



Capitation: the wrong direction for primary care reform

Pamela K. Mulligan, PhD

As Ontario residents clamour for improvements to a struggling health care system, the provincial government's primary care reform initiative has taken centre stage. The goal of this endeavour is to replace fee-for-service with capitation and to provide care to rostered populations through large networks of health care providers.^{1,2}

This plan for health care reform is fraught with strategic challenges and paves the way for privatization.

Background

In 1997, Ontario's Health Services Restructuring Commission (HSRC) published a vision statement recommending creation of integrated health systems (IHSs), based on capitation, rostering and risk-sharing.³ One year earlier, HSRC Chair, Duncan Sinclair, championed "a vital and expanded role for the private sector in managing and delivering publicly-financed services" under capitation.⁴ Pilot projects were launched in 1998, and a strategy for primary care reform involving providing care to rostered populations through capitation-funded groups was published.¹

The Ministry of Health and Long-Term Care (MOHLTC) has now committed substantial funds to expanding primary care reform provincially, with a goal of recruiting 80% of family physicians into capitated networks by 2004.² Under a joint MOHLTC-Ontario Medical Association agreement,⁵ nearly 150 physicians and 220 000 patients have already joined primary care networks (PCNs) in capitation-funded pilot projects. Funding for nurse practitioners has been increased,⁶ and legislation is under consideration to ease the transfer of health records among elements of PCNs.⁷

The "reforms"

"Reformed" Ontario will acquire the essential features of American health delivery organizations: rostering, capitation, risk-sharing, contractually linked provider networks, and financial incentives to minimize costs.^{8,9} This change comes at a time when dissatisfied Americans are struggling to regulate

abuses by capitation-based organizations and to control skyrocketing costs.^{9,10}

Under capitation, physicians will be required to join PCNs consisting of doctors and nurse practitioners offering a predefined range of services. Each patient will roster (sign a contract) with a physician and agree to obtain services only from the network to which the physician belongs. For each rostered patient, the government will allocate a fixed amount of money periodically, based on a per capita (capitation) rate, adjusted for age and sex.

Providers will use this prepaid fixed amount to cover all their expenses, including remuneration for doctors and nurse practitioners, operating costs, administration, and all costs related to treating the rostered population.

In 12 of the 13 primary care pilot projects, capitation exists in parallel with a fee-for-service component: physicians can bill up to \$30 000 annually for services to nonrostered patients. Furthermore, during the transition, nurse practitioners' salaries and some set-up costs are excluded from capitation funding. (The remaining project uses the capitation pool calculation to set fee-for-service billing limits.)

Because providers assume a financial risk under capitation (ie, they are not paid for costs beyond the prepaid capitation revenue), this system theoretically creates an incentive to provide care efficiently. Experience and analysis suggest, however, that this experiment is likely to yield very different results.

The trouble with rostering

Rostering is a basic, essential feature of capitation-funded systems.¹¹ As such, it serves primarily as a tool for predicting health costs. These costs are simply the product of the number of rostered patients and capitation rates.

Given Ontario's shortage of family physicians and its large geographic area, many regions will have neither the population nor the providers to support more than one PCN (if that). Restricting patients to a single roster, with no alternative for dissatisfied patients, invites challenges under the Canada Health Act.

From physicians' perspective, signing contracts and restricting patient choice recasts the doctor-patient relationship from a personal, fiduciary relationship to a legalistic, quasibusiness affiliation.^{9,10} Additionally, rostering unfairly penalizes physicians for patients' use of services outside the network¹ and will discourage doctors from working in non-urban areas where small physician groups and rosters will limit income potential and ability to pool risk.

Rosterings also creates administrative and financial burdens.¹¹ The development, adjustment, and monitoring of the terms and conditions of contractual agreements between the networked parties (providers, consumers, government) drain resources from medical care. In Britain, introduction of a "contract culture" (under the failed internal market reforms) led to a marked increase in administrative costs.¹²

Finally, although pilot projects give physicians the option to treat nonrostered patients, this option is nominal, offering less than one tenth of the current threshold for services to such patients.⁵ Given the emphasis on reducing costs and maximizing efficiency, a parallel fee-for-service funding option is unlikely to survive when the program is expanded provincially. Then physicians and patients might have no choice but to roster.

The dark side of capitation

Because provider groups assume financial risk for expenditures, capitation funding gives them an incentive to underprovide services (called "skimping" or "stinting").⁹⁻¹¹ A recent report (ironically intended to help Canadian policy makers design capitation funding for IHSs) acknowledged that "the incentive to underprovide care is an *inherent feature* of capitation funding"¹¹ (emphasis added). This feature of capitation continually places doctors in uncomfortable conflicts of interest that compromise patient care.^{9,10}

Under GP fundholding in Britain, concern about stinting was addressed by separating funding for physician incomes from that for purchasing services and by regulations prohibiting use of budget surpluses for extra income for doctors.¹³ This scheme was abandoned when it failed to reduce costs or improve outcomes.¹²

Transfer of financial risk to providers also creates incentives for biased selection, ie, for "cream-skimming" relatively healthy, low-cost patients and discouraging enrolment of high-cost, high-maintenance patients.⁹⁻¹¹

The HSRC recommended that no person be refused enrolment on the basis of health status,¹

but evidence shows that "capitated organizations can cream-skin in subtle ways to circumvent regulations that prohibit them from denying membership on the basis of health status."¹¹ These strategies include deliberately establishing practices in areas with healthy populations and providing poor service to high-risk patients, thereby encouraging them to withdraw from the roster.¹¹ Concerns about cream-skimming by Ontario's capitation-funded health service organizations (HSOs) contributed to the government's decision not to expand this program.¹⁴

In order to discourage biased selection and ensure financial viability of providers, capitation rates must adequately reflect the health care needs of those enrolled. Age and sex incompletely adjust for those needs.^{11,13} But developing and testing new risk-adjusted formulae is costly and can never eliminate risk selection or protect providers from unpredictable costs (eg, the onset of chronic illnesses).^{11,13}

Inevitability of risk avoidance

Many factors could contribute to risk avoidance by providers. Foremost among these are the financial incentives common in capitated systems, such as bonuses for limiting expensive services (eg, hospitalization).^{9,10} The need for such measures might be heightened by the fact that, without them, primary care physicians will be in a position to offload care (and shift costs) to the non-capitated sector (eg, secondary care) without loss of income.¹³ As pressure mounts to manage costs, doctors might be unable to avoid such incentives. Insufficient financial incentives were blamed for HSOs' failure to reduce hospital use.¹⁵

Other factors contributing to risk avoidance include diagnosis, treatment, and management of chronic illnesses, such as AIDS and heart disease, which drain scarce resources and physicians' time, and small roster sizes that offer limited income. Finally, consumer choice, considered a deterrent for skimping,^{11,13} will not mitigate this problem because many Ontario communities will be unlikely to sustain more than one PCN.

Risk avoidance can never be eliminated entirely. Methods that can reduce this problem (eg, blended systems and risk-adjusted capitation rates) also reduce efficiency.^{11,13} Physicians are in a lose-lose situation under capitation. Guided by personal and professional ethics, they want to give the best possible care but find themselves locked into a system where their own financial well-being conflicts with their patients' best interests.^{9,10}

No such thing as kinder, gentler capitation

Those envisioning a uniquely Canadian system that avoids the pitfalls of American managed care should consider two facts. First, capitation's intrinsic, undesirable characteristics (eg, the incentives for stinting and biased selection) are not limited to a multiple-payer, for-profit system. These characteristics also affect single-payer systems where organizations compete for enrolees.^{11,13} This includes Ontario's HSOs and PCNs.

Second, capitation-funded systems in Ontario will not be protected from the for-profit private sector. Although it is recommended that provider groups be "not-for-profit entities,"¹ contracting publicly financed services to for-profit companies is common in Canada and is likely to expand as the range of services funded by capitation expands. How long can it be before there is competitive corporate bidding for managing and delivering health care services to roster-defined populations?

Question of costs

Canadian health policy experts advise that, under capitation, "policy makers should not assume there will be cost savings in the short or longer term."¹⁶ They are correct. Ontario's capitation-funded HSO program failed to achieve its primary goal: lower costs through reduced hospital use.¹⁷

Capitation is a nasty proposition, which, by design, rewards doctors for withholding services, creates an adversarial relationship between doctors and patients, promises no reduction in costs, and moves us closer to privatization. ♦

Dr Mulligan is a life scientist and has published a number of articles concerning health policy.

Correspondence to: Dr Pamela K. Mulligan, e-mail pkmulligan@canada.com

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