diffusion) was significantly higher in those with macrovascular disease (48 patients) and this difference persisted after adjustment for age differences. In multivariate analysis the three most important independent variables associated with macrovascular disease in this male diabetic population were low-density lipoprotein cholesterol, plasma fibrinogen and age. In the smaller group of females studied, mean plasma fibrinogen was higher in those with macrovascular disease (25 patients) but the differences did not reach statistical significance.

In neither group were the indices of glycaemic control (fasting blood glucose and glycosylated haemoglobin) any higher in those with macrovascular disease. One cannot conclude from this that blood glucose has no aetiological role in vascular disease but it does illustrate the point that in order to identify those diabetic patients at particular risk of coronary heart disease and peripheral vascular disease one must be prepared to measure other variables. Just as Stone and Thorp found in their non-diabetic population, estimation of plasma fibrinogen and cholesterol may prove valuable.

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General practice in Canada

Sir,

Although general practice in Canada has many attractive features, the generalized fee for service payment system is not one of them. Rather than being a model for the College's initiative on remuneration for 'quality' as suggested by Dr P.M. Johnson (November *Journal*, p.541), it has several features that mitigate against quality and performance review.

General practice across Canada is by no means uniform. The concept of general practitioner subspecialists is rare in urban areas, but more common in remote and under-doctored rural areas. Practice in the 'office' and in hospital by family practitioners is leading certain provinces to question the very concept of the family practitioner, and to suggest his replacement by his hospital colleagues, in a system which would mirror some of the features of the practices in the USA.

A major problem with the fee for service system is that it is extremely expensive. Annual health care for a Canadian patient costs approximately two and a half times that of a British patient. Costs are escalating at an alarming rate and the system generates much unnecessary, and occasionally harmful medical treatment and investigation.

Ontario has introduced a different option of care which is the Health Service Organization (HSO), which bears remarkable resemblances to the National Health Service (NHS) in Britain in that patients register with the HSO who are paid a capitation fee. There are about 18 such organizations in Ontario, and in 1984 I had the opportunity to exchange practices with a doctor from one of them for six months. The differences in attitude and practice between the HSO and the fee for service system were instructive. It is obviously in a doctor's interest in a fee for service system to perform (and claim) for as many procedures as possible, whereas in a capitation system procedures have to have their value demonstrated. In a climate of practically universal annual medical checkups, yearly cervical smears, 100% circumcision rates and monthly well-baby checks, the HSO had to evaluate these procedures and if they were not useful had to try to educate its patients accordingly.

The HSO capitation system is much more complex and sophisticated than the NHS system. Fees are calculated on a daily basis and the amount varies depending on the patient's age and sex. If a patient registered with a HSO doctor sees another primary care doctor, the HSO doctor loses his capitation fee for that month, and so has a major incentive to be attractive, efficient and provide high quality medial care. The system permits other health professionals — nurse practitioners, social workers and counsellors to be funded by the practice.

The HSO practice where I worked looked after 10% of the local population using only 5% of the number of local doctors, and could therefore claim to be much more cost effective than the fee for service system. Apart from its high cost the other major criticism of the fee for service payment system is that it actively discourages continuing medical education. If the doctor is away on a course, not only is he not earning, he has to pay a locum who may lose his patients (the same problem arises if he is ill). The fee for service system also discourages audit and standard setting because not only do these activities not attract a fee, it is also very difficult to be objective about 'standards' where fees are involved.

The introduction of a more logical capitation system to the NHS with an efficiently computerized payment system, and perhaps negotiated weighting for different areas, would be a much more attractive option than universal fee for service which could generate an increase in the quantity of unnecessary procedures with absolutely no guarantee of improved quality of care.

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Failure of a patient participation group

Sir,

May I report our experience of a patient participation group. My partner and I planned a meeting, advertising it by means of a letter to patients and by a display board inviting patients to attend a meeting in a local school. Furthermore, we listed the areas that we thought would be worth discussion at this introductory meeting, namely: the care of children, screening the health of women, accessibility to the doctors and the reception services. We had been encouraged to do this by a 'Quality of care' evening workshop led by a Newcastle teaching practice who had clearly demonstrated the benefits of patient participation groups and whose practice list has a social class scatter similar to ours.

We were astounded that only three families expressed a wish to attend and we therefore cancelled the event. We asked ourselves why there was such a difference between our practice and the larger Newcastle teaching practice and could only come up with one factor which we postulate as a possible reason. As an urban practice we have made it a policy to accept patients who live near the surgery and because of the geography of Durham and the Belmont suburb this means that most of our patients live within two miles of the practice centre and live close to other patients of the practice. I suggest that because of this most patients have some clear understanding as to what might happen if they found themselves in a whole variety of circumstances and they quite clearly understood the way the practice worked. They reported to our receptionist that they had an ability to suggest change and be heard and thus found no need for debate.

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