



## Argument for blended funding

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In pointing out all the weaknesses of a pure capitation system, Pamela Mulligan (page 233) has fallen into a trap by assuming that family health networks will adopt all the well-known flaws of a capitation system. The physicians in the current primary care pilot projects in Ontario do not accept or support many of the characteristics that she assumes are inevitable in the capitation system, and neither do we.

After reading her critique, one might legitimately ask why anyone would consider working under such conditions. Dr Mulligan supported her argument very effectively by ignoring the problems associated with the fee-for-service model in family medicine. The incentives in a fee-for-service system encourage physicians to see as many patients as they can as quickly as possible. Anything that slows the “mill” down will reduce revenues. For harried family physicians in an underserved environment, dealing appropriately with the most needy patients produces the least revenue. Housecalls; hospital visits; obstetrics; and complex patients, especially frail elderly people and nursing home patients, are all “loss leaders” in a fee-for-service system. It is no wonder physicians are walking away from comprehensive family practice for more lucrative and less onerous work in walk-in clinics, emergency departments, and locum tenens practices while others are restricting their practices to high-volume, office-based services.

Dr Mulligan contends that, under capitation, family physicians might choose to follow incentives and ignore their patients’ needs. However, witness the current incentives and the fact that most family physicians are committed to providing the best possible care for their patients under very difficult and unrewarding circumstances and that they will likely continue to do so. Family medicine in Ontario and in other provinces has run on good will for far too long. Many family physicians are frustrated because their colleagues work in high-volume situations for 25 hours a week and receive

twice the take-home pay for half the hours worked. This situation provides the ultimate test of dedication to patients.

Because our members were up against a system that reduced their ability to practise the principles promoted during their years of training, the Ontario College of Family Physicians (OCFP) and the College of Family Physicians of Canada (CFPC) began to look for alternatives.

### Supporting the four principles

An exhaustive review of the four principles of family medicine in relation to practice found that the incentives and organization in a “rostered” system that used a blended funding model provided more support for those who practised the principles. The skills of clinicians are enhanced in a practice that demands that comprehensive care of the population be a component of physicians’ scope of responsibility. The blended funding model, with four methods of payment, including capitation, supports housecalls, use of other care providers, and comprehensive in-hospital and nursing home care.

The centrality of the patient-physician relationship is essential in a rostered population where family physicians are responsible for the ongoing care of a group of patients. In a high-turnover, fee-for-service practice, patient-physician relationships can be built; however, short visits might interfere with enhancing the relationship. Disincentives for care outside the office reduce the opportunity to strengthen the relationship by encounters during crises that occur at home, in hospital, or in nursing homes.

For family physicians who base their practice in the community, the disincentives of the fee-for-service model for out-of-office work reduce availability for community-based activities, including hospital and nursing home care. Confined to an office with limited time per patient, physicians might send complex or demanding patients to consultants or to emergency departments with minimal indications for secondary care. The responsibility for being

a resource to a defined population is most easily fulfilled in a capitation environment that allows physicians to clearly identify the people they are responsible for, specifically, high-risk groups requiring chronic monitoring, such as people with asthma, diabetes, or congestive heart failure.

In most traditional fee-for-service practices, unless patients book an appointment and come to a physician's office, they will not be recalled or followed. As fee-for-service drives more and more family doctors into restrictive forms of practice, patients are left with fragmented care and reduced access to basic services.

### Blended funding

The OCFP and CFPC are advocating a blended funding model that includes four payment components. First, physicians would be paid an annual fee for every patient enrolled with them. Patients would choose their family physician and entrust the coordination of their care and their health record to that doctor. In some provinces, "virtual rostering" uses billing data to identify anyone who visited a physician two or three times in the past 1 or 2 years. To be fully rostered, patients must provide written consent for physicians to share their medical information among the members of the group practice, specialists, and hospitals. This approach to rostering avoids time-consuming and expensive registering procedures. The capitation component of the blended funding model should be based on an age, sex, and severity-of-illness score. Using the British, Dutch, and British Columbia systems as models, negation of capitation fees for contact elsewhere in the health system is not included.

The second component would include fee-for-service compensation for after-hours emergency on-call services, obstetric services, and visits by non-enrolled patients.

The third method of compensation would be a session fee that recognizes specific populations requiring extraordinary levels of care because of their medical problems (eg, palliative care, frail elderly or people with HIV or AIDS). Compensation, considering the difficulties of providing care to some populations in specific locations, is recognized by a deprivation index for patients in the inner city or First Nations communities and by a rurality index. Session fees would also take into account a physician's seniority and the extra training needed to acquire knowledge and skills to meet the needs of the practice population or the community being served.

The fourth component would include bonuses for achieving positive outcomes in preventive care,

chronic care, or health promotion programs that were identified by the local community or the province as important in improving health status.

The capitation component of blended funding addresses the quantity versus quality issue inherent in the fee-for-service system. The fee-for-service, session, and bonus components address the problems of underservice by applying specific funds as incentives to meet community and provincial needs and objectives. The blended funding system brings balance to what is an unfair reward system. In a fully operational blended funding model, the best rewarded physician will be providing comprehensive care to approximately 2000 people in a difficult-to-serve area where there is a high burden of illness.

When family physicians understand the blended funding model, they agree that it would be more effective in rewarding comprehensive care and in providing the incentives to fulfil needed services for the community. Expanding the scope of practice to use family doctors' range of skills would definitely benefit the population by increasing access to comprehensive health care services. When the public understands that this model includes a commitment by group practices to provide a basket of essential primary care services on a 24/7 basis, they are excited and want an immediate roll-out of the program.

### Commitment to providing care

It is time for health planners and economists to recognize that family doctors are deeply committed to providing care according to the four principles of family medicine. Current incentives are promoting a degradation of the system by promoting an increasingly narrow scope of practice that is increasing fragmentation of care.

Providing excellent and comprehensive care remains the most poorly rewarded way to practise; yet it is the most effective for the population and the least costly for the health care system. Family physicians' and the public's common sense suggests that the funding model proposed by the CFPC and the OCFP is an improvement over the present sorry situation. ♣

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