

**Position Statement  
on  
Capitation's Impact on Medical Ethics  
(Approved by the Board of Directors: March 10, 2000)**

The basic tenets of the ethical practice of medicine are based on the following principles:

- 1) non-maleficence,
- 2) beneficence,
- 3) autonomy, and
- 4) distributive justice.

“Non-maleficence” is the standard term for “do no harm.” “Beneficence” simply means that every encounter with a patient should yield a positive benefit. “Autonomy” refers, in this case, to the simple concept that no physician can serve two masters; the physician’s obligation is to do what is best for the patient, regardless of what another third party is dictating to the contrary. “Distributive justice” means that the physician has the ethical responsibility to try to distribute medical resources to the community in a manner that tries to help the poor as well as the affluent. It makes serving in free clinics or providing pro bono patient care a core value of our profession. Any system of health care delivery must meet the test of the adherence to these principles or society will suffer.

The emergence of the managed care industry, which now is the model for the delivery of medical care to over half of the nation’s citizens and in some areas approaches an 85 percent market penetration, has posed vexing problems for physicians, their patients, and third-party payers whether private or governmental. Managed care, in all its variations, combines the business of the insurance industry with the delivery of professional health services.

### *Discussion*

*Fee-for service arrangements prevailed as the preferred vehicle for financing health care services since World War II. As employers began to offer health insurance, premiums were fixed in such a way that most patients did not bear the full cost of their health care. As employer premiums rose to meet the escalating cost of health care services, efforts by government, business and the insurance industry focused on controlling utilization and reducing health care costs. Group health cooperatives were formed as early precursors of the modern health maintenance organization.*

As managed care became more widespread, methods of cost containment became more prevalent by defining medical necessity, coverage policies, practice guidelines, practice profiling, and risk-sharing arrangements. Capitation, as a method of risk sharing, provided new ethical dilemmas in medical decision making. Fee-for-service reimbursement presented ethical challenges by assuring reimbursement for utilization of services and procedures that were ordered for the health benefit of the patient. Economic benefit is derived by the facility and the providers of health care services, while the insurer incurs the financial risk and cost of a fee-for-service system. These costs were typically shifted to the purchasers of health care services, such as employers and the government.

Capitation, in contrast, is defined as the payment of a fixed sum per patient per unit of time. Regardless of how the payment is distributed, the capitation sum is applied to cover the costs incurred in providing a pre-determined set of services to a pool of capitation patients. By providing a fixed budget with which to treat a pool of patients, physicians are motivated to minimize health care costs. The risk of not doing so is that the fixed budget agreed to in the capitation arrangement may not cover the cost of providing care to the capitation pool of patients, and therefore the health care providers bear the financial risk.

Capitation arrangements pose an ethical challenge through the risk-sharing model of encouraging economic incentive via reduced utilization of services, to the financial benefit of the physician and the managed care organization that share the risk. While some applaud the inherent incentive within the capitation risk-sharing system to increase efficiency and reduce over-utilization of resources, others suggest that there exists within a capitation system the insidious incentive to under treat patients and avoid patients with chronic or extreme illnesses.

A managed care organization's priority is to provide medical necessary care to individuals in the context of limited, controlled resources and population-based rationing decisions. The ethical framework for such rationing decisions must balance concerns for patient autonomy and justice, providing for the judicious and equitable use of distribution of resources.

The widespread implementation of capitation, as an integral part of the attempt to reduce or stabilize the cost of health care, creates an ethical dilemma for the medical profession that has never been faced before. Moreover, the expansion of a pre-payment methodology that shares the cost of treatment risk between the managed care organization and the physician has impacted with noteworthy speed the fundamental relationship between the physician and the patient. The inclusion of the managed care organization into the social contract for health care services creates a wedge between the physician and the patient, that being the fiduciary considerations of the physician on behalf of those sharing the risk, be they fellow physicians or the managed care organization. The physician's dilemma of "serving two masters" can result. Capitation poses a definitive dilemma--the constant choice between cost-efficient service and medically necessary treatment.

Legislation primarily at the state level has attempted to negate some of the more blatant transgressions that managed care systems have posed, such as gag clauses in contracts, and requirements of economic credentialing by hospitals and health care plans. These legislative attempts have met with limited success.

As a society, we have a right to determine what amount of gross domestic product (GDP) should be allocated to health care by the purchase of private insurance with premium dollars, and the appropriation of tax revenue for the care of indigent citizens. There is no consensus at this time as to what that percentage of GDP should be.

The American Medical Association (AMA) Council on Ethical and Judicial Affairs provided a report in June 1997, "The Ethical Implications of Capitation." That report suggests methods of mitigating the ethical concerns of a capitation plan through the following policy statement and recommendations:

### *E-8.051 Conflict of Interest Under Capitation*

The application of capitation to physicians' practices can result in the provision of cost-effective, quality medical care. It is important to note, however, that the potential for conflict exists under such systems. Managed care organizations and the physicians who contract with them should attempt to minimize these conflicts and to ensure that capitation is applied in a manner consistent with the interests of patients.

- 1) Physicians have the obligation to evaluate a health plan's capitation payments prior to contracting with that plan to ensure that the quality of patient care is not threatened by inadequate rates of capitation. Capitation payments should be calculated primarily on relevant medical factors, available outcomes data, the costs associated with involved

providers, and consensus-oriented standards of necessary care. Furthermore, the predictable costs resulting from existing conditions of enrolled patients should be considered when determining the rate of capitation. Different populations of patients have different medical needs, and the costs associated with those needs should be reflected in the per-member per-month payment. Physicians should seek agreements with plans that provide sufficient financial resources for all necessary care, and should refuse to sign agreements that fail in this regard.

- 2) Physicians must not assume inordinate levels of financial risk, and should therefore consider a number of factors when deciding whether or not to sign a provider agreement. The size of the plan and the time period over which the rate is figured should be considered by physicians evaluating a plan, as well as in determinations of the per-member per-month payment. The capitation rate for large plans can be calculated more accurately than for smaller plans because of the mitigating influence of probability and the behavior of larger systems. Similarly, length of time will influence the predictability of patient expenditures and should be considered accordingly. Capitation rates calculated for large plans over an extended period of time are able to be more accurate and therefore preferable to those calculated for small groups over a short time period.
- 3) Stop-loss plans should be in effect to prevent the potential of catastrophic expenses from influencing physician behavior. Physicians should ensure that such arrangements are finalized prior to signing an agreement to provide services in a health plan.
- 4) Physicians must be prepared to discuss with patients any financial arrangements that could impact patient care. Physicians should avoid reimbursement systems that cannot be disclosed to patients without negatively affecting the patient-physician relationship.

### *Conclusion*

The Academy recognizes the need to control national health care costs, while maintaining quality care. However, it is the view of the Academy that the four basic tenets of ethical medical practice are in serious jeopardy under capitation. The ability of physicians to deliver optimal care to their patients is constantly threatened. The ability of legislation, such as through a "patient bill of rights," may offer some protection. However, the best safeguard for patients and physicians will be the need for total transparency; that is, the patient must be fully informed as to the terms of the contract which governs the physician's ability to treat the patient, provide services, and to some extent make clinical decisions. The Academy supports the recommendations of the AMA Council on Ethical and Judicial Affairs Report, "Ethical Implications of Capitation" (June 1997). The Academy further concludes that by maintaining the four tenets of non-maleficence, beneficence, autonomy, and distributive justice as the foundation on which physicians function, physicians hold to an honorable medical profession that will not jeopardize the trust and confidence of the public who are served.

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*This Position Statement is provided for educational and informational purposes only. It is intended to offer physicians guiding principles and policies regarding the practice of dermatology. This Position Statement is not intended to establish a legal or medical standard of care. Physicians should use their personal and professional judgment in interpreting these guidelines and applying them to the particular circumstances of their individual practice arrangements.*