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
Ottawa, Ont
by e-mail

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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.

—David J. Barker, MD, CCFP
Oshawa, Ont
by e-mail

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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

start of the service rendered, and the usual market forces are applied: the price is determined by providers and the willingness of patients to pay. The chief problems are a monopoly situation and the financial status of patients.

On the other hand, capitation is just a salaried system with the salary depending on the number of "at risk" patients. It has the advantage that, whoever is technically able to be most peoples' doctor, gets the biggest financial reward. But as has been pointed out ad nauseam, the varying needs of some people render this an inequitable system. Where, however, the payer is a third party (the state as in medicare or an insurance company as in many private practices in the United States or Europe), fee-for-service is open to gross abuse not only by physicians but also by patients. Also, payers can, if desired, control the quality and quantity of service given.

The difficulties facing the salaried, whether capitation-determined or not, have been described in full by Dr Mulligan. In support of what she says, I remember a practice in an underdoctored area in the United Kingdom where all the principals were able to play golf three times a week because they regularly "pruned" their lists of demanding patients. They were unpopular with colleagues in neighbouring areas, whose practices were unfairly loaded with patients of higher risk or excessive demands.

From a civil servant's point of view, straight salary is bound to be the best, as it makes accountancy and discipline so much easier. It has the advantage to the doctor of fringe benefits, such as release from the high expenses of practice (all ancillary workers also being paid for by the state) and a pension plan comparable to those of other professionals, such as teachers, nurses, engineers, and civil servants. But how do you make it attractive for physicians to take on chronically sick or psychologically difficult patients? Most physicians in Canada live within short commuting distance of the prosperous United States where remuneration for the same work is so much greater.

Clearly, if we are going to be stuck with a third-party payer, some compromises will have to be made, which is why one must look very closely at the proposals of Rosser and Kasperski. The system in different parts of the country, for example, New Brunswick or Alberta, might have to be tailored to differing needs, such as between rural and urban practitioners. It is sad that, under the present system, rural family physicians who are at risk of working far more hours per week than their urban colleagues, look after greater numbers of patients per capita, have higher expenses, and thus get very little extra remuneration.

Those who think that the problems are simple are either fools or knaves. I believe we shall all eventually have the solutions fixed by politicians who have little knowledge and less interest, unless an appropriate blended system is obtained that can be adjusted for geographic, geriatric, and chronically ill content, and hours per week at risk.

—*Philip Rutter,* MD
Edmonton, Alta
by e-mail

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It is so refreshing to see a worthy article[1] in *Canadian Family Physician*. I have always wondered who started this whole thing on capitation and rostering. Canadians seem to pick up someone's old and discarded idea and claim it to be their own panacea for all the ills of medicare.

Has any poll been done for family physicians to see whether they support this idea? Is this a scheme the College of Family Physicians of Canada dreamed up to shore up their power base and influence on the government? Can Dr Rosser and Ms Kasperski[2] really be so naïve as to think that capitation will really lower health care cost? Didn't Premier Mike Harris effectively "capitate" and put physicians on salary since he took over Ontario? Has this lowered demands on health care?

I left Ontario in 1996 because of acute physician shortages. Capitation and rostering is the worst kind of micromanagement. Anyone who believes in it has never practised real medicine. The last physician I met at a continuing medical education meeting who rostered with the government informed me that clinic staff spent half their time negotiating funding for such things as computers and nurses. The saddest part of it was that he had to attend this meeting as a moderator for a drug company because he needed extra cash. He was not a happy doctor. I have not met a single doctor who is enthusiastic about this idea.

Blended funding as proposed by the authors[2] will only benefit more layers of bureaucrats in our thinly stretched system. The statement "The fourth component would include bonuses for achieving positive outcomes in preventive care, chronic care, or health promotion programs…" shows how greatly out of touch these authors are with reality.

Preventive health care is difficult and expensive under any circumstances. Study after study in epidemiology has shown that, even in the best circumstances with unlimited time and budget, compliance rates are very low even among the most motivated and educated population. How does rostering solve this problem? Rostering will make work more unbearable for hard-working general practitioners on the front line. They not only become slaves to their rostered patients for 24 hours a day, 7 days a week, but also to the government. Every decision they make will be agonizing because of conflict of interest. To sum it up, my British colleague shook his head and laughed, "We tried that in Britain years ago and that's why I am here. Good