way must wait and continue to speak out. Surely in a time of serious shortage of family physicians we can cut a better deal that serves not only the profession but also our patients.

—Bob Bernstein, PHD, MDCM, CCFP, FCFP
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by e-mail

References

1. Rosser WW, Kasperski J. Argument for blended funding [editorial]. *Can Fam Physician* 2002;48:236-7 (Eng), 247-9 (Fr).
2. Mulligan PK. Capitation: the wrong direction for primary care reform [editorial]. *Can Fam Physician* 2002;48:233-5 (Eng), 244-7 (Fr).

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Having read the two editorials in the February issue by Pamela Mulligan[1] and Walter Rosser with Jan Kasperski,[2] I cannot help but think that changes to the existing fee schedule could be a much simpler answer to keeping family physicians doing comprehensive care than any combination of capitation or complicated blended payment schemes.

If one of the problems to be solved by primary care reform and capitation is the overuse of very expensive emergency departments by patients who either cannot or will not see their family physicians at hours that are mutually convenient, then why not offer a premium for after-hours work by family doctors in their offices? I am sure it would lead to abuses with patients being booked in regular "premium" time slots, but I am also sure these patients would be happier and less likely to use emergency departments. Also, the money saved by not having emergency departments overloaded would more than pay for any extra expense engendered by the after-hours premium fee. There are lots of after-hours premiums already paid for various in-hospital visits and procedures as well as housecalls and nursing home visits, so why not physicians' offices?

The same principle of using the fee schedule to influence how doctors practise could easily pertain to complicated patient counseling (ie, patients with multisystem disease) or in-hospital care. I have been in practice for more than 20 years, but 2 years ago, I gave up my obstetrics privileges, and unfortunately soon I will be resigning my inpatient privileges. I say unfortunately because this is not good for the hospital, not good for my patients, and not good for my education. But it will be good for me financially, as inpatient care pays so poorly, and my time will be more financially productive in my office where I have more patients than I can handle.

I am certain that, if the fee schedule were altered to improve pay for after-hours work, obstetrics, and in-hospital care, I and many of my colleagues would continue to provide these services. The fee schedule is quite capable of influencing practice patterns. I believe it is not necessary to re-invent the wheel with capitation or blended payment schemes to achieve the goals of maintaining comprehensive care when the solutions can be so much simpler.

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Having read the recent articles[1,2] on remuneration of Canadian family physicians, it seems there are some facts not generally understood by many. Over the past 50 years that I have been practising medicine, I have been remunerated by fee-for-service in Canada and by capitation and straight salary in the United Kingdom. I think, therefore, that I have some idea as to the problems involved.

First, the problems involved depend on who is paying the piper. Fee-for-service might be the best way when patients are paying, because there is control right from the