A STUDY OF COMMUNITY CLINICS: EVIDENCE, CONCLUSIONS AND RECOMMENDATIONS

by the Community Clinics Work Group, Medical Reform Group

There is much that is unsatisfactory about the organization of health care in the province of Ontario in 1980. The following report represents the findings and conclusions of a committee of the Medical Reform Group which has examined the possible role of community clinics in helping to correct the problems of the health care system.

THE PROBLEMS

1) Preventive Medicine and Patient Education- The present fee schedule of the Ontario Health Insurance Plan does not even include a category for patient education. The fee for service system is notorious for providing incentives for physicians to see as many patients as possible in the shortest period of time. Physicians, working as private enterpreneurs, attempt to hire nurses and receptionists at the lowest possible cost. It is not in their financial interest to employ someone with training and experience in patient education or preventive medicine who would demand a higher salary. The lack of payment for these services is one of the contributing factors to the present health care system in which the overwhelming focus is on diagnosis and treatment of acute illness.

2) Inpatient versus Outpatient- Community practitioners are largely isolated from social service agencies which may be of benefit to the patient. The resources on which they can call in an attempt to manage a patient at home are often limited. When these resources do exist, there is minimal integration between physicians and the individual or

organization delivering the home care. This lack of fully developed outpatient services leads to a greater utilization of hospital care than would be necessary if adequate community supports were available.

3) Control of Health Care Delivery- The only control health care consumers have in the present system is the decision regarding which doctor to see. Neither patients nor health care workers, including doctors, have effective control over priorities in government health care spending in the community.

4) Hierarchy Among Health Care Workers- At present it is the doctor (or doctors) who decide how an individual office is to be run. Other office members, who are in the doctor's employ, have at best an indirect influence on the functioning of their workplace.

5) Education of Health Care Workers- Most primary care physicians in Ontario today do not have easy access to day-to-day educational activities. Doctors are often physically isolated from their peers, from specialists, and from those working in other related disciplines such as physiotherapy and occupational therapy. The opportunities for learning through informal contact with colleagues may be negligible. As a result, much of the doctor's information concerning therapeutic advances comes from the often misleading drug salesman, and from drug advertising in general.(1) These problems in continuing education of physicians also apply to allied health care workers.

6) Saving Money- The present Ontario government, in its words and its behaviour, has conveyed an intense concern with health care expenditure. There has even been talk of a crisis in health care costs. We do not believe that such a crisis exists. Health care costs as a percentage of

the gross provincial product have not increased significantly in the past ten years.(2) We feel that government concern should be directed more at guaranteeing optimal care, and less at decreasing costs.

Nevertheless, there is no doubt that there are inefficiencies in the present structure which lead to unnecessary expenditures.

COMMUNITY CLINICS: COULD THEY HELP?

In the following discussion, when we refer to community clinics we are speaking of a group of health care workers with a broad range of special skills, operating out of a single physical facility, and assigned the tasks of patient education, the practice of preventive medicine, and the diagnosis and management of illness. We are speaking of a clinic in which workers, including the physicians, are reimbursed according to the time they spend on the job, and not according to the number of patients they see. A clinic would be charged with the responsibility of providing comprehensive care, including 24 hour a day service. In addition, we are referring to a system of organization in which the power to decide on the disposition of funds would be shared equally between clinic users and staff.

1) Preventive Medicine and Patient Education- The stress on these two facets of patient care is one of the key distinguishing features between what we mean by a community clinic and traditional group practice. The practice of preventive medicine would operate on the levels of primary, secondary and tertiary prevention. Examples of the sort of approach we are referring to are as follows:

Primary prevention: Counselling concerning nutrition, pre-natal classes,

child care instruction, and family planning would all serve to prevent the development of physical illness and family dysfunction.

Secondary Prevention: This includes educational programs for such chronic diseases as diabetes, renal failure, and congestive cardiomyopathy (heart failure). Improved patient understanding of these diseases can lead to a more active life and fewer complications. Counselling for families with such ongoing problems as alcohol abuse, a disabled family member, behaviour problems with children, and chronic illness also falls into the category of secondary prevention.

Tertiary Prevention: Maintenance and rehabilitative programs for patients with such conditions as a previous cerebrovascular accident or severe chronic airflow limitation can decrease the morbidity associated with ongoing illness.

These three levels of prevention would be an essential aspect of the ongoing care of individual patients and would play a role in virtually every interaction between patient and health care worker. As well, organized programs for people with similar problems or concerns would be an integral part of the clinic's service to the community. This approach would both prevent the development of disease and help patients to cope successfully with physical and social problems.

Controlled trials designed to demonstrate a decline in morbidity as a result of preventive and educational programs are very difficult to do. Nevertheless, there is a growing body of evidence which testifies to the benefits of such programs. Programs for patients with respiratory disability have been successful in reducing hospital stay(3,4), improving work tolerance and diminishing anxiety, depression and hostility,(5) and in decreasing clinic visits.(6) Educational programs have been effective

both in decreasing utilization of medical services in children, without adverse outcome to their health(7), and in improving nutrition in high school students.(8) In the psychiatric context, consultation and teaching in a home for the aged resulted in a drop in requests for direct service, the establishment of group programs for residents, and a decrease in the incidence of psychiatric hospitalization.(9) The provision of diet counselling and supplemental milk to a group of low income pregnant women at high risk for subsequent infant morbidity led to a decrease in the incidence of prematurity and low birth weight infants.(10)

Clearly, the potential for educational programs and preventive medicine in decreasing morbidity and lessening dependence on medical personnel has just begun to be tapped. A community clinic with the resources to deal with patient education on the individual and group level would be an ideal way to explore this potential and would have widespread application.

2) Inpatient versus Outpatient- Being admitted to a hospital is an unpleasant experience for most patients. Hospital care is expensive, and the risk of nosocomial infection is significant. The advantages of hospital admission for conditions previously thought to require institutional care are being questioned.(11) Clearly, it would be desirable to shift as much of ongoing medical care as possible to the outpatient arena.

To do so, however, will require both a change in attitude on the part of the medical community, and a commitment to reallocation of funds by the provincial government. One of the required changes, that of shifting the focus from treatment of disease to preventive medicine, has been dealt with in the preceding section. In addition, increased availability of rehabilitative services such as physiotherapy and occupational therapy,

as well as expanded funding for supervision of the patient at home, are imperative. These services are at present limited, and as a result most doctors are much more comfortable admitting a patient to hospital than handling a difficult situation on an out patient basis.

Community clinics as we have defined them are ideally structured for the delegation and coordination of ancillary medical services. The executive council or governing board of the clinic would have direct insight into the needs of the community and the power to respond to those needs. Because clinic personnel would be working as a team, a health worker (whether nurse, physiotherapist, occupational therapist, etc.) visiting the home would have an in depth understanding of the patient's past problems and present status. Similarly, physicians would be kept closely informed of how the patient was doing in the home environment and therefore have a clearer idea of how to make the best use of avaiable resources. As well, the clinic would be in a position to establish a liaison with individuals and agencies such as teachers, legal aide, and Children's Aide and achieve a better understanding of the patient's situation. Such a team approach, with integrated ongoing care, was critical to the success of the respiratory rehabilitation programs referred to above.(3-6) Community clinics which have utilized preventive approaches and coordinated ancillary services have been successful in reducing hospital admissions.(12-14)

3) Control of Health Care Delivery- At the present time individuals in this society have little control over a process which, when they are ill, has a considerable impact on their lives. We believe that it would be desirable for the public to have an opportunity to influence the nature and quality of health care at the local level.

There are several reasons why public participation in clinic policy decisions is important. They are listed below:

I) The opportunity to participate directly in decisions which influence their lives is likely to engender a sense of responsibility and community in individuals. People whose present apathy results from a feeling that they have no effective influence on political decisions may be motivated to become involved in the clinic.

II) Public representation can provide feedback to those engaged in health care delivery concerning consumer satisfaction with both service and policy directions.

III) Community leadership has been effective in mobilizing individuals to take effective action in terms of personal disease prevention.(15)

IV) Local community representation can fulful some aspects of public responsibility which otherwise would be handled by a provincial beauracracy, larger and more rigid. This devolution of responsibility is desirable because the clinic would have the flexibility and responsiveness that would make it possible to change in accordance with local needs in a way that is impossible for the provincial government.

V) Community participation can bring pressure to expand health funding, countering provincial pressure to reduce it. Provincial governments are usually elected for reasons other than health policy and can be expected to pinch pennies in this field no matter what their ideology.

The public, then, must be directly involved in decision making in the clinic. How is power to be divided between the clinic executive council and the provinical government? We believe that the crucial decisions, those regarding the disposition of funds, should be in the hands of the clinic. It may be argued that because the government is supplying the

money, it is the government which should decide how it is spent. However, if the clinic is to be truly responsive to the needs and desires of the population it is serving, it must have the power to delegate resources as it sees fit. If it does not have this power, the clinic will be impotent to deal with many of the problems it will inevitably face.(16) Further, clinics in the past have had their character, patient population, and service modalities altered or restricted because of strings attached to money they received.(17-20)

If the government is to have a role in monitoring the function of clinics, it should be by reviewing outcomes. Documentation of whether the clinic is providing adequate service could be provided by a patient rota, number of patient visits to the clinic, number of home visits, documentation of educational activities and attendance at such, clinic admissions to hospital, clinic research activities, patient satisfaction surveys, morbidity and mortality levels of clinic patients and by other public health surveys of the clinic's patient population. The collection of this information could be divided between the clinic and the government. Criteria for evaluating appropriate functioning of the clinic would be negotiated between the clinic and the province. Under such a system the quality of patient care will be guaranteed while at the same time decision making will be shared by the clinic staff and the public they serve.

4) Hierarchy Among Health Care Workers- At present, decisions concerning patient care rest in the hands of the physician. This is true both in hospitals and private practice. Other health care workers act in a secondary role, carrying out instructions which they receive from the doctor. In solo and group practice, decisions concerning resource allocation are the

exclusive prerogative of the physician. A whole assortment of trivial hierarchies result from the essential one which is established by the physician's monopoly on decisions concerning patient care and on how money is spent.

We see the clinic as a setting in which the presently existing hierarchy could be broken down. First, clinic personnel would work as a team. This implies that decisions would be made by a consensus of the team members. Every individual would have the responsibility of guiding the team in areas of his or her expertise. Secondly, each clinic worker would have an equal opportunity to serve on the executive council and participate in decisions concerning policy directions and resource allocation. The community clinic would thus lead to a significant change in the roles existing in most current health care settings, that is, the physician as boss and other workers as employees.

An additional element which tends to maintain the present hierarchy is the large differential in income that exists between different health care workers. Although it is not essential to the achievement of the other goals we have outlined for the clinic, it would be desirable to see these income differentials reduced in the clinic setting.

5) Education of Health Care Workers- A program of formal education for the staff would be an integral part of the community clinic's activities. As well, through interaction with other members of the health care team, each individual would have informal learning opportunities which are rarely available within the present structure of health care delivery.

6) Saving Money- The major determinant of whether clinics get support from the provincial government is likely to be whether they can, in the short

term, save money. We do not believe this should be the case; optimal care should be the first priority. Nevertheless, it is unrealistic to anticipate the establishment of new clinics if they are more expensive than present structures of health care delivery.

It has turned out to be extremely difficult to accurately compare the cost of a community clinic to the cost of the more traditional ways of delivering medical care. Methodological problems are numerous. These are described in some detail in Appendix 1. A review of the literature reveals that in most cases these methodological problems have led to an underestimate of the cost reduction which clinics have provided.(21)

Despite these difficulties, there is much evidence to suggest that community clinics of the sort we have been describing will decrease health care spending without decreasing quality of care. American experience includes that of health-maintenance organizations. These are pre-paid group practices which emphasize integrated, preventive care. Total costs to enrollees of HMO's are 10 to 40% lower than those for comparable people with health insurance.(22-24) The Hunterdon Medical Centre in New Jersey provided a wide range of preventive, diagnostic and restorative programs. Hunterdon resulted in a significant reduction in cost per patient when compared with traditional systems in the rest of New Jersey and the United States. This reduction was comparable to that achieved by the Kaiser health plan, the most successful of the HMO's.(25)

Canada has a fairly extensive and growing experience with community clinics. Two studies of the clinic in Sault Ste. Marie have yielded conflicting results regarding the cost of care in the clinic relative to conventional care.(26,27) These studies, along with statistics which demonstrate a significant decrease in hospital utilization for patients of

the Sault clinic compared to the population in the rest of the Algoma health district are reviewed in Appendix 1.(28) Reports by Ruderman looking at three community clinics in Saskatchewan, and by Wolfe and Badgely examining the Saskatoon clinic, documented decreased costs generated by the clinics.(29,30) In the latter study, annual savings amounted to $3,000 per physician per year in favour of the community clinic doctors. On the other hand, McPhee found that three Saskatchewan clinics had a lower rate of hospitalization but no difference in total health costs.(31) Anderson and Crichton presented data for community clinic per patient costs which were intermediate between the less expensive solo primary care practices and the more costly group practices.(21,32) We know of no study which compared a community clinic or clinics with a suitable control group and found the former to be more expensive. Thus, although the data is limited and the methodological problems do not permit definitive conclusions, available information suggests that community clinics as a rule are less costly than conventional medical practice.

There are many reasons to anticipate that community clinics would be cost effective. By cost effective, we mean that the monetary cost of achieving a particular outcome, in this case the delivery of optimal medical care, will be decreased by use of community clinics as compared to traditional methods of delivering health care. The advantages of the clinic in this regard include: I the absence of a financial incentive for bringing patients back for unnecessary followup; II a focus on preventive medicine; III more extensive and integrated outpatient services; IV feedback from the community which permits the tailoring of services to community needs; V a structural flexibility which facilitates such tailoring; VI a decrease in hospital utilization.(25,29-31)

PATIENT ACCEPTANCE

Consumer satisfaction with different sorts of community clinics has been documented. A British paper described patient reaction when twenty physicians serving 44,000 patients moved in to a single centre. The majority thought it was an improvement, and the move did not impair accessibility.(33) Other papers have demonstrated that patients seem to have a positive response to a focus on specific community needs(34), community involvement and research(35), a "wholistic" approach to patients(36), and the provision of preventive and restorative programs(25). Since these are all features of the sort of clinic we envision, patient acceptance is unlikely to be a problem in the establishment of community clinics.

THE LOGISTICS OF SETTING UP A COMMUNITY CLINIC

It is beyond the scope of this paper to deal with the myriad of practical and policy decisions which will come up in the establishment of a clinic. However, we would be remiss if we did not address the following questions:

1) What is the Community in Community Clinic?- Although the ideal situation would be to have a well defined, pre-existing community which had itself defined the need for a clinic, such a situation would be very unusual. Community clinics have thrived in a wide variety of situations, with varying degrees of definition of the community they served. Thus, there does not seem to be a point in specifying what is meant be a community, nor in specifying the conditions under which a clinic should be established.

2) Clinic Priorities- Clinics have previously run into trouble when they have not had a clear idea of who they were serving, or what their priorities were.(18,37) We believe that any clinic, to be successful, must clearly

define its patient population, its goals, and its priorities. When this has been done prior to the establishment of the clinic, it has contributed significantly to the clinic's sucess.(25,38)

3) Financing- Obtaining funds is a major problem for the community clinics existing in Ontario at the present time.(38,39) The result is that many clinic workers are paid substantially less than they would be elsewhere. Those who stay with the clinic are politically dedicated and usually do not have the financial burden of a family to support. The limited funding has also meant that innovative programs have been difficult to establish.(38,39) A similar situation exists in Quebec clinics.(18)

It may be a difficult conclusion to face, but experience to date has shown that sincerity, dedication, and political commitment may be enough to work with temporarily, but in the absence of adequate funding, insurmountable problems arise quickly. These include the following:

I) Clinic administrators spend time trying to raise money instead of co-ordinating the activities of the clinic.(20)

II) A large volume of patients combined with limited resources changes the atmosphere of the clinic from that of a neighbourhood centre to that of a hospital outpatient department, and makes optimal care impossible.(19)

III) The changes in the clinic atmosphere and the difficulty providing high quality care lead to a deterioration in staff morale which results in a high staff turnover.(19,40)

IV) Dependance on renewal of funds forces clinics to modify their programs in accordance with what funding agencies will find acceptable. Thus, the clinic's self control is limited.(19)

Thus, there is no doubt that adequate funding, with reasonable assurance that money will continue to be available, is crucial for a

clinic to succeed.

In the absence of the rather unlikely event of a dramatic reversal in the attitude of the provincial grovernment to the funding of community clinics, we can offer no easy answers to the dilemna. Clearly, pressure must be put on the provincial government to come up with funds. This paper has documented that it should be in the interests of both the government and the people of Ontario for the government to do so. At present, the Ontario government is rather gingerly trying out the possibility of providing additional support for Health Service Organizations. The present government program for financing HSO's is dealt with in a separate paper.(41)

Given the present situation, it is neither possible nor desirable to make a single recommendation regrding sources of funds for the clinics. Variables which may effect financing decisions include the nature of the individual clinic (patient population, educational activities, patient volume), and the willingness of the provincial government to negotiate reasonably and in good faith. For any individual clinic the following may be appropriate means of funding: physician billings within O.H.I.P.; physician billings supplemented by government grants to cover educational programs, home care, physiotherapy etc.; or complete government funding through a capitation or global budget scheme. Whatever the final arrangement between the clinic and the province, no clinic should accept less money that it could generate if its doctors were paid on a fee for service basis under the then current O.H.I.P. schedule of benefits.

4) The Community Clinic Executive Council: Balance of Power- The reasons for public involvement in clinic decision making have been outlined previously.

There are, however, major problems associated with such involvement. Without a constituency, community representatives may just represent their own or their friends' individual interests.(42) These representatives are not the recipients of the information from other levels of organization, such as the health ministry, which flows to the clinic director. Nor are they participants in the informal communications which go on among health care workers. They do not have career goals which they are trying to achieve by participating in the clinic. There is a cost to participating in terms of time and energy, which is often too great for many people.(42) Their understanding of the language of health planning or the issues involved may be limited. Finally, the positions and power within the executive council may be assumed by those who are more articulate and politically experienced, leading to feelings of alienation among other board members.(19)

Measures may be taken to deal with some of these difficulties. The clinic must actively encourage the participation of as large a number of citizens as possible, thus minimizing the chance that narrow or selfish interests will be represented. Efforts must be made to keep the executive council in the mainstream of incoming information. Educational programs may be useful in increasing the knowledge and effectiveness of community members,(43) but increase the time and enegy required of them. We do not expect these suggestions will solve all the problems referred to, and as experience accumulates we must be alert to the possibility of new approaches that may help to remedy them.

A second set of problems arise from the interaction between staff and community representatives. Inevitably, the interests of these two groups will differ to some extent. These differences can cause a great deal of difficulty, and have led, on more than one occasion, to a complete

rupture between the board and the doctors, and the effective destruction of a clinic.(37,44)

The crucial decision in regard to the problem of staff-consumer disagreement is that of the composition of the executive council. By executive council, we mean the group which makes the final decisions concerning the clinic's policies and disposition of funds. Suggestions as to how such a group should be constituted include 1/3 physicians, 1/3 allied health professionals and 1/3 public.(45) However, we feel that the community and the clinic workers, including the physicians, should receive equal representation. This is likely to be the most effective means of preventing abuses of power by either group.

In addition, the planning bodies in any clinic would include a group whose purpose would be to oversee and evaluate long range planning, priorities and program function. This would be an advisory body and would not have the power to make final decisions. It would be constituted largely by community members.

There are a myriad of details which will arise in setting up the executive council and clinic committees. These include: the proportion of the community members that should be elected at large and the proportion that should come from interested organizations; the exact proportion of community members on the planning committee; wheter people should be members of more than one committee at one time; and the exact method by which the members at large will be chosen. However, these are all beyond the scope of this paper. We feel that the answers are not crucial, given first that parity has been established between the community and clinic workers on the final decison making executive council, and secondly that another body has been established to deal with broader, long range issues. Two

schemes describing how some of these details could be dealt with are included in Appendix 2.

Should the question be raised, the executive council would not have the power to interfere in the exercise of professional responsibility.

Despite the problems, there have been many clinics in which extensive and direct community participation in decision making has worked out very well.(14,34,38,46) Thus, there is good reason to believe that the administrative bodies, as we envisage them, would work well.

5) Reimbursement- Each clinic should negotiate the income of its workers. This would enable clinics to take into account such factors as the needs and expectations of individual staff members, the workload involved in different jobs, and the local cost of living. Salaries, fringe benefits, etc., would be negotiated between the staff union or organization and the community representatives sitting on the clinic executive. Reimbursement may be by hourly rate, half days worked, or yearly salary, but would not be on a fee for service basis. While reimbursement would be such that the clinic would remain competitive in attracting dedicated, high quality personnel, attempts would be made to reduce the discrepancy in pay that now exists between different jobs in the health care industry.

APPENDIX 1

The following is an enumberation of some of the problems associated with designing a study comparing costs of community clinics to those of traditional health care delivery systems. Many of these were pointed out by Badgely(21) in a review of four relevant studies. There is probably not a single study that contols for all the problems described below.

1) Perhaps the most difficult problem is finding an appropriate control group for the clinic which one is looking at. An ideal control group would consist of a practice or practices in which the demographic characteristics of the patient population was very similar to that of the clinic under examination. The following patient characteristics must be controlled for in a truly valid study:

I) Patterns of residence (urban centres are known to have a higher cost per resident than practices in rural settings)

II) Age distribution

III) Sex distribution

IV) Income distribution

2) Most studies have neglected to include any extra billings beyond those paid for by the patient's health insurance. This is because billings within provincial insurance are easily accessible while extra billings are almost impossible to quantitate. Since community clinics have invariably refrained from extra billing, neglecting this expense biases results against the clinic.

3) Extra services delivered in the clinic setting are often ignored, or when taken into account, dismissed as being irrelevant because they are

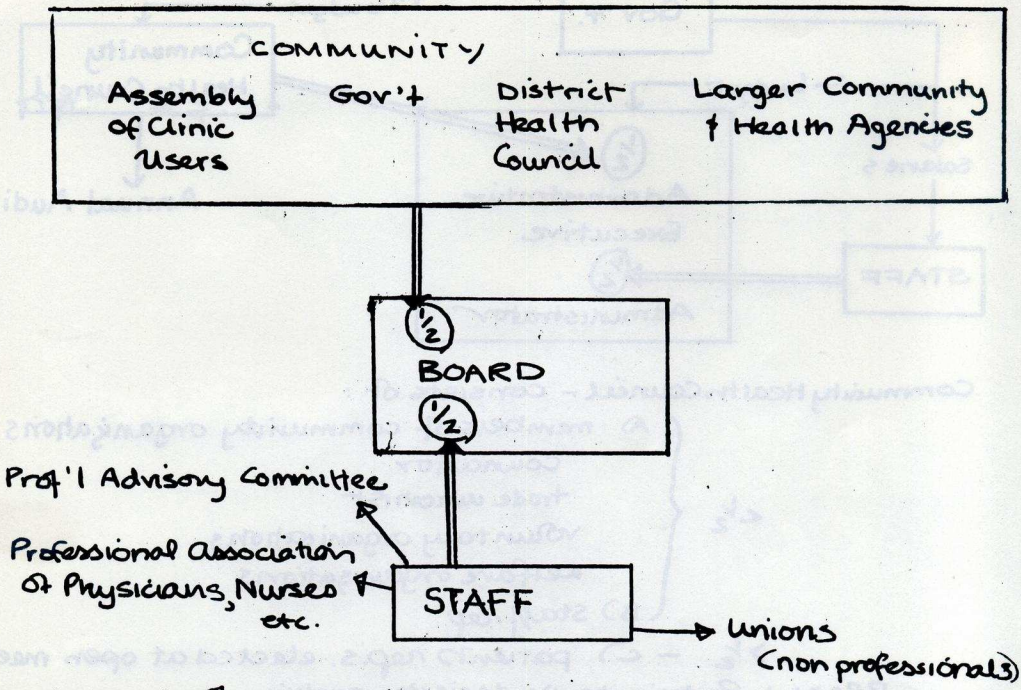
"intended to be a cost-saving measure in that they (are) intended to reduce the demands on physicians."(27) However, the presence of such personnel as a social worker, health educator or clinical psychologist in a clinic may obviate the need for a patient visit to a social worker or psychiatrist, or involvement by a social agency such as Children's Aid. This sort of saving is likely to be neglected by the study.

4) Equivalent services may be tallied as a clinic or control generated expense in one context and not in another. For example, if a physician sends a patient to a hospital for a radiograph, that cost may disappear in the hospital budget. If on the other hand the x-ray is done in the clinic radiology department, it may be included in the clinic generated costs.

5) There is a problem in how to deal with claims versus costs. For example, obstetricians may charge a set fee for each patient they follow through pregnancy and delivery. A general practitioner charging for each visit may generate the equivalent fee with a far greater or far fewer number of visits.

The above is by no means a complete enumeration of the methodological problems encountered in comparing community clinics to traditional settings, but it gives some idea of the difficulties involved. These difficulties are illustrated by the case of the clinic in Sault Ste. Marie. A study conducted in 1967-8 documented that clinic members spent 24% less time in hospital, had fewer surgical operations, and had a lower cost of care per patient served. A subsequent study(27) found that days in hospital were the same for the Sault clinic and a control group and that no particular savings could be documented for the clinic. Then, a more recent paper

described a significant saving when comparing the Sault clinic to a group practice in Oshawa.(47) Finally, if one looks at current rates of hospital admissions in the Sault and the rest of the Algoma district, one finds that the Sault has about 50% the number of hospital admissions on a per population basis.(28) The Algoma population has a significantly higher number of children under four years of age, and the population is generally more rural in character. The two groups appear otherwise comparable. Thus, it is somewhat difficualt, given these conflicting results, to decide where the truth lies.



Board consists of: community representation:

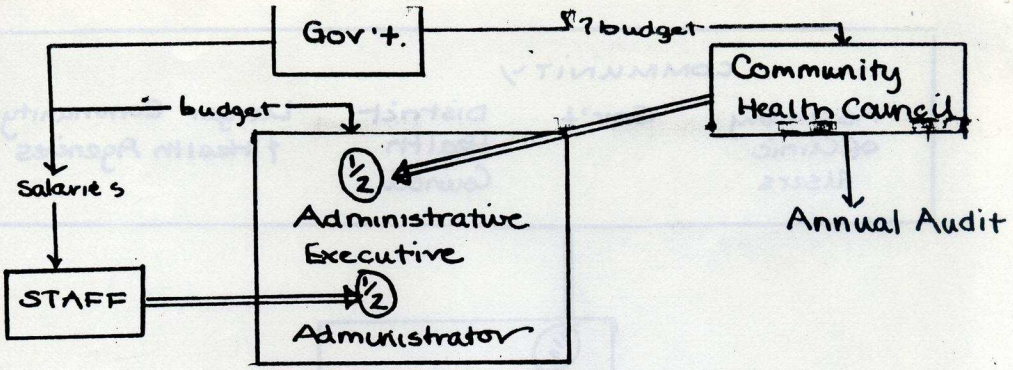
1/2 { A. Rep. of Municipal gov't (Local alderman)
B. Rep. from District Health Council
C. Rep.s. from Local Health organizations

1/2 Directly elected from clientele

Staff: Director of Clinic reports to board not as member.
1 rep. from prof'l advisory committee
Elected reps from staff as a whole.

Powers of Board:

1. To approve budget prepared by clinic director
2. To approve all hiring, and to provide a member of search committee's interviewing applicants
3. To propose and review programs.
4. To select director and to dismiss him/her after a formal process of review including outside arbitrators



Community Health Council – consists of :

- < ½
  - A) members of community organizations
    - councillor
    - trade unionist
    - voluntary organizations
    - welfare organizations
  - B) Staff rep
- > ½ – c) patients rep.s. elected at open meeting

Roles:
1. Participate in decision making
2. Represent needs & concerns of local popⁿ
3. Promote debate in community
4. Promote health education (in conjⁿ with staff)
5. Launch & co-ordinate public campaigns
6. Long term health needs planning (with executive)
7. Improve communication staff / patient
8. Can create sub committee
9. can submit independent reports to gov't.
10. to audit clinic annually
11. to have independent budget

Executive – consists of : ½ rep.s from health council
administrator
½ reps from staff.

Roles: 1. Administrative Decisions 2. Budgeting
3. Planning – Short Term
4. Can set up hiring committee, complaint committee
5. Policy Co-ordination 6. Not clinical decisions

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HEALTH SERVICE ORGANIZATIONS: CRITERIA FOR AN APPROPRIATE METHOD OF FINANCING

by the Community Clinics Work Group, Medical Reform Group

This paper will briefly discuss the Ontario government's present approach to increased funding for Health Service Organizations. The government appears to be considering funding any group of physicians who have at least one non-physician auxillary health care worker in their employ. The delegation of funds would be on the basis of capitation-negation. In this system, the province calculates the average per patient cost for specific physician-rendered services. Then, for each patient on its roster who is registered with the Ontario Health Insurance Plan, the clinic receives on a monthly basis the average cost appropriate to the services it offers that patient. For a clinic delivering primary care, this cost is, at present, $3.70 per month. Therefore, a primary care clinic with 1,000 patients would receive $3,700 per month. The clinic receives the same monthly payment for each registered patient regardless of how many services it provides. However, if a patient on the clinic's roster uses another primary care service during that month the clinic does not receive that month's $3.70 for that patient.

Further, the government is instituting an ambulatory care bonus. If a clinic demonstrates a rate of hospitalization which is lower than the average for its health region, it receives a bonus. The idea is to encourage the clinic to keep its patients healthier, thus avoiding hospitalization and saving the government money.

We have the following objections to the capitation-negation system:

1) The clinic is still encouraged to have as many patients as possible on its roster in order to secure the largest possible income. Therefore,

the incentive to high volume practice which presently exists in the fee for service system does not disappear.

2) A clinic which is in an area in which a high proportion of the patients are not registered with the provincial health plan (for example, an immigrant area in Toronto) would be at a significant disadvantage, for it would not receive the capitation payments for those patients.

3) Under the suggested system, astute physicians might establish a practice in a high income area with a predominantly young population. Epidemiologically, they would know that their patients would need significantly less care than the provincial mean. Therefore, their hours of work and their overhead would be lower, but not their income, since they would receive the monthly per patient fee whether or not they actually saw the patient. Of course, a clinic being established in a low income district with an elderly population would be at a significant disadvantage, for its patient population would require far more care than would be covered by the provincial mean.

4) Community clinics, to be a significant improvement over the present health care system, must be able to provide educational programs and improved home care resources. The present capitation-negation scheme makes no allowance for the cost of providing such services.

The ambulatory care bonus is equally misguided. First, it is unrealistic to expect a clinic operating in a low income area with an elderly population, however excellent its care, to produce lower rates of hospitalization than the mean for the area. Secondly, rather than the physician keeping patients out of hospital by keeping them healthier, the result may be that patients who need hospitalization are managed in the community to earn physicians their bonus. Thirdly, the way that rates of hospitalization may be realistically expected to drop is by use of educational and home

care programs. As mentioned above, the present government financing scheme provides no funds for such programs.

If the government is going to use the capitation-negation scheme it will have to provide some sort of adjustment for the demographic characteristics of the area in which the clinic is located. Secondly, if there is a genuine desire to improve care, some allowance for the educational and home care aspects which would be incorporated in a truly progressive clinic will have to be made.

An alternative to the capitation-negation scheme would be to provide the clinic with a negotiated global budget. Under such a plan any clinic (or H.S.O.) would define the patient population it is serving. An estimate would be made of the present outpatient services that the population would require, taking into account educational and home care needs. Such an estimate would also consider the demographic characteritics of the patient population. The cost of these services would then be calculated and the appropriate amount allocated to the clinic.

It would be reasonable, if the above approach were adopted, to be concerned about duplication of services. An unscrupulous clinic could fail to fulfill previouly negotiated services and send its patinets to other physicians and facilities for care. However, this problem could be circumvented by monitoring the clinic's performance on the basis of such parameters as the patient rota, number of patient visits to clinic, number of home visits, documentation of educational activities and attendance at such, clinic admissions to hospital, clinic research activities, clinic patient visits to other health facilities and so on.