

Physicians' Views on Capitated Payment for Medical Care: Does Familiarity Foster Acceptance?

Matthew K. Wynia, MD, MPH; Harold A. Picken, MD, MPH; and Harry P. Selker, MD, MSPH

Abstract

Physicians' attitudes toward capitated payment have not been quantified. We sought to assess physicians' views on capitated payment and to compare the views of those who did and did not participate in such payment. A written survey was given to 200 physicians with admitting privileges at a 600-bed Ohio hospital; 82 (41%) responded and were included in this study. Among respondents, 21 (26%) were primary care physicians, 18 (22%) were medical subspecialists, and 18 (22%) were surgeons. Fifty-eight (71%) were providers for managed care plans, and 35 (43%) participated in capitated payment arrangements.

Among physicians who did not participate in capitated care, 100% believed that there was a conflict of interest in capitated payment, and 77% (23 physicians) believed that participation in plans that reduce physician income in proportion to medical expenditures is not acceptable. Among those who did participate in capitated payment contracts, 95% (41 physicians) believed these plans posed a conflict of interest, and 72% (31 physicians) said this was not acceptable ($P=0.4$ and 0.66 for each comparison). There was no trend toward the opinion that capitated payment arrangements are acceptable with greater levels of

experience in capitated care ($P=0.5$ by Spearman test). There were trends suggesting that compared with those who were not receiving capitated payments, those who received capitated payment were 50% more likely to have never discussed capitated payment with any patient (63% versus 42%, $P=0.08$), were 70% more likely to very strongly oppose the use of capitation to pay their own family's physicians (49% versus 29%, $P=0.07$), and were 30% more likely to believe that it is impossible to stay in the practice of medicine without participating in capitated payment plans (84% versus 65%, $P=0.06$). None of the respondents reported that they had a contractual "gag clause," but 34% (27 physicians) said they would not speak publicly about any perceived risks of capitated payments anyway.

Among this sample of physicians, those who participated in existing capitated payment managed care plans had views that were as negative, or more negative, on the acceptability of capitated payment as did those of nonparticipating physicians. Many were participating in capitated payment plans in spite of these negative views because they feared that to do otherwise would force them out of medical practice. The hypotheses generated by this study must be tested in larger, national studies.

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From the Section on Managed Care Ethics, Institute for Ethics, American Medical Association, Chicago, IL, (M.K.W.), New England Medical Center, Boston, MA, (H.A.P.) and from the Division of Clinical Care Research, Department of Medicine, New England Medical Center, Tufts University School of Medicine, Boston, MA (H.P.S.).

At the time this research was conducted, Drs. Wynia and Picken were with the Division of Clinical Care Research, New England Medical Center, Boston, MA.

The opinions expressed in this article are those of the authors, and do not represent the official opinions of the Institute for Ethics or the American Medical Association.

Address correspondence to: Dr. Harry P. Selker, Division of Clinical Care Research, Department of Medicine, New England Medical Center, Tufts University School of Medicine, Boston, MA 02111.

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With the growing use of capitated payments for medical care among third-party payers (and perhaps because of it),¹ ethical concerns with capitated payment have become common in the popular press (*Time*, January 23, 1996:44-52; *Vogue*, February 1996:154-155; *Newsweek*, October 23, 1995:54-56) and in the medical literature.²⁻⁵ Little is known, however, of practicing physicians' views on capitated payment for medical care.

Ethical concerns with capitated payment have focused on its inherent financial conflict of interest between physicians and patients. Physicians who receive capitated payment for medical care, either individually or in a group, typically receive a fixed pay-

ment per month for each patient who designates the physician or group as his or her "provider." Expenditures for a defined package of services for these patients during the month are deducted in whole or in part from this fixed payment. This provides a powerful incentive to reduce expenditures, potentially at the expense of quality patient care. Recognizing this conflict of interest, many physicians and regulators have joined in calls to limit the use of capitated payment.^{6,7} Others, however, point out that all methods of paying physicians pose some conflict of interest, because all include financial incentives that could affect the level of care provided.⁴ For example, it is well accepted that fee-for-service payment encourages physicians to provide marginal or even unnecessary services.⁸ Some have held that capitated payment has many beneficial effects, particularly in promoting wellness and prevention.⁹ It is not unusual to hear experienced physicians state that capitated payment, when done well, provides fewer conflicts of interest and stimulates better healthcare than did the fee-for-service payment system.

The strongest proponents of capitated payment for medical care seem to be those with the most extensive experience and involvement with this form of payment. It might be expected that physicians, once they experience the benefits of practice under capitated payment contracts, will come to see these plans as ethically acceptable and financially and logistically attractive. It is quite reasonable to believe that physicians who participate in capitated payment plans should be more comfortable with this form of payment, if for no other reason than self-selection into capitated payment contracts by those who feel more comfortable with them from the outset. We are aware of no research to support this belief.

One recent study suggested that physicians receiving capitated payments thought that quality of care suffered under these payment schemes.¹⁰

We conducted a survey of practicing physicians in one city to determine whether experience with capitated payment for medical care correlates with the view that its financial incentives are acceptable. The population of physicians we selected for the survey receives a wide variety of types of payment for their services, including capitated payment. We assessed their related attitudes, practices, and choices for their personal care.

... METHODS ...

In September 1996, we distributed 200 written surveys to a convenience (nonrandom) sample of physicians with admitting privileges at a 600-bed teaching hospital in Columbus, Ohio. Physicians attending any of the series of grand rounds lectures on one day received the survey. We set a 2-week deadline for return of the surveys to the medical staff office and made no further attempts to contact or identify survey recipients. To encourage candor, names were not requested and recipients were informed that no attempts would be made to identify respondents.

The surveys contained questions in the following four general areas: (1) demographics, including the characteristics of the physician and his or her practice, and the types of plans in which the physician participated; (2) the physician's opinions about participating in managed care plans that entail capitated payments; (3) the frequency of the physician's conversations about capitated payment with patients; and (4) the physician's personal preferences for physician payment.

To categorize physicians by whether they participated in capitated care, we asked using an ordinal six-point scale, "For what proportion of your patients is care significantly capitated (ie, there is a fixed amount of money per patient for care, regardless of the actual requirements of care, that affects your compensation)?" For most of our analyses this ordinal scale was dichotomized to compare those participating in no capitated care contracts with those who had any degree of experience with capitated payments. Physicians also were asked whether they believed it was acceptable or not acceptable for physicians to participate in payment arrangements that discourage expenditures by reducing physician income in proportion to expenditures for care.

Statistical analysis was performed with the χ^2 test for categorical variables and the two-tailed *t* test for continuous variables. When a comparison included cells with fewer than five individuals, we did not attempt to show statistical significance. We used the

Table 1. Proportion of Survey Respondents with Given Characteristics (N=82)

Specialty	Percentage
Primary care physician	26
Medical subspecialist	22
Surgical specialist	22
Obstetrician/gynecologist	15
Other	16
Participation in Managed Care Plans	
Participate in any managed care plans	71
Participate in capitated payment contracts	43
Have any amount of income at risk in managed care contracts	62
Have more than 10% of income at risk	21
Have more than 25% of income at risk	14

Spearman correlation coefficient to assess whether having a greater degree of experience with capitated payment correlated with considering the financial incentives of capitated payment to be acceptable.

... RESULTS ...

Of the 200 surveys mailed to physicians, 82 (41%) were returned within 2 weeks and were thus used for analysis. Seventy-four (90%) of these respondents answered the question about experience with capitated payment. The practice characteristics of all respondents are given in Table 1. Most respondents had some experience with managed care contracting; more than 80% of all respondents were providing some care under such contracts.

We compared responses from physicians who were and those who were not currently receiving capitated payments and found no statistically significant differences in any of their opinions about capitated payment for medical care (Table 2). Almost all responding physicians saw at least some conflict of interest in capitated payment (all of 31 in the group who did not and 41 of 43 who did receive capitated payment [95%]), and 62% (46 physicians) saw a very clear conflict of interest in capitated payment. In both groups, more than 70% believed that the conflict of interest inherent in capitated payment was not acceptable. There was no change in this measure among those with higher proportions of patients for whom they were paid a capitated rate ($P = 0.54$ by means of Spearman correla-

tion). There was a notable, nonsignificant trend among those receiving capitated payments toward a greater willingness to give up more than 10% of one's income to avoid capitated payments (42% versus 26%, $P = 0.19$), and two (5%) of those receiving capitated payments would be willing to give up more than 25% of their income if they could avoid these payments. However, most of those receiving capitated payments (84%, 36 physicians) believed that they could not continue to practice medicine if they were to refuse to participate in plans that pay by means of capitation. Even among those not currently receiving capitated payments, 65% (20 physicians) believed they would eventually need to accept capitated contracts.

Most physicians believed they could speak publicly about perceived risks of capitated payment should they feel that it posed a threat to patient welfare, although a substantial minority (34%, 27 physicians) stated that fear of economic consequences, exclusion from plans, or professional isolation would prevent them from doing so (Table 3). Very few had any contractual agreements that prevented them from discussing with patients how they were paid ("gag clauses"), although more than half (59%, 46 physicians) expected they would have these contractual limitations in the future.

Overall about half of physicians (54%, 43 physicians) had never discussed capitated payment with any patient, and those who participated in capitated payment managed care plans were 50% more likely to have never discussed this method of payment with any of their patients (42% versus 63%, $P = 0.08$).

Table 2. Percentage of Respondents who Answered "Yes" to Questions About Capitated Payment for Medical Care

Question	Physicians Who Do Not Receive Capitated Payments [%](n)	Physicians Who Receive Capitated Payments [%](n)	Total [%](n)	P Value for Difference
■ Is there some or very clear conflict of interest in capitated payment for medical care?	100 (31)	95 (41)	96 (79)	0.40
■ Is physician participation in payment arrangements that discourage expenditures by reducing physician income in proportion to expenditures for care <i>not</i> acceptable?	77 (23)	72 (31)	74 (57)	0.66
■ Would you be willing to give up more than 10% of your income to avoid capitated payment?	26 (7)	42 (17)	38 (27)	0.19
■ Is it impossible to avoid capitated payments and stay in the practice of medicine?	65 (20)	84 (36)	76 (60)	0.06

A slight majority of respondents (54%, 40 physicians) recognized that fee-for-service payment also poses at least some conflict of interest (Table 4). Nevertheless, they strongly preferred fee-for-service over capitated payment as a method of paying their own families' physicians. Overall, 43% (34 physicians) stated that they very strongly opposed capitated payment for their own families' physicians. Those who

participated in capitated payment managed care plans were 70% more likely to feel this way (50% versus 29%, $P = 0.07$). No respondent very strongly preferred that his or her own family's physicians be paid a capitated rate. The actual strength of this preference against capitated payment is further expressed by the fact that only three respondents (4%) believed that their own physicians were, in fact, paid a capitated rate. It is

Table 3. Percentage of Respondents Who Answered "Yes" to Questions About Discussions with Patients About Capitated Payment

Question	Physicians Who Do Not Receive Capitated Payments [%](n)	Physicians Who Receive Capitated Payments [%](n)	Total [%](n)	P Value for Difference
■ If you had reservations about the safety of capitated payments, would you be unwilling to speak out publicly against it?	32 (10)	37 (16)	34 (27)	0.67
■ If so, is this because you would				
fear economic consequences?	70 (7)	69 (11)	85 (23)	0.37
fear professional isolation?	30 (3)	19 (3)	33 (9)	N/A
fear exclusion from plans?	90 (9)	50 (8)	85 (23)	0.09
■ Do you have, or expect to have any contractual restrictions on discussing risks of capitated payment with patients?				
Currently have restrictions	0 (0)	7 (3)	6 (5)	N/A
Not currently, but expect such restrictions	65 (20)	51 (22)	59 (46)	0.17
■ Have you never spoken to a patient about capitated payment for medical care?	42 (13)	63 (27)	54 (43)	0.08

N/A = Not applicable. Cells with fewer than five individuals, so statistical testing was not performed.

Table 4. Percentage of Respondents Who Answered "Yes" to Questions or Statements About Preferences for Physician Payment

Statement	Physicians Who Do Not Receive Capitated Payments [%](n)	Physicians Who Receive Capitated Payments [%](n)	Total [%](n)	P Value for Difference
■ Is there some or very clear conflict of interest in fee-for-service payment for medical care?	48 (15)	58 (25)	54 (44)	0.70
■ I very strongly do not prefer capitated payment for the physicians of my own family members.	29 (9)	50 (21)	43 (34)	0.07
■ My own healthcare is through a managed care plan	61 (19)	67 (28)	64 (48)	0.76
■ My own physician is paid a capitated rate.	3 (1)	5 (2)	4 (3)	N/A

N/A = Not applicable. Cells with fewer than five individuals, so statistical testing was not performed.

notable, however, that at least 18% to 23% of respondents did not know how their own physicians were paid.

... DISCUSSION ...

Among this nonrandom but diverse sample of physicians, in a city with moderate (41%) managed care penetration, capitated payment for medical care appears to cause particular discomfort. Although the majority of respondents saw some conflict of interest in fee-for-service payment, they believed that capitated payment is substantially worse. Even among those who currently participate in capitated payment managed care plans, 72% believed them to pose an unacceptable conflict of interest, and none would strongly prefer capitated payment for their own family's physician. Only three physicians reported that their own personal physician was paid a capitated rate.

Despite these generally negative feelings about capitated payment, many respondents (43%) held some capitated payment contracts, and most (76%) believed that they would need to hold such contracts in the future. Eighty-four percent of those currently receiving capitated payments believed that they could not continue to practice medicine without them. This suggests that a substantial number of physicians are accepting payment contracts with which they are uncomfortable ethically because to do otherwise, they believe, would be financially ruinous.

It may be somewhat surprising that those who participate in capitated payment managed care plans hold views of capitated payment so similar to those of physicians who have no firsthand experience with this method of payment. Experience with capitated payment, we had postulated, might lead to greater comfort with its financial incentives. This did not appear to be the case among this group of physicians, and it may even be the reverse. There were trends suggesting that those with experience participating in capitated payment plans were more likely to be willing to give up 10% or more of their income to avoid this form of payment ($P = 0.19$) and were more likely to very strongly oppose capitated payment for their own or their family's doctors ($P = 0.07$).

One explanation of our findings may be that physicians' views might be heavily influenced by their colleagues' experiences. For example, physicians throughout entire cities or regions may hold similar views toward capitated payment that may depend on their collective experience with the specific capitated plans operative in those regions. Individual experience would then play a lesser role in shaping opinions.

Another explanation may be that our survey was relatively small, and our inability to reject the null hypothesis may have been a type 2 error. However, the several trends suggesting more negative views among those with experience in capitated care do not support this possibility. Finally, it may be that experience with specific capitated plans may color perceptions of capitation in general. Perhaps those with experience with capitated plans other than those with which our respondents were familiar would have different views. In any event, our surprising preliminary finding suggests that future research should include physicians from diverse communities and that more detail regarding physicians' exact degree and type of experience with capitated payment should be collected to probe more fully the effect of experience on attitudes toward capitated payment.

We were surprised, given recent calls for financial disclosure,⁶ that a substantial majority (63%) of physicians participating in capitated managed care plans had never discussed with a single patient that they were receiving capitated payments. Because only three respondents had contractual prohibitions against these conversations, future studies should explore physicians' reasons for being hesitant to discuss with patients how they are paid. Future studies also should explore the nature and content of physician-patient conversations about payment when they do occur.

This survey was intended to generate hypotheses, and thus it poses more questions than it answers. In addition, the study had important limitations. We surveyed a convenience sample of physicians in only one city (Columbus, Ohio). In a convenience sample, physicians are selected to receive the survey in a nonrandom manner. In this case, they received the survey if they chose to attend grand rounds on a particular day. We selected Columbus in part because it is a mid-sized city with a moderate degree of managed care penetration, and our sample included physicians from a variety of specialties and with a broad range of experience in managed care. However, our sample may not be representative of physicians in other cities nationwide. In addition, response bias is possible in any survey. That is, those who respond to the survey may have stronger feelings about the subject matter than those who do not. In this case, one might postulate that those with strongly positive and strongly negative views on capitated payment may have been more inclined to respond.

Despite the limitations of this study, our finding that these physicians are so uncomfortable with the ethics of capitated payment should be taken seriously by health policy makers and payers. Although these

physicians were ultimately willing to accept what they considered to be otherwise unacceptable payment arrangements to continue to practice medicine, the implied psychological stress of working under ethically worrisome conditions has several important implications. For example, if even a sizable minority of physicians are practicing under this ethical stress it could seriously affect the willingness of physicians to recommend their profession to promising young people. Physician satisfaction, patient satisfaction, and outcomes also may be correlated.¹¹ Furthermore, concerns evidenced by physicians with experience in capitated payment systems may reflect actual deficiencies in physician practice and patient care that they have seen in these systems.¹⁰ Finally, although most of those who receive capitated payments have not discussed this method of payment with their patients, 46% of physicians overall have done so. If many physicians are relaying their concerns about capitated payments to their patients, the public backlash against this form of payment may only be beginning.¹²

In conclusion, in this exploratory survey we found that physician experience with capitated payment does not foster acceptance but may strengthen a pre-existing discomfort with the incentives of this type of reimbursement. If our findings are replicated nationally, this should prompt serious reconsideration of the use of capitated payments for physicians, at least in some forms. If physicians believe that capitated payment for medical care is fundamentally disruptive to the ethical framework of patient care, and especially if this opinion is shared by patients, then the patient-physician relationship may be at serious risk. If this is the case, we should soon explore different methods for paying physicians. Even if other methods do not produce the immediate cost savings achievable with capitated payment,^{13,14} our preliminary results suggest the possibility that in the long run, the use of some current forms of capitated payment for medical care could prove to be a false economy.

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