ETHICAL ISSUES IN CAPITATION: HOW CAN FINANCIAL INCENTIVES AFFECT PATIENT CARE?

Mark Callahan, MD

Physicians are practicing medicine in a rapidly changing health care environment that presents unfamiliar challenges to their ability to make ethical care decisions. The traditional fee for service (FFS) contract between patient and physician is increasingly influenced by efforts to improve utilization management, contain costs, and establish physician credentialling and accountability programs. The fiduciary contract between physicians and patients still exists, but the insurer is no longer a silent partner in health care. As providers take on new administrative responsibilities, assume more financial risk for the care decisions they make, and receive less compensation for their services, conflicts of interest may arise.

Many physicians are concerned that managed care has had a negative impact on their ability to provide ethical care [1–4]. Physicians are still obligated to provide patients with truthful advice and high quality care, but they should not allow financial motivations to alter their clinical judgment. All physicians must make decisions that affect their patients' autonomy and well-being. Under managed care contracts, however, these decisions may be complicated and challenged by efforts to conserve resources and improve quality [5–7]. This article explores some of these ethical conflicts in the context of the following scenario in which a physician must respond to a breast cancer patient's interest in bone marrow transplantation.

> Dr. Clark is a partner in a 70-physican, integrated multispecialty medical group that has a main office and 5 satellite offices in the local area. The group provides care for Medicare and Medicaid patients, patients with traditional indemnity insurance, and members of health maintenance organizations (HMOs). The group currently contracts with 2 HMOs for global capitation, accounting for almost 30% of their patients. Most patients are admitted to a high-quality teaching hospital located near the main office, but many of the physicians also have admitting privileges at a competing community hospital.
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> On Tuesday, Dr. Clark arrives at his office after morning rounds at the hospital. His schedule for the day includes 11 patients in the morning and 17 in the afternoon, and a noon utilization meeting. Dr. Clark's morning is quite hectic as he tries to remain on schedule and still address his patients' complex medical and psychological needs. The message he hears at the noon utilization review meeting is disquieting: The group's hospital bed days and specialty referrals are above projections for the quarter. The practice administrator estimates a significant loss for the current year, and contract negotiations for next year's capitation rates are not going well. Everyone pledges to carefully review their practice patterns, and a senior physician proposes instituting a hospitalist program to reduce inpatient costs.
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> When Dr. Clark returns from the meeting, Mrs. Silverman and her husband are already in the examination room. Mrs. Silverman belongs to a capitated managed care plan, and Dr. Clark has been her physician for almost 10 years. She is a bright, active woman in her early 50s, and a breast lump found on physical examination 3 years ago proved to be malignant. Dr. Clark worked closely with Mrs. Silverman throughout her surgery and follow-up care. She attends a breast cancer survivor's group, and her family is very involved and supportive.
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> Unfortunately, Mrs. Silverman's breast cancer recently metastasized, and she and her husband want to discuss bone marrow transplantation. She is aware of a recent multicenter study of the procedure, which she learned about on television, and she has discussed this information with her support group, family, and oncologist. Mrs. Silverman is confused about the study results. She cannot understand why some physicians interpret the trials to indicate that the procedure provides no significant benefit, whereas others state that the trials are incomplete [8]. Mrs. Silverman looks to Dr. Clark for guidance.

Mark Callahan, MD, Assistant Professor of Medicine, Weill Medical College of Cornell University, Director of Outcomes Research, New York Presbyterian Healthcare System, New York, NY.

Reimbursement Systems and Financial Incentives

Although critics of managed care argue that financial incentives adversely affect patient care, the FFS system also provides financial incentives that influence physician behavior [9]. By aligning physician compensation with a patient's desire for testing and services, FFS contracts can encourage overuse of limited health care resources (eg, ordering unnecessary radiographs to be performed at a physician's office). Such testing also increases the probability of false-positive test results and complications or negative outcomes that result from unnecessary intervention, both of which lead to the consumption of additional resources.

In response, managed care plans attempt to reduce financial incentives for overuse of services by aligning physician income with a reduction in utilization. Under managed care capitation, a physician or group of physicians is paid a predetermined fee to provide a range of services to members or patients. The amount of money paid to the physicians is fixed for the contract period and does not depend on the volume of services used. However, capitation may "incentivize" physicians to withhold care by placing their income at risk for services they provide or order; physicians may allow their desire to remain within budget to overshadow their concerns for providing quality care to their patients [10,11].

Capitation can be applied to any range of services and may influence physician behavior in various ways. For example, under global capitation, a physician group must pay for specialty, diagnostic, and hospital services out of a fixed budget provided by a health plan. Funds not used for overhead costs or services provided to members are distributed to the group as income or bonus payments. The greater the cost of services provided to patients, the less money is available for physician compensation. When physician income is linked to the amount and type of services provided to patients, capitation systems may create economic incentives that perversely and negatively influence patient care [10,11]. Capitation may put advocacy for the individual patient at odds with physician income.

The Importance of Veracity

> Dr. Clark is conflicted. He reviews the recent reports on bone marrow transplantation for breast cancer patients. Most of the larger studies show no benefit, but a small European study suggests there may be a survival advantage to transplantation [8]. Dr. Clark believes that the toxicity and side effects of bone marrow transplantation are not balanced by a survival advantage, but the data are still uncertain. In the back of his mind, he hears the utilization manager reporting on the cost overruns for the capitation program. An expensive bone marrow transplant will only worsen the picture. Even after the group's reinsurance is invoked, the group will incur significant costs. (The reinsurance program at Dr. Clark's group practice covers 80% of the costs in excess of $25,000 for a single episode of an individual patient's care.)

Physicians are obligated to act with veracity (ie, with honesty and truthfulness) when dealing with patients. Acting with veracity not only involves telling patients their true diagnosis and prognosis; it requires sharing with patients the full range of possibilities for evaluating and treating their illnesses, as well as an honest assessment of the risks and benefits of those options. However, managed care and capitation programs can challenge this ethical principle, both directly and indirectly.

Talking to Patients: Gag Clauses and Altered Messages

In the past, many managed care organizations (MCOs) included gag clauses that prohibited physicians from talking to patients about treatment options that were not covered by their insurance plans [12,13]. These clauses restricted physicians' ability to speak freely and truthfully with patients and have since been removed from most managed care contracts through a combination of legislative and political pressure [14].

Of more immediate concern, however, is the possibility that capitated programs may financially influence how physicians talk to patients about treatment options. Financial incentives operate in complex ways and can lead to a distortion of the physician's obligation to the patient [15,16]. For example, Dr. Clark may argue more strongly against bone marrow transplantation in Mrs. Silverman's case if he is overly concerned about cost overruns. Although absolute truths do not exist in most areas of medicine and treatment must be individualized for each patient, physicians at financial risk may alter the way they present information to patients, potentially violating the ethical principle of veracity.

Maintaining Veracity in Patient Encounters

To maintain veracity in patient encounters, physicians should have open and frank discussions with patients. Honest discussions about the costs and benefits of treatment options may encourage patients to disclose their own concerns about side effects or excessive costs. For example, a patient with no insurance will not likely be able to afford an expensive treatment, and a patient without a prescription benefit may only be able to afford an inexpensive medication alternative.

Without open and honest physician-patient encounters, important issues like these may be ignored.

More importantly, physicians should not allow their personal compensation to influence their discussions with patients. Many authors recommend that physicians disclose to patients the financial incentives under which they or their group practice operates [17]. Physicians who cannot resolve conflicts such as Dr. Clark's can arrange for a patient consultation with another physician who is expert in the field and who does not have a direct financial stake in the treatment decision.

Physicians should avoid managed care programs that invoke gag clauses or financial incentives strong enough to impair their ability to honestly address their patients' needs [16]. Alternatively, physicians can join larger group practices in which the financial costs of expensive care for individual patients are spread across larger populations, thereby reducing the impact of any given patient's needs on physician income. Finally, in an attempt to moderate the conflict between physician income and patient care, the federal government has set limits on bonuses linked to utilization. Under the federal requirements, physicians may not receive a utilization-related bonus payment from a Medicare HMO that is greater than 25% of their total income.

Decision Making and Patient Autonomy

> Dr. Clark is inclined to dissuade Mrs. Silverman from undergoing a bone marrow transplant. He is fairly certain that any survival advantage afforded by a transplant is outweighed by the excess mortality associated with the procedure itself. In addition, the toxicity, infectious complications, fatigue, and nausea of the high-dose chemotherapy will impact Mrs. Silverman's quality of life for however many months she has left to live. As they discuss these issues, Mrs. Silverman becomes more depressed and less communicative. She throws her hands up in the air and says to Dr. Clark, "You're the doctor. Tell me what to do."

To make appropriate decisions about their care, patients need accurate and reliable information; such information should enable patients to participate in decisions about which course of diagnosis and treatment to undertake [18]. Under indemnity plans (ie, traditional FFS insurance plans), patients were free to choose their doctors and hospitals. A patient could seek a second opinion or a new treating physician or hospital without preapproval or authorization from the insurance company or primary care physician (PCP). Managed care reimbursement programs, however, may make it difficult for physicians to help their patients remain autonomous. For example, most managed care plans provide patients with approved lists of physicians and hospitals that limit their choice of providers, and many patients must receive approval from their PCP before seeking specialty or hospital care. Health plans that use capitation are often the most restrictive in this respect.

Patient autonomy can also be challenged indirectly when physicians are faced with financial incentives to reduce costs. Physicians whose income is at stake may attempt to influence their patients to choose less costly diagnostic or treatment options. All physicians should help patients make appropriate decisions about their care, but many may be tempted to make decisions for patients who face difficult or complex circumstances, such as Mrs. Silverman's. This assistance should be offered with care and respect for the patient.

In this scenario, Dr. Clark realizes that the complexity of the decision, Mrs. Silverman's depression over the severity of her illness, and other factors may have hindered Mrs. Silverman's ability to express her own desires and to make an autonomous decision. Patients such as Mrs. Silverman often need time to understand and reflect on difficult or confusing information and should not be expected to make immediate decisions.

Beneficence: The Art of Doing Good

> Dr. Clark addresses Mrs. Silverman's depression and frustration, acknowledges the limitations of the current medical literature on bone marrow transplantation, and presents his views on the risks and benefits of the procedure. Mrs. Silverman and her family request time to think about her options, and Dr. Clark agrees to discuss the issues again next week. Dr. Clark offers to give Mrs. Silverman a referral for an outside consultation to obtain a second opinion.
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> After his long day, Dr. Clark reflects on Mrs. Silverman's case. He wants to help her make the best treatment decision, to balance the hope for curing the cancer with the possibility that it may recur. Despite his clinical judgment that a bone marrow transplant is not in Mrs. Silverman's best interest, he worries that financial issues are influencing his decision.

Under FFS medicine, good care was thought to be aggressive and thorough. Acting with beneficence—the responsibility to "do good" for one's patients [18]—involved providing the most professionally appropriate treatment and care to individual patients. Being paid for the services one provided fundamentally shaped physicians' interpretation of this ethical value: Physicians' financial incentives and the value system of the medical culture were aligned. However, managed care has forced physicians to become more responsible for balancing the

needs of the individual with the needs of the population. Physicians are now responsible for groups of patients insured under a given health plan, and physicians who contract with capitated plans must allocate a fixed set of resources across that population. As in the case of Dr. Clark, "doing good" for patients no longer merely involves being concerned with a single patient's outcome.

For example, from the population perspective, acting with beneficence may now involve building outreach and screening programs that benefit the entire population of insured patients. However, providing outreach programs also reduces the resources available for expensive individual care. Patients with unusual or expensive diseases, or those who seek treatments that are costly or have not been proven to be clinically beneficial, may find their needs at conflict with the population's needs. Likewise, in many of today's for-profit MCOs, resources saved by reducing marginally effective expensive care may not be spent on outreach or screening programs, but could be retained as profits for shareholders or managers of the company.

Conclusion

These complex issues are constantly evolving. New payment mechanisms that balance financial incentives are under development, and physicians are forming larger integrated groups that allow capitated risk to be spread across larger patient populations. Patients and federal and state regulators are demanding increased disclosure of financial incentives, while many MCOs are adopting independent third-party appeals mechanisms [19,20]. These appeals mechanisms allow the physician and patient to appeal a utilization review decision to an expert who does not have a financial stake in the proposed treatment.

Ultimately, managed care can introduce multiple ethical conflicts into the physician-patient relationship. Patients need assurance that financial incentives are not influencing their physicians' decisions in unethical ways, and physicians need practice settings that allow them to be patient advocates while maintaining an appropriate accountability for quality and effectiveness. The return of strong physician leadership may help to safeguard both physicians and patients from such ethical conflicts. As experts in providing patient care, strong physician leaders can influence the health care system at all levels, from the bedside to the hierarchies of HMOs, academic medical centers, and acute care facilities. Maintaining a strong foundation of trust between the physician and the patient will allow for open and honest discussions of critical issues currently surrounding care delivery (cost, quality, access, appropriateness). A foundation of trust and ethical care at the bedside will legitimize the voice of physicians as they participate in increasingly heated public and political dialogues about the future of managed care and the health care system.

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