

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.

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2. Rosser WW, Kasperski J. Argument for blended funding [editorial]. *Can Fam Physician* 2002;48:236-7 (Eng), 247-9 (Fr).

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It is so refreshing to see a worthy article<sup>1</sup> 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<sup>2</sup> 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<sup>2</sup> 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? Rostered 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

thing I am retiring.” I sincerely hope that these authors<sup>2</sup> realize they are speaking for only a very few doctors.

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1. 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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I read the editorial<sup>1</sup> by Dr Pamela Mulligan in the February issue. I agree that capitation is not the answer to primary care reform. It has not worked in Great Britain under a public system, and it has not worked in the United States (health maintenance organizations) under a private system. Neither of those systems are noted for looking after their patients very well, if at all. Many believe that, somehow in Canada, our experience will be different. It will not.

In Great Britain, in order to get doctors to do anything useful, they had to introduce fee-for-service incentives. The College of Family Physicians of Canada recognizes this in its model by stating that all difficult activities that current fee-for-service doctors refuse to do will have to be done on a fee-for-service basis. Rosser and Kasperski<sup>2</sup> concede right from the start that capitation will not provide the necessary incentives to actually provide services to patients. Hence, the model must resort to a fee-for-service component to achieve service in these areas. The third and fourth components of their model are smoke screens that would disappear the first time the provincial government faced a funding crisis. Can you imagine the hoops one would have to jump through to be recognized as having the necessary seniority and expertise to warrant a bonus?

As for positive outcomes, what would they be based on? If governments had to pay for positive outcomes, there would never be any under their

measurements. That is the history with all provincial governments, and it will not change just because the payment system has changed. These two items would just be an added cost to government, and they would not pay it except under the first contract, which would be used to lure primary care physicians into the scheme.

That leaves then the basic argument of capitation versus fee-for-service as the best way to provide service to patients. The fee-for-service model is in place in most of our society and in most of the world. If you want a hot dog, you pay for a hot dog. If you want your accountant to provide you with advice, you pay for the service. Whether you are a hot dog vendor or an accountant, the service you provide is your revenue. In bad times you will do anything you can to protect your revenue and slash your

costs. In a fee-for-service model, service is always protected because it constitutes revenue.

In a capitation model, service is shifted to the cost side of the equation. The “business” of capitation is recruitment and retention, not service. Once you are paid the capitation fee, every service that you offer cuts into your profit. In the nonmedical world, it is easy to buy insurance but hard to collect it, especially if you happen to be a repeat claimant. It should come as no surprise then that health maintenance organizations in the United States and GP clinics in Great Britain concentrate on recruitment and inexpensive services (free coffee) rather than on providing medical care. Service provision is very expensive and must be avoided except when it interferes with the business of recruitment.