outcomes. But modest positive effects, albeit with low statistical power, are clearly observable.

More convincing evidence for efficacy was provided recently by a meta-analysis of the effects of psychosocial interventions in adults with cancer.¹² Meyer and Mark retrieved 62 studies comparing treatment and control groups for various psychosocial, behavioural, and psychoeducational interventions. They classified the outcomes of each study into five summary categories: (1) emotional adjustment, which included outcomes such as mood state, self esteem, locus of control, denial, and repression; (2) functional adjustment, which consisted of outcomes such as socialising and returning to work; (3) symptoms related to the disease or treatment, including nausea, vomiting, and pain; (4) medical outcomes, such as leucocyte activity, the response of the tumour, and the progression of disease; and a final category, (5) global outcomes, in which several areas from the four other categories were combined. The results of the meta-analysis were expressed as a unit free effect size ranging from 0 to 1, calculated by dividing the difference in the means of the control and treatment groups by the pooled standard deviation. They showed significant beneficial effect sizes of from 0.19 to 0.28 for all the summary categories except the medical outcomes category, which at 0.17 was not significant. These positive effects are within the range expected for psychological procedures that "work"; they are, however, small, and consequently some people might question their clinical importance. Meyer and Mark point out that within medicine in general even quite modest effects can have an important impact on the outcome of treatment.

Although type II statistical errors are possible because of small effect sizes and relatively few treatment-control comparisons, no significant differences in effect size were found between the different summary categories for different types of psychosocial interventions. This is worthy of further research. We need more information about the most effective types of interventions, as well as some innovative work on different combinations that might produce even greater benefits to patients.

Meta-analysis has become an increasingly important and established method of determining benefit from medical procedures. The analysis conducted by Meyer and Mark is the first that explicitly examines the putative benefits of psychosocial interventions for patients with cancer. The results, together with the data now accumulating from larger, more methodologically sound evaluations, begin to place psychological interventions firmly on the list of requirements for good cancer care. Such interventions should no longer be seen as an optional extra but as an integral part of every patient's management plan. The delivery of medical care is becoming increasingly evidenced based; for the non-believers in psychosocial care here is that evidence.

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Registering patients and paying capitation in family practice

Lessons from Canada

It may surprise British doctors to learn that universal registration of citizens for primary care is controversial and exists almost nowhere else in the world. They might ask: "How can one take responsibility for a patient's preventive care, and for facilitating appropriate use of community services and referred care, without a defined list of patients?" Indeed, unsatisfactory answers to such questions, implying a less than adequate primary care system, have provided impetus for considering patient registration in other countries.¹ We use the current controversy in Canada to explore the issue.

Currently, primary care in Canada is delivered on a fee for service basis by doctors operating privately in solo or group practices. These doctors have no contractual obligations to government payers with regard to location, the mix of services provided, or the organisation of the practice. Although some special arrangements exist to improve the geographical distribution of doctors or to experiment with capitation payment or health centre models,² these cover less than 5% of the population.

Canada's federal and provincial governments and its doctors support the idea of changing to a system based on registration. But they have also expressed their concerns.³⁻⁶ The present debate centres on a report on the funding and reorganisation of primary care that was released for consultation this autumn by the federal, territorial, and provincial committee advising the government on health services.⁷ The details of the model proposed by the committee are less important than the principles: to move away from fee for service payment, register patients with a primary care organisation (which has defined contractual commitments), and pay each primary care organisation on a capitation basis. Similar proposals have come from various doctors' organisations in Canada that are interested in registration, comprehensive care, and new payment options.^{3,4} Registration has therefore become intertwined with the debate on how to pay doctors.⁸ The result is a guaranteed controversy.

For Canada's governments the impetus is mostly to replace a fee for service system, which encourages the provision of an ever increasing volume of services, with a more predictable

and stable system of capitation payments. In addition, both they and the doctors see the potential for encouraging group practice and teamwork and clearly delineating the responsibilities of the primary care organisations while holding them accountable for the services and health of a registered population.

Doctors have at least two other motives for supporting the proposal. Firstly, they are being driven away from the fee for service approach because the government is limiting their economic freedom by introducing increasingly strict measures to contain costs. These include ceilings on income for individual doctors and the profession as a whole, reductions in fees, and controls over the use of services.⁹ Secondly, they are drawn to the clinical freedom offered by registration and capitation. A report from the College of Family Physicians of Canada concluded that the fee for service system of payment does not serve family physicians well "because it is procedurally oriented and volume-driven."⁵

Governments' main concerns are whether this system is compatible with a free choice of provider, which is required by law and has historically been interpreted as applying to each visit rather than committing patients to one doctor for a period of time; and, even if it is compatible with free choice of provider, whether the public will buy into the idea of fixed registration. Doctors' main concerns are, firstly, that the adoption of a system of registration and capitation should be voluntary for doctors ("family physicians must be able to choose the form of remuneration best suited to their practice"⁶), and, secondly, that primary care organisations should be run by doctors and not "managed by yet another level of bureaucracy."⁷

Are the governments' concerns justified? So far the public, through the media, is viewing the debate as being about the way to pay doctors and not about reorganising primary care. On this level it largely supports the change. As one newspaper editorial commented, "The capitation report deserves approval in principle with a strong commitment to continue exploring the options it recommends."¹⁰

It is less clear whether such support from the public will continue if the restrictions rather than the advantages of registration become the focus of debate: the trade off for the patients is between comprehensive care under an identified primary care organisation versus less freedom to change providers from visit to visit. In a populations based survey in 1993, 97% of respondents indicated that they had a family doctor and 76% were "very comfortable" with him or her.¹¹ If it is possible to generalise from Finland then there is further reassurance from the experiment there with a personal doctor programme: only 6.7% of citizens refused their initial assignment to a general practitioner.¹²

Results from an unpublished survey that we conducted in Canada in the mid-1980s are, however, less encouraging. Overall, 24% of respondents said that they were unwilling to be "locked in" to a specific primary care practice, even in return for additional benefits.

Satisfying doctors' desires to retain the option of fee for service payment alongside registration and capitation may prove difficult. Doing so would raise the problem of "double charging," when a registered patient, for whom the government is paying a capitation fee to a primary care organisation, visits a doctor not in a primary care organisation and to whom the government must pay a fee for the service delivered. Obviously such a dual system leads either to increased government costs or to one of two political hot potatoes: displaced costs to the patient or the refusal of payment to the fee for service doctor. Requiring registration for the fee for service doctors ameliorates but does not eliminate this problem.

Finally, who will be in charge of the primary care organisations if they are established? This is likely to be the real political battle ground for Canada's foray into registration. The doctors' concern is "the very real risk that [primary care organisations] could undermine the patient-doctor relationship."⁶ But other issues are also at stake. Primary care organisations are the potential building blocks from which vertically integrated health care organisations might grow—Canadian equivalents of American style health maintenance organisations. Such vertical integration would place within one organisation the budget for all levels of health care; from primary care (including diagnostic tests and drugs) through hospital care, to long term care, rehabilitation, and home care. They would open up even more possibilities that are now emerging for the 60 new total fundholders in Britain, but with the additional attraction that whoever runs the organisation will be likely to reap at least some of the financial rewards gleaned from efficiencies.

There are those who believe that the most appropriate groups to control the primary care organisations would be Canada's newly created local community health boards. Nurses in some provinces are pushing for their own version of community health centres as the basis for reform. Hospitals, like doctors, see that vertical integration offers potential for increasing their revenues at a time of fiscal restraint. By controlling these new health care organisations and adopting a purchasing role, they gain access to pooled funding from primary, secondary, and tertiary care budgets that were previously insulated from each other. Finally, private sector investors are beginning to see the financial opportunities in servicing the management needs of primary care organisations. In other words, from the seed of efforts to improve the quality and continuity of care by registering patients for primary care may grow a many limbed tree of interests competing over Canada's emerging health care organisations.

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