settle in under- serviced areas, aggregate caps on physician salaries through negotiation with provincial medical associations, and decreasing or lack of increase to hospital budgets (Chappell, 1993). More recent reforms have included regionalization in most provinces (with Ontario being the major exception) because it is believed to offer both integration of services and allows for decision making at the local level. It is too early yet to know the result of this restructuring, but Sullivan and Scattolon (1995) argue that regional boards with no budget or policy setting authority will be unsuccessful at ensuring consumer participation. Another question for Canada, a geographically expansive country with a relatively small population, is whether regional populations contain too few people to effect economies of scale or the coordination of services. Furthermore, at the present time, payment for physicians and for drugs (Pharmacare) lies outside of the regional health authorities and, therefore, do not allow for true integration.

A current focus attracting much attention is the primary care organization. Marriott and Mable (1998) note that primary care has been defined as essential health care that is universally accessible to individuals and families by means acceptable to them and through their full participation. Primary care is usually considered the first level of contact with the national health care system for individuals and families and should be delivered as close to home as possible. It includes health promotion, illness prevention, curative, supportive, and rehabilitative services. Key elements of a primary care model include:

- The development of general practitioners working in a group environment (this could include a network of solo practices).
- The development of multidisciplinary teams, including general practitioners as well as others such as nurse practitioners, counsellors, and nutritionists.
- Patient registration and rostering, whereby the organization is responsible for specific individuals rather than a geographic area.
- Funding on a population or a capitation basis (that is, a set amount of dollars is provided per person).
- Core services, including health promotion, sickness prevention, diagnosis and treatment of illness, urgent care, 24 hour accessibility, and management of chronic illness.
- High quality specific information of records that will allow for greater certainty for costing and benefit analysis and better analysis of benefits.

Primary care is still more an idea than a reality in Canada; hospitals are still largely funded on a global budget basis and allocation to physicians and other fee-for-service providers, such as walk-in clinics and physiotherapists, is based on a market allocation model (practitioners are paid for their services to clients who choose who they see). Reimbursement follows as a function of the volume and mix of services delivered. Physicians are still, by and large, paid on a fee-for-service system. The changes taking place in hospitals are leaning to more and more outpatient surgeries. New technologies and drugs allow this shift in practice with a patient discharged immediately into the home. Deber et al. (1998) report as much as 70-80% of surgeries are now being performed on an outpatient basis in some hospitals in Toronto.

Despite the rhetoric, there are few examples that health promotion and disease prevention are yet being considered as serious mandates for the formal health care system.