Capitation's Uncertain Future

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"Capitation on the Rise." So reads the misleading headline of a widely read 1999 practice management article. A survey of physicians in office practice concluded that 44% received capitation payments in 1998 compared with 40% in 1996.¹

Why misleading? Because in estimating the prevalence of capitation, the important measure is the percent of revenues derived from the capitation dollar. For physicians with capitated managed care contracts, that figure hovers around 24% and is not increasing.² Except in a few geographic areas, capitation has never been the predominant mode of physician reimbursement.

Several well-regarded health care consultants are sounding the death knell for some forms of capitation. "There has been a dramatic drop in global capitation," says Peter Kongstvedt.³ Global "capitation as we know it will cease to exist in the near future," predicts health executive Ed Berger.⁴ "The rush away from [hospital] capitation has become a stampede," adds consultant John Bertko.⁵ Global and hospital capitation appear to be a casualty of managed care's (temporary or permanent) decline.

Some HMOs are abandoning primary care capitation as well. HMOs are "not getting good value for their primary care capitation dollar," explains consultant Clifford Frank; they find it cheaper to pay physicians on a fee-for-service basis.³ In a rare meeting of the minds, both HMOs and physicians have their doubts about capitation. Dozens of physician organizations have gone bankrupt as a result of falling capitation rates.⁶ Only 30% of medical practices are making a profit from capitation, down from 52% in 1997. Many physicians are refusing to accept capitation contracts.⁷

HMO enrollment dropped for the first time in history, down 400,000 from 1999 to 2000—another indication that capitation is declining. Preferred Provider Organizations (PPOs)—which pay fee-for-service—are growing and insure more Americans than HMOs.

If capitation is not the payment mode of the future, where does that leave this issue's article "The Future of Capitation" by Goodson et al.? ⁸

In my view, capitation's (temporary or permanent) decline makes the article even more important. As Goodson et al. point out, "Our foremost responsibility is to manage the individual health risks of our patients, be they risks associated with lifestyle, predisposition to illness, or diagnosed conditions. We also have a broader social responsibility to prudently use the resources society allocates to health care, society's financial risk." It is difficult to reconcile those dual responsibilities since individual health risks and society's financial risk are often in conflict. Without capitated (budgeted) financing, that difficulty may approach impossibility.

The United States is about to experience a health care cost crisis that will dwarf the double-digit medical inflation of the late 1980s. In the year 2010, a huge, educated, and demanding baby-boomer population will begin to reach the milestone of 65 years of age, and start to get sick. At the same time, expensive genomic technology will move from bench to bedside. The health care needs and desires of Americans will far outstrip our financial capacity to meet those needs and satisfy those desires.

The allocation of scarce resources could be accomplished via two contrasting methods: 1) The market. Those who can pay get what they want and need; those that can't, don't, and 2) The budget. Health care institutions receive a predetermined amount of money and the leadership (hopefully clinicians and patient representatives) of those institutions decide how to spend the budgets. (Institutions' budgets may be created through capitation payments—which define a budget by the capitation rate multiplied by the number of enrollees—or by global budgeting mechanisms such as those used in public hospitals.) Budgets are far more equitable than markets and have the added advantage of controlling costs. Goodson et al. advance some principles according to which budgeted payment can be used to allocate health care dollars in a manner that is fair to patients and physicians.

Without question, capitation has been sorely misused to the benefit of for-profit health plans and physician entrepreneurs. The bonus schemes—thankfully declining in importance³—that 1990s-style American capitation concocted are unethical and poisonous to the clinical endeavor. But capitation can be a positive force if risk adjusted (a big "if"), and paid to a physician- and patient-run integrated delivery system, which allocates dollars based on evidence-based medicine and patient priorities.

While capitation payment is waning, fee-for-service is enjoying a resurgence within managed care. In 1995 only 18% of HMOs were using fee-for-service for some of their payments to primary care physicians; that figure jumped to 70% in 1998.⁹ If fee-for-service is rejuvenated as the dominant payment mode, budgets will be difficult to enforce, costs will be unmanageable, and individualism rather than collegiality are likely to rule the priority-setting enterprise.

It is essential to distinguish between 1) payment to a provider institution, and 2) payment to the individual clinician. The above discussion of resource allocation involves the former. For a moment, let us consider payment to the individual clinician.

One of the most embarrassing discoveries of health services research is the finding that physicians' clinical practice varies depending on whether we are paid fee-for-service or capitation. Goodson et al. provide the evidence, and many of us have seen this phenomenon among

colleagues (or even ourselves). A high proportion of primary care physicians in managed-care systems are subject to financial pressures,¹⁰ a finding that should not excuse us for succumbing to monetary influences. We all know in our hearts that clinical decisions should be based on scientific evidence artfully combined with patient preference; how we are paid should play no role.

Those who search for the perfect payment mechanism—one that neutralizes the economic impulse within physicians—are unlikely to find that pot of non-gold. Unethical or pressured physicians will figure out how to game any system. However, some payment modes do balance the pressures and help us do the right thing. Casalino used the term “balanced incentives” to describe mixed fee-for-service and capitation payment.¹¹ Robinson found that independent practice associations (IPAs) in California use balanced incentives—blended payment methods—widely, to reimburse physicians.¹² This is a positive trend away from bonus schemes that reward physicians who deny care to their own patients.

To conclude, let us return to the resource allocation problem. How about Goodson et al.’s statement that practicing physicians “have a broader social responsibility to prudently use the resources society allocates to health care?” Do we serve two masters, the needs of society and those of our individual patients?

Levinsky’s classic 1984 article “The Doctor’s Master” is unwavering in its answer: “When practicing medicine, doctors cannot serve two masters. It is to the advantage of both our society and of the individuals it comprises that physicians retain their historic single-mindedness. The doctor’s master must be the patient.”¹³

Levinsky is right. However, how do physicians confront the deepening gulf between patients’ needs/wants and society’s resources? The answer lies in the critical need to reorganize our health care system on the basis of integrated delivery systems run by clinicians and patients.

Resources should be allocated by those institutions (with overall national guidelines), not by clinicians in the act of caring for individual patients. When clinicians are fulfilling our responsibilities as leaders and committee members of integrated delivery systems, we concern ourselves with societal issues. At the bedside and in the exam room, we do everything possible that is best for our patients. — **THOMAS S. BODENHEIMER, MD**, *University of California, San Francisco, Department of Family and Community Medicine, San Francisco, Calif.*

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