thing I am retiring." I sincerely hope that these authors[2] realize they are speaking for only a very few doctors.

*—Michael Leung, MD, CCFP*
*Vancouver, BC*
*by e-mail*

**References**

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

...

I read the editorial[1] 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[2] 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.

In any publicly funded medical system, enforcement is concentrated on the number of services, but in a totally different fashion for fee-for-service models and for capitation models. In a fee-for-service system, number of services is monitored to ensure that the fewest possible services are provided. In a capitation system, number of services is monitored to ensure that the largest number are being provided. That tells you all you really want to know about the two payment systems. I think most patients would rather decide which services they do not want than find out what services are available to them.

*—Kenneth Kolotyluk, MD*
*Executive Director*
*Society of General Practitioners of British Columbia*
*Vancouver, BC*
*by e-mail*

**Reference**

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

...

I was intrigued to read the article on capitation[1] by Pamela Mulligan in the February issue, which followed publication of Benjamin Chan's research findings[2] in the *Canadian Medical Association Journal*. Chan's study documents the declining comprehensiveness of primary care in Ontario.

It is my understanding that capitation, as a cornerstone of proposed primary care networks, is proving to be a hard sell for many of the reasons outlined by Dr Mulligan. To these reasons must now be added the evidence that comprehensive primary care is also becoming a hard sell. Any group of family physicians contemplating becoming a primary care network must now be very concerned about the long term, in addition to the immediate implications of primary care networks.

What are the legal implications of not being able, as a primary care network, to continue to provide comprehensive services to a group of rostered patients? In the light of Chan's disturbing findings, this would be my main concern.

*—John Biehn, MD, CCFP*
*London, Ont*
*by mail*

**References**

1. Mulligan PK. Capitation: the wrong direction for primary care reform [editorial]. *Can Fam Physician* 2002;48:233-5 (Eng), 244-7 (Fr).
2. Chan BTB. The declining comprehensiveness of primary care. *Can Med Assoc J* 2002;166(4):429-34.

...

Congratulations, Dr Pamela K. Mulligan. You have managed to insult every health service organization (HSO) physician practising in the province of Ontario. I have practised in Kitchener for 30 years, and, in that time, have delivered care under the fee-for-service system, the "opting out" system (patient is billed for services and reimbursed by the Ontario Health Insurance Plan), and—for the last 13 years—the fully capitated "HSO system."

Under all these payment methods, the quality of medical care I provide has not changed: no "cream skimming," no "providing poor service to high-risk patients, thereby encouraging them to withdraw from the roster." If Dr Mulligan came to my office, she would see a preponderance of elderly, diabetic, and cardiac patients—hardly the HSO milieu that she predicts for me. In my call group, all HSO physicians are available 24 hours, 7 days a week. An average weekday evening has eight to 10 calls and two to three patients seen back at the office. Weekends average 30 to 40 calls and 10 to 15 people seen per 24-hour day.

My partner holds the call group record of 100 patients seen in 1 day on call, 2 years ago during an influenza outbreak over Christmas—certainly a novel interpretation of underproviding services (called "skimping" or "stinting"). The main advantage to the capitated system for me is that I can take a holiday and still have an income to cover my office expenses while I am away. I hope this does not sound too radical to Dr Mulligan.

I deeply resent the implication that family doctors in this province cannot be trusted to separate the medical care they deliver from the payment system under which they operate. We have, unfortunately, far too many people making a living studying health care and far too few providing it.

*—Brian S. Traviss, MD*
*Kitchener, Ont*
*by fax*

**Reference**

1. Mulligan PK. Capitation: the wrong direction for primary care reform [editorial]. *Can Fam Physician* 2002;48:233-5 (Eng), 244-7 (Fr).

# Correction

In the March 2002 issue of *Canadian Family Physician* (*Can Fam Physician* 2002;48:550), Dr Mélissa Mailhot's byline was inadvertently omitted from the French version of Residents' Page.

*Canadian Family Physician* apologizes for any embarrassment or inconvenience this might have caused Dr Mailhot.

...