

# **POLICY CONSIDERATIONS IN IMPLEMENTING CAPITATION FOR INTEGRATED HEALTH SYSTEMS**

## **Executive Summary**

Jeremiah Hurley, Ph.D.<sup>1,2</sup>

Brian Hutchison, MD, MSc.<sup>1,2,3</sup>

Mita Giacomini, Ph.D.<sup>1,2</sup>

Steve Birch, D.Phil.<sup>1,2</sup>

John Dorland, MSc.<sup>4</sup>

Robert Reid, M.D., Ph.D.<sup>5</sup>

Gioia Pizzoferrato, M.A.<sup>1,2</sup>

<sup>1</sup>Centre for Health Economics and Policy Analysis, McMaster University

<sup>2</sup>Department of Clinical Epidemiology and Biostatistics, McMaster University

<sup>3</sup>Department of Family Medicine, McMaster University

<sup>4</sup>Queen's Health Policy Unit, Queen's University

<sup>5</sup>Centre for Health Services and Policy Research, University of British Columbia

Address Correspondence to:

Jeremiah Hurley

Centre for Health Economics and Policy Analysis

Health Sciences Centre - Rm 3H1D

McMaster University

Hamilton, Ontario Canada L8N 3Z5

e-mail: hurley@mcmaster.ca

This summary is provided in both official languages. The full report is only available in English.  
**Executive Summary**

This report is intended to guide Canadian policy makers in designing capitation funding for integrated health systems (IHSs). It is based on a synthesis of research evidence and on the experiences with capitation funding in a number of jurisdictions. Capitation funding refers to the allocation of monies from a provincial or regional government to an IHS through fixed, pre-specified payments per time period for each enrollee of the IHS. Because the IHS does not receive additional payments if it provides additional services to an enrollee, the IHS assumes financial risk associated with meeting enrollees' health needs. Like all funding methods, capitation creates incentives for both desirable and undesirable behaviour by IHSs. On the positive side, capitation funding gives an IHS incentive to provide only effective services, to produce those services efficiently, and to use them efficiently to enhance enrollees' health. On the negative side, capitation funding gives an IHS incentive to under-provide services (reducing quality of care) and to selectively enroll individuals with above-average health (potentially creating problems of access for high-risk individuals).

### **Models (see Section III)**

There are four basic models for capitation-funded IHSs, each of which creates distinct policy challenges:

- regionally-based IHSs in a system that includes only capitation funding;
- regionally-based IHSs in a system of parallel funding streams (e.g., capitation, fee-for-service);
- enrollment-based IHSs in a system that includes only capitation funding; and

- enrollment-based IHSs in a system of parallel funding streams (e.g., capitation, fee-for-service).

**We recommend the model of regionally-based IHSs in a system with only capitation funding because it minimizes some of the most difficult policy challenges associated with capitation funding, including risk selection, calculating risk-adjusted capitation rates, the nature and extent of IHS competition, and enrollment policies. Alternatively, if an enrollment-based model is chosen, we recommend an approach led by primary-care providers, building on emerging primary-care reform efforts.**

An enrollment-based system must develop policies to address the policy challenges noted above. The potential for risk selection can at best be managed, not eliminated. It must be managed through a coordinated set of policies concerning enrollment, risk-adjusted capitation, service coverage, and risk-sharing through blended payment. Regulated competition among providers of services to IHSs should be encouraged, but because consumers often cannot easily judge quality of care, competition among providers at the patient level should be allowed only on a limited set of care process dimensions. Even then it should be closely monitored. Because many rural areas would be unable to support more than one local IHS, an enrollment-based approach may require regionally-based IHSs in rural areas.

We believe that a non-parallel system of funding based on capitation offers important advantages in advancing the objectives of Canadian health care policy.

**The current political reality (particularly with respect to the views and position of provincial medical professions) may necessitate parallel systems of funding with capitation and fee-for-service side-by-side. Any parallel system of funding should minimize the scope for physicians to serve patients in each of the parallel funding**

**If a regionally-based system of IHSs is created, we recommend that it be funded through needs-based capitation, with a small proportion of programmatic and special funding as is appropriate. If an enrollment-based approach is adopted, we recommend a blended funding approach in which capitation dominates and which includes practice allowance or programmatic funding to meet special needs**

### **Capitation, Blended Funding, and Risk-sharing (see Section IV)**

In most jurisdictions, capitation funding for regionally-based IHSs is not blended with other payment types. By contrast, capitation payments for enrollment-based populations are commonly supplemented by non-capitation funding. Blending retrospective non-capitation payments with prospective capitation payments reduces the total risk the IHS bears. A blended system that shares risk can reduce the incentives for under-provision and risk selection as well as the probability of insolvency. It can also reduce the IHS's incentive for efficiency (especially where the blend includes retrospective, utilization-based funding); so there is a trade-off between efficiency and these other policy objectives. Recent surveys of physicians suggest that blended payment approaches garner substantially more support than do approaches based on capitation alone.

Formal risk-sharing arrangements through reinsurance may be required for IHSs with small enrollee populations. Under either model, one-time funding allocations for start-up costs and infrastructure are appropriate.

### **Enrollment and Rostering (see Section V)**

The enrollee roster is a basic, essential component of a system of capitation funding.

The enrollment process and the quality of the roster affect performance. Careful design of the enrollment policies can help address potential problems, such as risk selection. Regionally-based IHSs in unitary systems of funding generally create the fewest administrative requirements for the rostering process because the roster simply includes the residents of the region.

By contrast, enrollment-based roster policies must specify the process by which an individual joins a roster, the process by which an individual can dis-enroll, the conditions under which a practice can accept or refuse an individual, the

#### **If an enrollment-based model is chosen, we recommend that:**

- **enrollees register explicitly with an IHS;**
- **enrollees be required to re-register with an IHS at regular intervals (even if they do not switch IHSs);**
- **there be lock-in policies congruent with the Canada Health Act;**
- **IHSs be prohibited from denying enrollment on the basis of health status**
- **there be no maximum roster size for an IHS; and**
- **that minimum roster sizes be established to ensure that each IHS can pool risks effectively.**

data elements for a roster, how the roster information is shared between the practice and the funding organizations, and the process for updating a roster. The Canada Health Act (CHA) may limit the policy options for some of these design dimensions with respect to medically necessary physician and hospital services, but it can accommodate a range of enrollment policies. Overall, survey data indicate that Canadians are supportive of rostering.

All capitation-funded IHS models require policies relating to outside-use. Neither an IHS, the enrollee, nor the provider of the services should be penalized for an enrollee's appropriate outside-use of emergency services. In this case, the funder should fully reimburse the provider of the emergency services.

In contrast, most policy responses to an enrollee's non-emergency outside-use are a variation on one of five basic options as to whom is held financially responsible:

- the enrollee's "home" IHS ;
- the enrollee;
- the provider of outside services;
- the funder; and
- a mixture of one or more of the above.

**We recommend that financial responsibility for non-emergency outside-use should be shared among the home IHS, the providing practice, and the provincial funding agency. Enrollees should not be held financially responsible for non-emergency outside-use.**

### Scope of Services (see Section VI)

**All IHSs should be responsible for a common set of comprehensive services. Use of IHS surpluses should be restricted to enhancing the delivery of the common set of comprehensive services and not to expanding the set of services offered. Research and education should not be funded through enrollee capitation.**

### Quality of Care and Performance Monitoring (see Section VII and VIII)

The effect of capitation funding on the quality of health care is one of the most important, most contested, and least understood issues in health care. Capitation contains conflicting incentives with respect to quality: some can be expected to enhance quality (e.g., the incentive to maintain the health of enrollees to avoid high future health care costs, the greater flexibility to organize services to meet needs effectively), others to reduce it. (e.g., the incentive for under-provision). Research shows that quality of care in capitation-funded organizations is neither systematically better nor systematically worse than in non-capitated organizations. From a policy perspective, there is neither reason to expect capitation funding to cause quality to suffer in capitation-funded IHSs, nor reason to believe that quality will automatically be enhanced.

**Quality will be most strongly influenced by effective quality assurance programs and efforts to build a culture that emphasizes quality. We recommend programs of quality assurance within IHSs that include active participation by IHS providers.**

Systems of performance appraisal should be established that monitor skimping, risk selection, and the extent to which IHSs take a population perspective in meeting health needs, and that create strict financial accountability. The implementation of IHSs should include rigorous evaluation and commit resources to the evaluation from the beginning.

### **Implementation (see Section IX)**

Implementation holds the key for the success of IHS reform. Experiences from other jurisdictions suggests a small number of principles to guide implementation:

- start from where system participants are;
- value simpler, manageable, understood approaches over complex, sophisticated systems that promise a great deal but which

have a higher probability of being unworkable and of trying to take system participants too far too fast; and

- ensure that the essential, basic features of the IHS model are present from the start (even if they take slightly different forms in different settings).

- **Do not use pilot projects; do not force instantaneous, full-scale adoption all at once. Take a middle path based on a clear articulation of the system ultimately envisioned and an unequivocal decision to implement reform, but one allowing gradual implementation starting with those most eager to adopt the new approach and with the services that are best understood. Build on success to**