Capitation by any other name…

Rosser and Kasperski’s editorial (page 236 and 247) is not a critique of my views against capitation but an argument in support of a blended funding model. Rosser and Kasperski do not dispute the undesirability of pure capitation. Instead, they imply that no one supports it, ignoring the fact that currently 12 of the 13 primary care pilot projects, involving nearly 150 physicians and 220,000 patients, are funded by pure capitation.

Inherent in the assertion that physicians in the pilot projects “…do not accept or support many of the characteristics that [Dr Mulligan] assumes are inevitable in the capitation system…” is the erroneous assumption that there are other benign forms of capitation that are acceptable. Rosser and Kasperski overlook the fact that the features against which I have argued—rostering, prepayment on a per-capita basis using risk-adjusted formulas, risk sharing, and incentives for underprovision of services—are the basic, defining characteristics of all capitation systems, including Ontario’s pilot projects. To the extent that capitation is present, these features are present.

Rosser and Kasperski’s support for capitation-based blended funding is based on the misconception that capitation’s undesirable characteristics are attenuated when it exists as a component of a system with other, non-capitated elements. But these aspects of capitation will be no less present in a blended system, where capitation will be by far the predominant form of remuneration, than in a system funded by pure capitation.

Furthermore, attempts to mitigate the incentives for stinting or cream skimming by such means as sessional fees for some high-cost patients (eg, those with AIDS) will be largely ineffective, because such funding will apply only to a small fraction of the roster.

Finally, the suggestion that capitation will deter physicians from seeing “volumes of patients” ignores the fact that doctors currently do so primarily because of an acute physician shortage and hospital downsizing without a corresponding increase in community resources.

Ironically, three of the four components of Rosser and Kasperski’s model are non-capitated payment methods for such services as after-hours care, care for high-cost patients, and health promotion. While family doctors should be appropriately compensated for continuity and comprehensive services, there is no logical connection between such remuneration and capitation. A capitated system is not necessary for funding such services, nor is capitation required for coordinating services.

The College of Family Physicians of Canada recently recommended a primary care model for comprehensive and continuing care in which family physicians are leading coordinators.1 This model is based on enhanced human resources, interdisciplinary teams supported by information technology, and financial incentives for providing (not withholding) services. It mandates neither rostering nor capitation.

Rosser and Kasperski’s assertion that a capitated system will enhance the ability to practise according to the four principles of family medicine is misguided. Capitation is a blunt instrument for budgetary restraint. It uses financial incentives for underservicing and offloads the financial risk for health care from the government to physicians. It is an unwarranted leap of faith to think that family medicine will be enhanced under capitation, whether pure or blended.

—Pamela K. Mulligan, PhD
Grimsby, Ont

Reference