

CEJA Report 4 – A-97 The Ethical Implications of Capitation

INTRODUCTION

The systems through which physicians are reimbursed for their services have grown varied and complex. To date, discussion of the actual impact of these changes on the quality of patient care has been limited by a lack of data. However, there is much to be gained from discourse within the profession concerning the potential effects these systems may have. At the Annual Meeting in 1996, the House of Delegates recognized the need for this discourse and adopted Resolution 5, which recommended that:

- 1) The American Medical Association study the ethical aspects of capitation and its impact on both physicians and their patients; and that
- 2) These ethical concerns and issues be reviewed by the Council on Ethical and Judicial Affairs.

With the intent of responding to this resolution and of contributing to the necessary discussion of capitation, the Council presents the following report.

CAPITATION AND FINANCIAL INCENTIVES

It is crucial to distinguish pure capitation arrangements from other financial incentives as they are traditionally defined. Financial incentives target the monetary interests of physicians and are designed to use the pressure of potential income variations to encourage certain behaviors. Capitation, on the other hand, is defined simply as the payment of a fixed sum per patient per unit time. If capitated payments are given to individual physicians, the physician's salary will be derived from what remains of the capitated pool, and an inherent financial incentive will be created that could affect the provision of care. Other capitated plans, however, provide payments to a group of physicians whose personal incomes are in turn provided through a wide variety of payment systems ranging from salary to bonuses to fee-for-service. In these plans, the immediate parallels between capitation and other, more direct financial incentives are not so clearly established.

Regardless of how the physician is personally reimbursed, the capitated sum is applied to cover the costs incurred in providing a pre-determined set of services to the pool of capitated patients. Physicians may be expected to apply capitated funds to cover only their own services, or as in the case of some primary care physicians, the pool may also be used to cover the provision of outside laboratory tests, specialty care, hospital stays, and ancillary services. Individual physician income may at least partially be attached to the capitated pool through additional financial incentives, such as bonuses or withholds. An analysis of the ethical merits and conflicts associated with such direct incentives is presented in a different Council report.¹ This report intends to address only the ethical implications of providing care for patients under a fixed budget without attempting to analyze the multifarious reimbursement systems that could be applied as a subset of capitation to influence physician behavior.

Capitation has many of the defining characteristics of other financial incentives. By providing a fixed budget with which to treat patients, physicians are motivated to minimize costs because of the possibility that patients could conceivably find themselves without the resources to obtain treatment if the pool is not managed effectively. Additionally, physicians who practice as a part of a group under capitation typically experience significant

pressure to stay within the allotted budget from colleagues who share the resource pool and from insurance companies, employers, and other third-party payers. Although it is not clear whether physicians are motivated to be cost-conscious and efficient by the concerns of colleagues, payors, or patients, it seems clear that capitation successfully shifts the mentality of practicing physicians.^{2, 3, 4, 5}

ANALYSIS OF THE PHYSICIAN'S ROLE UNDER CAPITATION

Although operating under a fixed budget does not necessarily introduce the clinician's personal income into the patient-physician relationship, it can alter the role of the physician. Medicine has long held that the primary obligation of physicians is to advocate for the interests of each individual patient. In a capitated environment, however, patients covered by the same pool have overlapping interests, and explicitly tying the care of multiple patients to a single, limited funding source bestows upon the physician an additional obligation to consider the potential depletion of that resource when making treatment decisions. The extent to which these duties are in conflict is dependent upon the strength of each component obligation. Physicians practicing under capitation have an individual responsibility to maintain the resource pool, and the degree of pressure they experience to act on that responsibility is inversely related to the number of physicians in the capitated plan. Very small plans therefore make physicians more acutely aware of their responsibility to the capitated pool which may in turn create conflicts with their primary obligation to individual patient care.

Even in large plans, physicians practicing under capitation are encouraged to consider the costs to the plan of different treatment options. It is entirely appropriate for physicians to feel some obligation to safeguard broader health care resources; indeed such an obligation has existed for decades.⁶ Adopting dual roles is only cause for concern when the roles are given equal or nearly equal status and the primacy of individual patient care is threatened.

THE PHYSICIAN AS INSURER

When discussing capitation, it is useful to note some of the parallels between physicians under capitation and insurers. While the analogy is by no means perfect, some comparisons are helpful. Insurers receive in the form of a premium a fixed sum from each member of the covered population. With that sum, they are responsible for paying all legitimate claims in order to fulfill the guarantee of protection implied under the term "insurance." Their duty to their subscribers, therefore, is to manage a global budget against shortfalls. Fulfilling this duty requires that they judge individual claims to determine if they in fact meet criteria for coverage. It also requires that they examine each claim in light of its potential impact on the system's ability to pay future claims. All the descriptions to this point could equally describe the position of physicians practicing under capitation.

Perhaps the primary function of insurers can best be described as making broad-level decisions about plan resource allocation. Recognizing that decisions about the application of limited medical resources may be appropriate, the Council has previously stipulated that any allocation decisions that will affect patient access to care must be decided on a broad (ideally societal) level.⁷ Given their unique knowledge of what constitutes acceptable levels of health care, the input of physicians into these global decisions is crucial. It is therefore appropriate for large groups of physicians who accept capitated payments together to take an active role in assessing which services will be covered under their capitated resource. It is imperative, however, that such determinations be disclosed to patients prior to their enrollment in the plan.⁸

As physicians under capitation assume many of the roles traditionally held by insurers, however, these decisions could be brought to the bedside. The uncertainties of clinical practice place inherent limits on the degree of precision specific rules for coverage can be expected to attain, and it is tempting to place the burden of allocating resources on the shoulders of individual physicians. This shift in responsibility can be achieved by capitating single physicians or small groups of physicians and allowing them to establish rules of resource utilization. The Council has previously opposed this form of allocation because it depends upon variable factors in an individual's practice and may lead to standards of provision that are not consistent across different physician practices.⁹ Furthermore, because these decisions are based in part on the resource use of a relatively small group of patients, fluctuations in clinical practice may result in standards that are not even consistent within one physician's practice across different time periods.

IMPLICATIONS FOR PATIENT CARE

The effect on patient care of the physician's role as it is defined under capitation ultimately hinges upon the availability of funds to provide treatment. The adequacy of plan resources is affected by a number of factors. First, the efficiency of a physician's practice can impact the availability of resources. By reducing overhead or any unnecessary services, physicians can increase the effective size of the capitated pool.

A second factor is the rate of capitated payment. A capitation rate that is insufficient to fund all necessary care even under circumstances of ideal efficiency could adversely affect the care available to plan patients. Some have argued that setting the capitation rate too low will impact quality and therefore detract from the payor's ability to compete in the medical marketplace. In other words, quality control and patient protection will be provided by market forces. Additionally, it has been argued that medical malpractice claims and liability suits will provide a check against deterioration in the quality of care. The level of protection these safeguards can provide is highly debatable, not least because quality is so hard to assess by any objective available measure. That point notwithstanding, it seems that liability and market forces are tools better suited to preventing a slide below minimal levels of care than to upholding the standards of optimal care.

Regardless of how effective liability and free-market economics may be in protecting patients, the fact remains that as determinants of the capitation rate these issues largely miss the point. Capitation is a means to reduce costs. Its value to the health care system, however, is linked only to its ability to eliminate unnecessary and wasteful practices. In keeping with this goal, the rate of capitation should be determined by the identifiable needs of the covered patients and not by market trends or the probability of legal action. It is difficult for payment rates based on either purely economic or legal premises to reflect the appropriate goals and aims of the profession, including the provision of necessary care and the preservation of ethical practice.

Admittedly, basing capitation payments on a determination of necessary services is difficult given the general lack of consensus even among physicians as to what constitutes optimal care. Debate between professionals concerning specific treatments has long existed and recent data suggest that there are broad differences in practice patterns across geographic areas.¹⁰ An inadequate supply of definitive outcomes data further complicates attempts to define necessary care for a given population, to say nothing of assessing the appropriate cost of that care. However, even an estimate based on available information is superior to a figure that does not attempt to incorporate the nuances of varying levels of care.

It is imperative that the capitation rate reflect the medical needs of plan patients because a pool that is insufficient to cover necessary care can lead to serious ethical conflicts for the physician. The most obvious of these conflicts arises between patients. If the financial resources are inadequate to the task of providing all necessary care, the physician has no choice but to prioritize individual patients on the basis of relative need. There are a number of implications associated with this process. First and perhaps most troubling, some patients may be denied care that could be of material benefit. For instance, cases of marginal or discretionary need may be targeted for refusal of treatment, or less costly and less effective treatments may be substituted for more expensive but more effective interventions. As marginal need may become too liberally defined under financial constraints, additional necessary care may be denied.

A second concern raised by inadequate capitation rates is that confidence among patients that the physician is in a position to advocate for their individual needs may be severely undermined. Patients engage in treatment relationships on the assumption that physicians act as advocates for individuals. They cannot assume that all requested treatments will be paid for or even provided, but they can rely upon their physicians to act in a manner that is responsive to their particular needs. Encouraging a physician to deny or alter care for one patient on the basis of the competing needs of another patient will have significant and deleterious effects on the trust that lies at the core of the patient-physician relationship.

MITIGATING ETHICAL CONCERNS AT THE LEVEL OF A CAPITATED PLAN

Because the capitation rate is so pivotal in the ethical analysis of the system, the factors that should be considered when evaluating the size of a capitated payment need to be stated. First, the individual medical needs of enrolled patients should be assessed and accommodated in the capitated plan. This can be accomplished in a number of ways. For example, capitated payments made to each physician can be adjusted according to the general characteristics (age, gender, existing chronic conditions) of the patients represented in his or her practice. In this way, physicians with a disproportionate number of sick patients will be given a slightly larger capitated pool from which to provide appropriate care. Even more simply, the expenses generated by a similar patient population in previous years can be used as a benchmark to establish a capitated rate that will facilitate the provision of necessary care.

The uncertainties of clinical practice preclude the establishment of exact capitation figures and while medical factors and parameters of necessary care are indispensable to the process of setting capitation rates, they can lead to only a close approximation of probable costs. These estimates are superior to rates set on the basis of market economics but still result in risks that the pool will be inadequate to provide all required care. For this reason, additional means to protect patients in a capitated system from the potential effects of budgetary shortfalls need to be considered. For instance, the size of the plan can mitigate or prevent fluctuations in costs that will lead to unpredicted but necessary rationing on the part of the physician. The laws of probability dictate that the expenses incurred by a very large patient population over an extended period of time will consistently approximate a definable average. The Health Care Financing Administration has estimated that the expenses incurred by patient populations in excess of 25,000 members do not vary significantly from year to year.¹¹ It seems then that spreading financial risk by capitating large pools of patients will reduce variations in the available budget and therefore prevent physicians from having to base their treatment decisions on unforeseen or potential budgetary crises. This approach also improves the ability of plans to predict annual expenses and to set the rate of capitation according to the foreseeable use of resources.

Increasing the number of physicians who are capitated as a group will have a similar effect on the level of financial risk as increasing the size of the patient pool. By providing capitated

funds to a large physician group, the effect of any single treatment decision on the pool of resources is diluted, thereby reducing the incentive to consider potentially competing interests of other patients while providing treatment to individuals. Sharing a capitated pool over a group also promotes the mutual assumption of responsibility for treatment decisions, which in turn promotes peer review between group physicians and reduces the element of individual responsibility for allocation decisions.

The time over which capitation rates are calculated will also affect the accuracy of predicted use and will therefore affect the physician's perception of the impact individual clinical decisions may have on the available budget. Increasing the time period over which resource use is measured greatly increases the probability that excessive costs will be counterbalanced by periods of underutilization. This dissipates the immediacy of the cause and effect relationship between one clinical treatment and the ability to provide other interventions in the future.

Even under ideal circumstances, the capitated physician runs the risk that a small number of patients could require a level of care sufficiently extreme to create a conflict with the interests of other patients covered through the same pool of capitated funds. Most plans and physicians recognize the need for protection against such an occurrence and have provided some form of stop-loss plan. Once a set spending limit is reached, these plans pay the vast majority of costs incurred in treating individual patients. The need for these provisions is underscored by the fact that even the possibility of a catastrophic case could seem sufficiently pervasive to encourage physicians to treat their patients too conservatively in order to preserve funds against such an event. It could also lead plans to identify those patients likely to require such catastrophic care and to discourage or prevent their inclusion in a capitated pool. As neither of these options is acceptable, protection against excessive losses resulting from the treatment of a single patient must be implemented.

MITIGATING ETHICAL CONCERNS ON THE LEVEL OF THE PHYSICIAN

Even with safeguards, physicians have an obligation to determine if the rate of payment is sufficient to provide all necessary care. In previous reports, the Council has established an obligation on the part of physicians to appeal denials of coverage for necessary treatments. Capitated physicians have a corresponding responsibility to appeal for a larger budget if established payments are inadequate to the task of providing care. Similarly, physicians have an obligation to ensure that the pool for which capitated payments apply is sufficiently large to compensate for unpredictable variations in the cost of providing services. As a final protection, physicians should be covered through some form of stop-loss plan.

Assessing the rate of capitation as an individual physician is clearly a difficult task. As a general rule, however, payment systems can be judged in part on the basis of whether or not they are appropriate to discuss with patients. Patients have a right to all information that may impact on the care they receive, including the reimbursement plan under which that care is delivered. Physicians should avoid arrangements that cannot be justified to patients and therefore cannot be disclosed without negatively affecting the patient-physician relationship.

CONCLUSION

Appropriately constructed, capitation can be applied to reduce the costs of health care and further the interests of patients, physicians and the health care system in general. Capitation encourages physicians to act on their obligation to the health of more global populations through increased efficiency and attention to necessary allocation decisions. Even under ideal circumstances, however, providing physicians with a fixed budget not only encourages

attention to broader obligations, but also requires physicians to recognize and consider potential conflicts that may exist between patients in the course of clinical care. While it is difficult for capitated physicians to ignore the competing demands of the larger group, they must continue to fulfill their primary obligation to act as single-minded advocates for the needs of each individual patient.

If not carefully constructed, systems of capitation can create conflicts which can in turn impact patient care. If physicians have insufficient funds available to provide all necessary care, plan patients will be placed in competition for plan resources and the physicians may be forced to evaluate patient need on a relative scale with the intent of minimizing expenditures rather than maximizing quality of care. There is also the possibility that inappropriately designed systems may result in discrimination against the sick. The potential for these conflicts to arise is influenced by a number of factors including the rate of capitation, the size of the patient pool covered by capitated payments, the size of the physician group for whom the pool applies, and the time period over which capitated rates are calculated.

RECOMMENDATIONS

The Council recognizes that the application of capitation to physicians' practices can result in the provision of cost-effective, quality medical care. It is important to note, however, that the potential for conflict exists under such systems. In an effort to minimize these conflicts and to ensure that capitation is applied in a manner consistent with the interests of patients, the Council recommends the following:

- 1) Physicians have an obligation to evaluate a health plan's capitation payments prior to contracting with that plan to ensure that the quality of patient care is not threatened by inadequate rates of capitation. Capitation payments should be calculated primarily on relevant medical factors, available outcomes data, the costs associated with involved providers, and consensus-oriented standards of necessary care. Furthermore, the predictable costs resulting from existing conditions of enrolled patients should be considered when determining the rate of capitation. Different populations of patients have different medical needs and the costs associated with those needs should be reflected in the per member per month payment. Physicians should seek agreements with plans that provide sufficient financial resources for all necessary care and should refuse to sign agreements that fail in this regard.
- 2) Physicians must not assume inordinate levels of financial risk and should therefore consider a number of factors when deciding whether or not to sign a provider agreement. The size of the plan and the time period over which the rate is figured should be considered by physicians evaluating a plan as well as in determinations of the per member per month payment. The capitation rate for large plans can be calculated more accurately than for smaller plans because of the mitigating influence of probability and the behavior of large systems. Similarly, length of time will influence the predictability of patient expenditures and should be considered accordingly. Capitation rates calculated for large plans over an extended period of time are able to be more accurate and are therefore preferable to those calculated for small groups over a short time period.
- 3) Stop-loss plans should be in effect to prevent the potential of catastrophic expenses from influencing physician behavior. Physicians should ensure that such arrangements are finalized prior to signing an agreement to provide services in a health plan.
- 4) Physicians must be prepared to discuss with patients any financial arrangements which could impact patient care. Physicians should avoid reimbursement systems that cannot be disclosed to patients without negatively affecting the patient-physician relationship.

REFERENCES

1. See CEJA Rep. 3-A-97
2. Epstein AM, Begg CV, and McNeil, BJ. The Use of Ambulatory Testing in Prepaid and Fee-For-Service Group Practices. *The New England Journal of Medicine*. April 24, 1986; 312: 1089-94.
3. Hillman, AL, Pauly MV, and Kerstein, JJ. How do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations? *New England Journal of Medicine*. July 13, 1989; 321:86-92.
4. Clancy CM, Hillner BE. Physicians as Gatekeepers: The Impact of Financial Incentives. *Archives of Internal Medicine*. April, 1989; 149:917-920.
5. Jacqueline Kosecoff, et al. Prospective Payment System and Impairment at Discharge. *JAMA*. October 17, 1990; 264: 1980-1983.
6. See Principle VII, AMA Principles of Medical Ethics.
7. See for example: Council on Ethical and Judicial Affairs, American Medical Association. Ethical Issues in Managed Care. *JAMA*. 1995; 273:330-335.
8. *Ibid.*
9. *Ibid.*
10. See generally: Wennberg, John E. et al. *The Dartmouth Atlas of Health Care*. American Hospital Publishing: 1996.
11. See 42 CFR § 417.479(h)(1)(v) as published at 61 Fed. Reg. 69,049-69,050.