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expert voices

Essays on Trends, Innovative Ideas and Cutting-Edge Research in Health Care

Paying Doctors

It's now very complex. But a better way may be emerging that promotes higher quality care.

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How should physicians get paid? It's a question at the core of the debate over managed care. That's because how physicians get paid affects the way they practice medicine — a point the managed care debate has brought to the public's attention in a big way in the last few years.

It is too soon to say that a definitive answer to this question is evolving. But the experience of the last decade has taught important lessons that are now helping to shape new ways of compensating doctors. The aim is to strike a critical balance between two seemingly opposite methods of paying doctors.

Doctors have a powerful incentive to do *too much* for patients if they get paid a fee for every service, test, or procedure. This is known as "fee-for-service" payment and it prevailed for decades in the era before managed care (pre-1985 or so).

But physicians have an equally potent incentive to do *too little* for patients if they get paid a set amount per patient per month. This method of payment is known, indelicately, as capitation. It expanded rapidly in the early 1990s as managed care spread. But lately it has begun to wane. (See table.)

The new payment methods seek to blend elements of fee-for-service and capitation. Not surprisingly, the ideal is to maximize the attractive features of each. To grasp what those attractive features might be, let's define four key goals of physician payment.

• ***Productivity and patient service.*** Medicine remains in many ways a one-to-one service, where physicians should be encouraged to work long hours, perform many procedures and be attentive to the needs and preferences of each individual patient.

• ***Risk acceptance.*** Physicians should receive extra praise and compensation for treating the sickest patients (who account for the bulk of health care spending) and should not be rewarded financially for "skimming" the healthy and "dumping" the ill.

• ***Efficiency and appropriate scope of practice.*** Physicians should be rewarded for steering between the shoals of under-treatment and the rocks of over-treatment, providing the appropriate level of care in the appropriate setting and maintaining a scope of practice that neither treats patients who should be referred out nor refers patients who should be treated directly.

• ***Cooperation and evidence-based medicine.*** Physicians should be encouraged to cooperate with other clinicians, to adopt evidence-based best practices and to narrow unjustifiable variations in how similar patients with similar conditions are treated.

The tensions are clear. Fee-for-service payment performs well on the first criterion. It rewards productivity and patient service – since every office visit and hospital admission generates its own financial reward. Fee-for-service also performs well on the second criterion; physicians who treat very sick patients will perform many more procedures and receive payments for each.

But fee-for-service performs poorly on the third criterion, since unnecessary visits, tests, and procedures receive the same reward as

Physician Participation in Managed Care and Capitation, 1996 and 1999

	1996	1999
Doctors with managed care contracts (% of all doctors)	88%	91%
Mean revenue from managed care (% of revenue)		
All doctors	38.4%	49%
Doctors with managed care contracts	43.6%	54%
Doctors with capitation contracts (% of all doctors)	36.7%	35.2%
Mean revenue from capitation (% of revenue)		
All doctors	8.4%	7.4%
Doctors with capitation contracts	23%	21%

SOURCE: R. Adams Dudley and Harold S. Luft, "Managed Care in Transition," *New England Journal of Medicine* (April 5, 2001): 1087–1092.

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Capitation Payment by Speciality, 1999

	% OF REVENUE FROM CAPITATED CONTRACTS
Anesthesiologists	7.2%
Cardiologists	5.3%
Dermatologists	4.7%
Family Practitioners	14.6%
General Surgeons	3.8%
Internists	12.2%
Neurologists	4.5%
Ob/Gyns	3.9%
Pediatricians	16.4%
Psychiatrists	1.7%

SOURCE: American Medical Association, Physician Socioeconomic Statistics 2000.

Diversity and flexibility in physician payment reform outperform uniformity and rigidity.

more appropriate care. Fee-for-service also does poorly on the fourth criterion. Piece-rate payment supports the cultural autonomy and organizational fragmentation that has long impeded cooperation and evidence-based standards of care. Put another way, fee-for-service payment gives physicians no incentive to collaborate with their colleagues to figure out what's the best and most cost-effective course of treatment for a patient.

Capitation offers a contrasting set of incentives. It performs well on the third criterion, since physicians are rewarded for a cost-effective style of care. Likewise, it performs well on the fourth criterion, since population-based payment supports population-based, epidemiological and collaborative approaches to the prevention and treatment of disease.

But capitation performs poorly on the first criterion — with doctors receiving no additional reward for performing additional procedures. Capitation also fails to satisfy the second criterion, since payment rates set in advance are only imperfectly adjusted for disease severity and hence penalize physicians who treat particularly sick patients.

Blended Payment to the Rescue

The blended methods being experimented with today differ for primary care and specialty doctors. That's because these two groups of doctors function quite distinctly in today's health care system. Employers and managed care plans expect primary care doctors to be a "port of entry" for patients to the health system. They are charged with overseeing patients' general health needs and coordinating their care. Specialty physicians, in contrast, usually enter the scene when a patient needs more advanced care.

Under primary care capitation, doctors typically get a flat monthly payment that can be adjusted for the expected severity of each patient's condition. But it can not vary according to the intensity of treatment that the patient receives.

Over time, the liabilities of capitation in primary care have become more evident. Put bluntly, some patients do not get the care they need because doctors have too much incentive to limit it. That's partly because health plans sometimes faltered at setting per patient rates that would fairly compensate doctors for their risk.

The solution? Supplement the flat monthly payment with separate fees for such services as mammography and vaccinations, injectible medications, costly office supplies, and visits to nursing homes and emergency departments. In addition, capitated primary care doctors increasingly are paid on a fee-for-service basis for consultations and procedures that lie on the frontier between primary and specialty care. For example doctors today often get "carved out" fees for sigmoidoscopy, well-woman exams, wound treatments and removal of benign lesions.

This scheme encourages doctors to do these costly but beneficial procedures. It also weakens capitation's incentive for selection of low-risk patients.

Capitation was slower to be adapted for specialists. Paying them a flat, per person fee is more problematic. It's harder, for example, to gauge how many patients they will see and the average level of care that will or should be delivered.

Two blended payment methods are being used to encourage specialists to deliver high quality, appropriate care. The first — typically called departmental capitation — establishes a monthly budget for an entire specialty and for a defined population. That budget is based on historical patterns. Individual doctors are then paid from the budget, which can be administered by a health plan or a physician organization, such as an Individual Practice Association or IPA.

Initially, doctors continue to submit claims for patient visits and procedures on a fee-for-service basis. But now the amount they get reimbursed varies inversely with the number of claims submitted *by all physicians* in the department. This ensures that the group stays within its budget. Thus, excessive or inappropriate care by one physician can reduce the payments received by the others. This gives specialists a powerful incentive to monitor their colleagues practice patterns and adopt standards of practice.

Under a second method, called "contact" or "case rate" capitation, specialists get paid a bundled fee for an "episode" of care. Surgeons, for example, would be paid a set fee for all pre-operative care, the operation itself, and all post-operative follow-up.

Both methods have proven effective so far but the jury is still out on their long-term success.

What lies ahead

It's appropriate that we pay close attention to how our doctors get paid and what incentives they have when they treat us. Both government and the private sector have an obligation to establish a fair framework for paying doctors and to improve upon the status quo. Both are newly striving to make their systems better. Neither at this point has a strong advantage in physician payment innovation.

What is clearest after the last decade of turmoil and rapid health system change is that diversity and flexibility in physician payment reform outperform uniformity and rigidity. The public and private sectors should monitor each other closely and adopt what seems to be the best new ideas and methods.

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