logic of providing care only after a person had become ill, and promoting in its place a preventive, comprehensive, continuous approach that took the surrounding environment into account. Such an approach implied major changes in medical methods of practice along with changes in the patient's or "client's" expectations of the health care system. (p. 236)
>
> The list of planned CLSCs was, in fact, drawn up on the basis of studies of public health and social indicators using mortality and morbidity rates to identify the most well off areas and the areas with the most serious shortcomings of care. (p. 241)

But in addition to this epidemiological approach, there were external influences brought to bear by social activists concerned with community

8 The national study of CHCs to be discussed below, was set up by Maurice Le Clair in 1971. He was influenced by the Quebec approach to system reorganization.

development. These external influences were American. They stemmed from the neighbourhood health centre (Office of Equal Opportunity) models of the war on poverty (March 1968) rather than the HMO models which influenced Ontario. Lésémann (1984) said:

> The new type of local health centre ... was based on the principle of polyvalent health teams which would be active on the neighbourhood level and which could increase the effectiveness of health care by adapting it to the particular needs and "culture" of the local area. (p. 68)
>
> But, ... the two kinds of centre belonged to two different institutional traditions and the attempt to combine them ... seriously distorted and even undermined their evolution and development. ... Delivery of service and public participation rapidly appeared antithetical; planning and programmes conflicted with peoples' anticipation of their own needs; medical and community action soon became poles that were often diametrically opposed. (p. 237)

This dual objective for the CLSCs created problems of priorities. Should they be seen principally as centres for promoting health and delivering health care or as community development centres?

Lésémann (1979) reported that eleven of the first twenty-five centres were explicitly allocated to the major disadvantaged neighbourhoods in Montreal and Quebec City and certain other underprivileged towns or rural areas. In most of these areas there were already active citizens' groups. The other fourteen were set up as part of the reorganization of health care to replace the hospitals or other health facilities that were lacking, especially in isolated areas.

> The community service centre was identified with strategies for dealing with poverty and the need for a coordinated and integrated approach to this problem by all service organizations. ... [This model] relied heavily on public participation as a strategy for the social integration and organization of a people whose disintegration and disorganization constituted a danger. The ruling class sought, in fact, to "reach out" to the people. (pp. 236–37)

It should be noted that the CLSCs were at the foot of a hierarchical model in which the next level up was the Department of Community Medicine (DSC) in the district hospital. The old public health service had been abolished: the DSCs were to be the bodies responsible for policy analysis and development of community health programs and the CLSCs for carrying out their policies.

Lésémann (1984) saw the Quebec government's support for the CLSCs as an attack on the established medical and social work professionals by the

rising technocrats who were now in the position to make health and social service policy. He said that this new power elite (politicians and bureaucrats), which had planned and were beginning to implement a different provincial structure of health and social services, appealed to the radical left in the professional groups, to the community organizers (animateurs sociaux), and to some unionized general practitioners, to support the Quiet Revolution's changes in health and social service organization in the province but they were unsuccessful in winning over many members of the medical profession.

Lésémann (1984) identified two main objectives of CLSCs:

1. The search for the greatest productivity in the organization of services
2. The use of health and social service organizations as an instrument of social and political control of the population groups excluded from production (p. 236)

As in the other provinces where CHCs were set up, there was strong resistance from the majority of the medical profession, despite the fact that the government had tried to appeal to the lower status general practitioners for cooperation. Rodwin (1984) described how:

> The service oriented CLSCs provoked a strong response from the Quebec Federation of General Practitioners. In order to counterbalance the competition of CLSCs, it organized the creation of roughly 450 polyclinics in which physicians are sovereign and are reimbursed on a fee-for-service basis by the QHIB [Medical Plan]. The polyclinics range from small group practice offices to large multispeciality organizations. Often their distinguishing characteristic is the quality of their twenty four hour reception services. ... The bulk of ambulatory care in Quebec ... is still provided largely by solo practice, polyclinics or outpatient hospital departments. Although many of the CLSCs have made remarkable improvements in the direct provision of primary health care and social services to various communities that were poorly served previously, they have thus far failed to significantly re-allocate health resources towards comprehensive medicine. (pp. 145–46)

Desrosiers (1986a) has analysed general practitioner resistance on three levels — the FMOQ (union) wanted to be the sole negotiator for all general practitioners whether working in polyclinics or CLSCs, so they bargained to get direct payment for doctors from the medical plan, not payment through CLSC administration, and they worked to get a committee of doctors set up where three or more were employed in CLSCs. Thus, said Desrosiers, they managed to differentiate the doctors from all other CLSC employees and drove in a wedge. Now there was an association of CLSC doctors with a specific contract.

As well many clients bypassed the CLSCs completely. They went directly to the hospital emergency departments for care, believing that, if necessary, this portal would give them more effective entry into institutional services.

The government, committed to the development of the new structure of service organization, had to sort out its priorities for CLSCs. In 1974 the ministry reorganized and made it clear that it was more interested in providing expert services than in promoting advocacy activities. Community development was to be set aside in favour of functional integration into the social affairs network as "a complementary resource." By that it was meant that all CLSCs would have to take responsibility for serving certain "basic needs" such as home care and care for the handicapped (which had emerged as being important services following deinstitutionalization). These were to be organized out of the CLSCs (as was occupational health and safety, dental care, school health, etc., at a later date).

There was some resistance to this move of the ministry. The CLSCs formed a federation which at first expressed strong opposition to the emphasis given to service delivery over community development issues. However, within the next year, the federation became caught up in union negotiations as the employers' representatives and as such became more prepared to accept the ministry directives.[9] It became a strong lobby group for expert service delivery (Fédération des CLSC du Québec 1986a,b, 1988a,b, 1989; Poupart 1986; Gingras 1988).

There was a slow but gradual growth in the number of centres. In 1981 the minister (Quebec 1981) committed himself to providing complete CLSC coverage of the province (166 centres were to be set up, although this seems to have been an overestimate as there are now 159). A review of the position was made by the province in 1989 and 1990 (Quebec 1989b, 1990a).

In 1985 the Parti Québécois government decided it was time to review the restructured provincial health care system first introduced by Castonguay in 1971. The period from 1971 to 1985 had seen many struggles. Lésémann (1979) and Renaud (1981, 1987) were concerned about the growing power of the technocrats (politicians and bureaucrats), who thought they could change society through using the mechanism of state regulation. But the technocrats were not always successful in gaining control. One group which the technocrats had challenged were the self-regulating professionals whose

9 In 1977 the government and the federation tried to reach agreement on a joint definition of the meaning of CLSC. This was publicized in the FCLSC information bulletin (although the ministry refused to ratify the agreement). Rodwin (1984) noted that the Parti Québécois would not take a clear position at this time whether in favour of or against defining responsibilities or encouraging the growth of CLSCs (p. 137).

monopoly position was closely examined. New regulatory legislation was brought in (with the intention of protecting consumers more adequately). Yet it was found to be impossible to get much closer control over the seven self-regulating professions where only the experts could judge the quality of work of other experts and where the professional organizations had exclusive power to admit and discipline members.

Lésémann thought that during the seventies there had gradually developed a recognition that it was impossible to control medical power and that the CLSCs should operate only in the non-profit sector. Had the government accepted the coexistence of two parallel structures of medical care by the end of the 1970s? Were CLSCs to provide only for rural areas and the urban poor?[10] Renaud (1977) had justified their existence "as an essential sort of social movement representing human concern for others in a capitalist society." He had also shown (Renaud et al. 1980) that the CLSC physicians were more careful in their diagnostic work.

There was of course a third group in the power struggle, as identified by Alford (1975): the consumers of services, the community members. But they had little power *vis-à-vis* the professionals or the technocrats. Brunet and Vinet (1979) had shown the lack of power of the community representatives in the CLSCs, theoretically jointly managed by consumers and producers, though Godbout (1981) was less pessimistic about consumers' ability to influence change. However, he too was concerned that both users and producers of services were being told what to do by an ever-increasing central technocratic power. Unless there were another wide-scale consumers' social movement, he thought, a challenge to the bureaucrats was not likely to be effective.

Toward the mid 1980s there was a general desire to take stock of the Quebec health care system as it had developed in the previous fifteen years. The government set up the Rochon Commission in 1986 (Quebec 1988) to inquire into the total structuring of services[11] and Brunet (1987) was commissioned to review the CLSCs independently. There had been considerable changes in attitude to the situation and to some of the ideas about organization which did not seem to work very well.[12]

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10 A study by Delude (1985) indicated that they were not much used by anglophones but before 1985 there were not many CLSCs in anglophone areas because the CLSCs had first been opened in the poorer areas.

11 Rochon was appointed by the Parti Québécois. When the government changed, the Liberals set up a committee to inquire into privatization (Quebec 1986), but this was not followed through and Rochon was reappointed to finish his inquiry.

12 Marc Renaud and Claude Larivière, personal communication, 1992.

There were some who said that the CLSCs should abandon providing personal medical care services. Demers (1987) argued that they should leave medical care to the polyclinics and focus on health promotion activities. Trying to do both was "mission impossible." Brunet also proposed that services should be streamlined. They could not be all things to all people and the crisis of identity needed to be resolved. He recommended that priority should be given to servicing high risk groups, to reducing inequalities and to providing supportive community services.

Following the Brunet report, Bozzini (1988) wrote an evaluation of the model. He concluded that the government had accepted the two models of medical care, that CLSCs offered a different kind of medicine: "more community oriented, nearer to holistic medicine, tied in with the psychosocial components of basic primary care, more attentive to complex problems such as family violence, mental health, sexual abuse." Brunet had proposed that there should be complementarity, harmony with the private clinics and avoidance of duplications. "In brief," Bozzini said, "one enters the era of the alternative-complementary sector. ... It is too early to make predictions on how this cohabitation will develop" (p. 370). But he saw the CLSCs as the attempt to create a new society, a new culture, and so their discussions on policy within the Fédération de CLSCs and within the province generally were very important.

Later the Rochon report confirmed that service objectives should prevail, for there was no end to the growth potential of advocacy groups and streamlining should take place. The Rochon committee recommended a change in policy which built on a commissioned research paper by Quiviger (1987). This argued that government should recognize the resurgence of voluntary organizations since 1971. At that time the old charitable organizations had been swept aside in favour of funding community development through CLSCs. Now more consideration should be given to subsidizing independent voluntary bodies and linking their activities into a coordinated community approach, after consultation at the regional level.

In due course the Minister of Health and Social Affairs (Quebec 1989a) responded to the Rochon Report. *Improving Health and Well Being in Quebec: Orientations* set out the policy directions of government and identified several changes. There was to be a new policy for funding voluntary organizations:

> The network of services [that was established in the 1970s] took over from private institutions and charities. Methods of intervention were gradually assimilated into the public system's models. Mutual aid and voluntary work then found little place in a system that enhanced modernity by adopting values often opposed to the spirit of voluntary action. ... Today we no longer believe that pub-

> lic services have all the answers. ... The present day community movement is no longer confined to the traditional networks that once fostered it. ... The scope, quality and originality of its contribution attest to the impossibility of interpreting health and well being solely through the prism of public intervention. (p. 77)

This statement distinguished the work of voluntary community service activity from that in the established state services. Then the report went on to define the responsibilities of each level of the government structured service beginning with the CLSCs, which were to offer: medical and nursing services, psychosocial services, home care, services for children and families at risk, services for young people in trouble, mental health services and services for high risk groups.

Another response was produced by the minister's successor (Quebec 1990b). Disincentives were to be brought in to change public behaviour in demanding medical care. There was to be an introduction of charges for attendance at emergency departments for non-emergency consultations. Instead patients were to be encouraged to go to primary care physicians in the CLSCs or to polyclinics.[13] The CLSCs were to provide more information about their work and to be open for longer hours of service. Physicians in private practice were to undertake preventive activities, provide or link up with home care services and collaborate in providing a twenty-four-hour service or lose financially. In this reform CLSCs were expected to be the big winners: their revenues would be substantially increased. They were to replace the emergency departments of hospitals and to become the main portal of entry to the health care system.[14]

In both reports the ministers proposed new organization structures for community participation. The governing bodies of regions and CLSCs were no longer to be joint consumer/professional structures, but in future, to be composed of consumers only. Bill 120, an *Act Respecting Health Services and Social Services and Amending Legislation* (Quebec 1990), was passed in 1992, implementing these recommendations.

A National Investigation (1971–72)

Discussion of the national investigation of CHCs (John Hastings, chairperson) has been postponed until now so that the models chosen in three prov-

13 A profile of physicians available to give primary care was published early in 1990 (Maheux et al. 1990). Quebec, unlike other Canadian provinces, had followed the American pattern in which patients could choose their own specialists and go to them without referrals from general practitioners.

14 Marc Renaud and Claude Larivière, personal communication, 1992.

inces could be considered as the basis for that investigation. The story of the CHCs in Ontario, Saskatchewan and Quebec has been told both before and after the Hastings committee investigation as it seemed best to discuss these developments without interruption. It should be noted, however, that this national investigation (1971–72) came midway in the Ontario negotiations some time after the sides had been taken in Saskatchewan and contemporaneously with the establishment of the Quebec CLSCs.

A new Deputy Minister of Health had joined the federal government soon after it had affirmed its commitment to Medical Care Insurance, 1966. Dr. Maurice Le Clair decided that it was time to take stock, to review what should be the next move forward in health policy making (Andreopoulos 1975). Le Clair was influenced by his previous experience in planning primary care in Quebec. Among other investigations he decided to commission a national inquiry into community health centres as part of a possible restructuring in order to implement a comprehensive system of care. The committee was to make recommendations regarding the development of the model in Canada and whether it should be on a demonstration or more general basis (Canada 1972).

The committee took into consideration the CHC models developed elsewhere, not only in Canada (Roemer 1973; Badgley 1972; Kohn and Radius 1972), and consulted with a number of experts on the feasibility of introducing the concept into Canada (Fish 1972; Alix 1972; New 1972). Special attention was given to the idea of consumer participation (Klein 1972; Haughton 1972).

The sociologists on an advisory subcommittee identified the following problems as likely to have a negative influence:

1. Community involvement: citizen participation. There was ambiguity about the degree of participation which would be tolerable to health professionals, administrators, politicians and citizens
2. Priorities: Spectrum of Medicine and Social Services: Ambulatory Care. There was ambiguity about the range of services to be provided, the mix of health and social services and the self sufficiency of the centres in providing primary care
3. Staffing: New Categories of Health Workers. The relationships of health professionals were likely to change in the proposed clinics. There were ambiguities about team work
4. Funding. Traditional methods of funding would need to be changed if the centres were to become viable, but in what direction should changes be made? How should doctors be paid?
5. Structures. The concept of "CHCs" implies decentralization but who, then, should be in control — doctors or laymen? How best could control problems be resolved? (Crichton, 1979, 21–22)

Despite the fact that many of the expert advisers had expressed their doubts about the feasibility of introducing CHCs (Canada 1973b), the committee reported to the Council of Health Ministers of Canada (Canada 1972) that there should be:

1. The development by the provinces, in mutual agreement with public and professional groups, of a significant number of community health centres ... as non-profit corporate bodies in a fully integrated health services system
2. The immediate and purposeful reorganization and integration of all health services into a health services system to ensure basic health service standards for all Canadians and to assume a more economical and effective use of all health care resources
3. The immediate initiation by provincial governments of dialogue with the health professionals and new and existing health service bodies to plan, budget, implement and evaluate this system; the facilitation and support of these activities by the federal government through consultation services, funding and country-wide evaluation (p. i)

The rationale given was: "In summary, CHCs are increasingly seen as an important means for slowing the rate of increase in the cost of health services and for more fully reflecting the objectives, priorities and relationships which society wishes to establish for health care in the future" (p. ii).

Crichton (1979), reviewing the work of the committee in retrospect, argued that there had not been enough time for it to do its job properly. The chairperson, anxious to have a unanimous set of recommendations, assumed that there was a real consensus among the members, when in fact there were hidden disagreements. At one point there had been open conflict over a paragraph relating to payment systems, but a formula had been found which papered over the split. She thought that the recommendations were a reflection of the belief system of the chairperson and his supporters rather than a clarification of the true situation. This bias in the report did not become clear immediately, but hostility began to be shown within a short time after publication, a hostility which escalated quickly and divided the community of interest into two distinct camps — for and against. Some six years after the report was published, Hastings (1978a) was still optimistic, but by then he had identified the opposition — the medical profession, the hospitals and some of the provincial administrators. This was a formidable coalition of interests to have working against the model.

Experiences in Other Provinces

Manitoba

Manitoba had elected a New Democratic Party (NDP) government in 1971 and it quickly developed a new health policy (Manitoba 1972). Dr. Ted Tulchinsky, who had experience in CHC development in Ontario and on the federal investigating committee, was invited to join the government in order to develop a group of about fifteen CHCs. "There was some conflict between the medical profession and the Manitoba government at this time which went far beyond the issue of setting up health centres and was related to the broad question of professional autonomy and professional rewards" (Crichton 1979).

In 1991 Crewson[15] reported that the District Health Centres Act, 1972, enabled interested sponsors to choose a variation of the model which would suit local situations. Nine centres — four urban and five rural — were set up. One Winnipeg clinic became an outreach arm of the University of Winnipeg Health Sciences Centre. All were relatively small institutions. Though most chose to have salaried doctors, they had been given a choice regarding payment mechanisms.

How the health centres came through this period of struggle has not been documented. In 1978, an informed observer thought that the rural health centres came closest to the CHC concept, although the urban centres were more innovative in their ideas (Crichton 1979). With the election of a Conservative government in that year, all CHCs were challenged and expected to evaluate their services in order to get continued provincial funding. Meanwhile the labour movement in the province came out in strong support of the concept (Black, Cooper and Landry 1978). Presently there are five rural and ten Winnipeg CHCs.[16]

British Columbia

In British Columbia an NDP government was elected in 1972. The history of the CHCs in the province can be traced first from articles about the REACH Clinic and other health centres which had been started in 1969 before the government decided to take a hand in policy development. Tonkin (1979), Harrison (1982) and Clague et al. (1984) have described government interventions after 1972. The NDP commissioned a report on health needs of the province from Foulkes (1973) who recommended a broad restructuring of

15 Herman Crewson, personal communication, 1991.

16 Phyllis MacDonald, personal communication, 1991.

services, including the development of CHCs. By the time Foulkes' report was published the government had recognized that there were going to be problems in implementation for he had been embroiled in heated discussions with community groups when he toured the province to sell his ideas.

In the meantime, however, the Community Health and Human Resources Centre (CHHRC) Development Group had been set up by the provincial government to examine requests for provincial support of CHCs. These requests were prioritized and funding was provided to start up services in five areas where there appeared to be need. (These were mainly rural areas, though James Bay in Victoria was an inner city enclave).

Tonkin (1975), reviewing the situation generally in the province, listed four other downtown clinics in Vancouver (the Fairmont Centre linked to a union-based insurance company, the downtown CHC in a depressed inner city area, the Pine Street Clinic — a public health outreach clinic for street people — and the Women's Health Collective). He also mentioned the student health service on the University of British Columbia campus. All these were functioning in addition to the provincially backed centres. Most of these have survived to the present day, though evolving over the years. The REACH Clinic has developed a subsidiary, the Mid Main Community Health Centre Association (1990).[17]

When the NDP government was defeated in late 1975, the Social Credit government decided to end further support for new CHC development and set up an audit committee to review the existing clinics. Unable to ignore the positive report of the audit committee (British Columbia 1977) the government decided to continue to maintain them, but there was only one further development of the CHHRC program after 1975,[18] until the present NDP government gave strong encouragement to the movement in its new directions policy. Clague et al. (1984) have indicated that it was not only political opposition which had killed the idea, but that the bureaucrats responsible for provincial public health policy had found that CHCs did not fit in with their plans for service delivery and had undermined any innovative proposals.

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17 The Mid Main Community Health Centre Association is providing an opportunity for nurses from the Vancouver Health Department to develop their skills in community development. The clinic also works in partnership with the department on multicultural issues, youth clinics, prenatal and postnatal classes, immunization clinics, volunteer coordination and baby clinics.

18 A provincially funded community health centre was set up in a new mining settlement at Tumbler Ridge in 1985 where there were no other services.

Other Provinces

The basis of this study was a literature review, and although efforts were made to visit and discuss developments with as many provinces as possible, those which did not publish discussions about their CHCs may be underrepresented in this discussion.

These developments were brought to notice:

1. Alberta decided to not take action on CHCs but to revamp its outdated public health programs (Brunelle and Norquay 1978). However, through voluntary action, a downtown CHC was started in Edmonton serving displaced native peoples as well as inner city poor people (Kelly 1980; P. McClelland 1984). The Alexandra Community Centre was set up in Calgary
2. Nova Scotia has been conservative in its approach. There is one "anomalous clinic" (to quote the administrator),[19] the North End Clinic in Halifax, which serves an inner city clientele and has been in existence for more than twenty years. There is no documentation on this clinic except for a report on a health education project (Martell 1989)
3. Newfoundland already had its cottage hospital service when the CHC idea was promoted but it did start up a university coordinated CHC in an urban renewal area of St. John's (Brooks 1975)
4. Rural health centres are discussed further in Chapter 14. These are not necessarily CHCs which have an ideological base. They may be restructurings of rural hospitals

Canadian Council on Social Development (CCSD) National Conferences on Community Health Centres: Evaluations of Progress

In 1983 the CCSD called a national conference on CHCs to examine the reasons for their failure to evolve. Eschauzier (1983) listed these reasons as:

1. Lack of political commitment and uncertain and inappropriate methods of funding
2. Professional resistance
3. Inter-professional conflict
4. Unclear role for community participants
5. Resistance from other established organizations
6. Image problems re poor and under privileged
7. Lack of models and practical guidelines for operators
8. Lack of documented evidence re worth

19 Johanna Oosterveldt, personal communication, 1990.

The CCSD continued to keep the subject alive, holding another conference in 1985 on community-based health and social services, at which the problems associated with expanding the role were again reviewed and reported by Gilmore (1986).

The Future of CHCs?

Throughout the 1980s other people worked to keep the idea of CHCs alive. Rachlis and Kushner (1989, 1994) and Angus and Manga (1990) promoted the idea in their publications. Angus and Manga concluded their review of consumer sponsored health delivery as follows: "There does not appear to be much doubt that the system will change. ... Any alternative health care delivery model which stresses community participation, health promotion and disease prevention and different reimbursement mechanisms will form an integral part of that change. ... Hence it would seem fruitful to foster and enhance the community participation approach in health and health care" (p. 56).

In the last few years the context has been changing. The majority of provinces have set up regional boards of selected consumers and are working hard to develop community health councils with lay participation in policy development. It seems likely that some of these will want to promote CHCs in their areas.

Other Alternative Medical Care Delivery Modalities which Emphasize Coordination of Services

Angus, Tregunna and Dunne (1989) have identified eight alternative models of ambulatory medical care which can be substituted for the traditional patterns of practice, and all of these will be explored (though not under the same headings). Angus et al. point out that the medical care system is unlikely to change while incentives to physicians and other health professionals are not sufficient to encourage change. However, the failure of the CHC concept to become accepted as a major substitute for traditional medical care organization has led to a search for other models which might be more acceptable to the medical profession and more likely to succeed. Health economists and other planners have been trying to find what these other models might be.

Development of Health Service Organizations in Ontario

Adaptation of the United States' HMO model continues to be regarded as a distinct possibility, if only Canada can find the right modifications to make, so that it will fit in with the established structures (Boisvert, Gosselin and Pineault 1987).

After the introduction of Medicare, the Ontario government embarked on the process of funding HSOs rather than CHCs only (as explained earlier), thus opening the door to development of a wider range of alternatives than community sponsored clinics alone. The six types of HSOs and the two methods of funding were discussed above. All HSOs are funded by capitation and must provide general practitioners' services. Some may provide specialists' services. Other objectives of HSOs are: to create an environment supportive to physicians and other health care personnel which allows flexibility in meeting the needs of the HSO population, and to develop a coordinated health care delivery system that is accessible, economic and efficient, which emphasizes health promotion and prevention activities and decreases institutional care through using ambulatory care, self care and home care. However, there is no financial linkage between hospitals and doctors' offices as in the American HMOs.

Towards the end of the 1980s the Ontario government began to encourage more group practices to move into the HSO modality (Peachey and Linton 1988; Henderson 1990). Roch (1986) thought that the oversupply of physicians was making the concept of alternative delivery modalities more attractive to general practitioners, although specialists were less likely to be recruited. And the most difficult posts to fill in HSOs were those of managers. Weinkauf and Scully (1989) have also reviewed the reasons for the resurgence of interest in the concept, while Birch et al. (1990) made a critical appraisal of research on HSOs up to that time.

Towards Comprehensive Health Organizations in Ontario

Reviewing other possible alternative delivery modalities (ADMs), Stoddart and Lomas (1986) made it clear, that for funding bodies, the American HMO model is the most attractive alternative organization structure because it solves the problem of vertical integration. While improving the internal management structure of medical practices should not be underestimated, it is tightening the link between office practice and the hospitals that is the most important way to increase cost effectiveness. Decreased hospital utilization is the key issue, therefore, for establishing effective ADMs, "a minimum requirement will be some mechanism for control over hospital capacity" (Stoddart and Lomas 1986, 2). However, reformers realized that the absence of enrollment "lock-in" in the capitation funded (HSO) practices of Ontario[20] had made it difficult to achieve the savings of the American

20 The Canada Health Act, 1984, had reasserted the principles of free choice of physician and free choice of patient. This had been interpreted as preventing "lock-ins." The conference thought the act did not actually say that "lock-ins"

HMOs.[21] "Effective enrollment of patients is central to the concept of an organization which manages care in both its members' and its own interests" (Stoddart and Lomas 1986, 3).

Roch (1986) said that in order to move forward, governments would not need to introduce new legislation. And so in 1989 Ontario decided to sponsor Comprehensive Health Organizations (CHOs) (Ontario 1988b, 1991a), defined as non-profit corporations which undertake to provide or purchase *a full range* of health and related services to a defined population. A management team guided by a community board made up of patients, members, providers and community representatives was to run a CHO. Linton and Peachey (1990) later identified two emergent models of CHOs — the one which has attracted smaller communities' interests and the city hospital model (Mickevicius 1991). Another model has been developed in Ottawa where the hospitals have given up a part of their budgets to fund two community-based CHOs in the city.[22] Doctors have expressed some concern that the CHO model will result in underservicing because incentives encourage a decrease in referrals. They asked: was this quite ethical? (Linton, Peachey, and Boadway 1990; Brosky 1990).

Organizations des soins intégrés de santé (OSIS) in Quebec

Quebec decided to set up three pilot CHOs (based on the American HMO model) in Montreal, Quebec City and Sherbrooke (Beaudin 1989). These link primary care with hospital services. The OSIS are financed on a prospective payment basis within the provincial health care system (Levine 1988). The organizations take the responsibility for delivering directly, or contracting for, all publicly insured services for a voluntarily enrolled population over a period of time. Charrier (1989) indicated that opinions about their success were divided.

Multiservice Centres

Multiservice centres may provide all or some of the following services: medical care, pharmacy, physiotherapy, occupational therapy and social services. The work of these centres was reviewed by Hepworth (1976). Stewart (1982) has set out the objectives of multiservice centres:

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were illegal, but challenges were likely to be brought which would be disruptive if "lock-ins" were tried out.

21 Fox, Heiann and Steele (1987) have assessed reasons for success and failure of American HMO models, and Abel-Smith (1988) considered international experience.

22 Gail Peters, personal communication, June 1990.

1. To enable the gradual establishment of an efficient, effective and comprehensive network of accessible community services
2. To make maximum use of, and actively coordinate, existing services, programs and resources both in the professional and voluntary sector
3. To place an equal emphasis on promotion of healthy life styles and quality of services
4. To achieve maximum community participation in the planning of services

Stewart reported on the methods used to achieve those objectives of horizontal coordination in a suburban multiservice centre in Nova Scotia. The emphasis was placed on the horizontal integration of services which could be publicly or privately provided. The centre uses "team case management" to promote collaboration between service agencies, and interagency meetings and seminars to promote communication. The centre has set up a representative community board with subcommittees involved in planning, management, budget supervision and development of public relations. Marentette and Kurji (1988) have argued that multiservice centres can form a good base for community development. However, as noted in Chapter 9, doctors have not been very interested in moving into multiservice centres despite the fact that they can continue to be paid by fee-for-service.

Hospital Affiliated Ambulatory Care Centres

As Angus, Tregunna and Dunne (1989) pointed out, the need for more beds, the need to free up existing beds, and/or the desire to expand their market can lead hospitals to consider providing ambulatory health care services. These authors distinguished between hospital-based ambulatory care (clinics in the same building as primary, secondary and tertiary care hospitals) and free standing clinics in remote centres affiliated with a hospital. It was only the free standing clinics that they thought met the definition of ambulatory care centres. However, the 1991 program for the Canadian College of Health Service Executives' (CCHSE) Ambulatory Care Conference was concerned not only with community-based satellite clinics and extramural hospital care but also with hospital-based services.

Clinics attached to the hospitals usually provide care which cannot easily be given in doctors' offices: surgeries such as tubal ligation (Fraser 1990), or monitoring of serious chronic illnesses which require specialist supervision, such as haemodialysis treatment (Peters 1980). But there are diet counselling clinics (Schwartz, Bell and Webber 1987) and other educational services such as a blood pressure screening clinic (Abbott, Alstad and Yeo 1989) or a psychogeriatric monitoring clinic (Kral, Palmer and Yakovishin

1986) which may not have any good reasons for being hospital centred other than that the money to pay dieticians, nurses, psychologists and so on has been in hospital budgets.

Angus, Tregunna and Dunne said that there are many arguments for and against free standing clinics but the main ones they identified were (for) the wider range and better quality of care which may be provided by a hospital and (against) the irreconcilable differences in the goals and functioning of hospitals and ambulatory care services, including the hospital's focus on institutional care as opposed to community-based care.

Multi-Institutional Arrangements

Gelmon and Fried (1987) reviewed the literature on multi-institutional arrangements. Most of the studies were American but one section on the Canadian experience reviewed mergers of hospitals with other services across the provinces. Apart from three studies in Quebec, where there had been pilot projects of rationalization between rural hospitals and CLSCs these were not studies of hospitals with ambulatory care centres attached (C. Bégin 1977, 1984; Bégin, Bergeron and Joubert 1984). These were studies of coordination of acute and long term care institutions.

The Hospital-Community Partnership Project, British Columbia

The British Columbia government set aside a small proportion of its hospitals' budgets in the *Hospital-Community Partnership Program* (1989b) for:

1. Programs to assist in utilization management of hospital services, such as quick response teams; short term assessment and treatment centres' geriatric evaluation, assessment and rehabilitation units; adult day care centres and palliative care teams
2. Programs to prevent disease, promote health and generate healthy public policy such as prevention of heart disease

Although the main requests for funding were to improve hospital utilization, some breakthroughs were made in community development projects (Ryan, Rowlands and De Paoli 1991). Later following the report of a provincial inquiry into health services in the province entitled *Closer to Home* (British Columbia 1991), the government funded a series of projects in the community. These grants are to continue after the proposed projects come to an end for development of community services.

In 1990 the government of Saskatchewan also invited applications for monies from hospital budgets to be set aside for community projects (Saskatchewan 1990b).

However, one can regard these as interim activities. Most of the provinces have now restructured themselves into regions which will have the responsibility for improving coordination at the local level.

Walk in Clinics

In the opposite direction from improving coordination of services and continuity of care is the development of walk in clinics (Milne 1987). There has always been a continuum of primary care, at one end of which the family doctor stresses the importance of the continuity of the doctor-patient relationship (Biehn 1990) while at the other end, the physician asks no questions beyond the ones immediately necessary for making a current diagnosis. Walk in clinics are simply an extension of this continuum at the impersonal end, whereby service is provided quickly and without long-term commitment, in shopping malls or other centres of community activity. These walk in clinics may be community-based or hospital emergency department-based.

A study of a paediatric walk in clinic by Feldman and Cullum (1984) showed that clients came there for two main reasons: the broad range of services offered (laboratory, radiology and pharmacy in addition to medical care), and the hours convenient to them, outside regular office hours of paediatricians. Béland (1989) found that continuity of use of physicians' services varied with the volume and regularity of use. Low volume was associated with change. Rizos et al. (1990) examined the implications of walk in clinic developments for family practice organization (hours, competition for income, etc.).

Miller et al. (1989) described Ontario walk in clinics and reviewed the literature. They have questioned their cost effectiveness.

Independent Health Facilities

In most provinces walk in clinics appear to be working within the medical or hospital insurance plans but in Ontario at the end of the 1980s the government thought it was necessary to legislate to bring "the independent health facilities" under better control. In that province a number of entrepreneurs had started to offer day care services in an out-of-hospital setting, providing medical and surgical procedures in an environment somewhere between a doctors' office and a hospital. The Minister of Health decided that new legislation was necessary to ensure that such facilities were properly funded, that quality control was increased and that the proliferation of new diagnostic centres was curbed through regulating licencing and funding (Ontario 1989b). Examples of services which can now be given are:

1. Outpatient surgery procedures such as cataract surgery or orthopaedic procedures
2. Comprehensive and integrated services such as women's health programs
3. Diagnostic services such as bladder and heart investigations, radiology and ultrasound
4. High technology procedures such as laser technology in the treatment of diseases of the eye and uterus

The *Independent Health Facilities Act* was expected to eliminate user fees for regulated facilities.

This issue has now become a major concern for other provinces too. Should private clinics be allowed to charge the provincial government for services provided outside the public hospitals? If so, at what level should these changes be met? Should private clinics be allowed to exist at all? These questions will be addressed in the final chapters on policy development.

Summary

This discussion of alternative care delivery models is divided into two parts: a report on the evolution of community health centres and a listing of other alternative delivery models such as Health Service Organizations (HSOs) and Comprehensive Health Organizations (CHOs) in Ontario, Organizations des soins integré de santé (OSIS) in Quebec, multiservice centres, hospital affiliated ambulatory care centres, multi-institutional arrangements, the British Columbia and Saskatchewan Hospital-Community Partnerships, walk in clinics and independent health facilities.

The development of community health centres (CHCs) varied from province to province because different models were used — Ontario's based on United States Health Maintenance Organizations (HMOs), Saskatchewan's on the British Peckham community health centre model and Quebec's on the American neighbourhood health centre (OEO) idea but also on an epidemiological analysis of provincial needs and a provincial health plan.

Building on the experiences of these provinces, a national committee (Canada 1972, 1973b) recommended that provincial governments should encourage development of CHCs across Canada but the proposal met with considerable hostility from the established medical profession. Except in Saskatchewan and Quebec, the CHCs which have been established now tend to serve inner city or rural populations, though there is a renewed interest in the concept for overall use since regions have been formed.

This chapter goes on to examine how the Province of Ontario has developed its payment system for doctors to include not only CHCs but other

forms of group practice (HSOs). And groups which reduce the demand for hospital services for their patients may be remunerated as Comprehensive Health Organizations.

After looking at other alternative practice organizations, such as walk in clinics, the chapter ends by raising the issue of independent health facilities and their relation to the mainstream system.