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# Capitation & Physician autonomy: Master of the Universe or Just another Prisoner's Dilemma? (What Can Britain's National Health Service Experience Teach Us?)

Frances H. Miller

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# CAPITATION & PHYSICIAN AUTONOMY: MASTER OF THE UNIVERSE OR JUST ANOTHER PRISONER'S DILEMMA? (What Can Britain's National Health Service Experience Teach Us?)

*Frances H. Miller\**

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\* Professor of Law, Boston University School of Law, and Professor of Public Health, Boston University School of Public Health. Tony Harrison, David Hughes, Alan Maynard, and Rudolf Klein made important contributions to an earlier draft of this article. Tom Rodrigues, Boston University School of Law '96, provided valuable research support.

## I. INTRODUCTION

**CAPITATING PROVIDERS IS THE LATEST** frontrunner for the title of best new cost-effectiveness technique for improving U.S. health service delivery. Capitation's incentive structure, allowing providers to keep any savings generated by delivering health care more efficiently, prods physicians to focus on cost-effectiveness when recommending treatment.<sup>1</sup> That focus is critically important because doctors effectively dictate patient treatment regimes, notwithstanding the rhetoric of informed consent.<sup>2</sup> In theory, capitation stimulates physicians to secure better care for their patients at lower aggregate cost, because the financial prosperity of providers increases in direct proportion to their success in keeping patients well.<sup>3</sup>

Health insurers and PHOs<sup>4</sup> have been busily extolling capitation to doctors not only as a way of prospering financially, but also as a means for recapturing the clinical autonomy they lost under managed care. Physicians enmeshed in prisoners' dilemmas of micro-management under current managed care systems<sup>5</sup> are attracted by capitation's potential for restoring their status as masters of the treatment universe. Since capitation gives them control over budgets for much—if not virtually all—of patient care, physicians can prescribe the therapeutic regimes they be-

1. See generally DAVID I. SAMUELS, *CAPITATION: NEW OPPORTUNITIES IN HEALTHCARE DELIVERY* (1996); Marsha R. Gold et al., *A National Survey of the Arrangements Managed-Care Plans Make With Physicians*, 333 NEW ENG. J. MED. 1678 (1995); James C. Robinson & Lawrence P. Casalino, *The Growth of Medical Groups Paid Through Capitation in California*, 333 NEW ENG. J. MED. 1684 (1995); Symposium: *Capitation*, 22 AM. J.L. & MED. 167 (1996).

2. See George J. Annas & Frances H. Miller, *The Empire of Death: How Culture and Economics Affect Informed Consent in the U.S., the U.K., and Japan*, 20 AM. J. L. & MED. 357 (1994).

3. See generally Mary A. Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291, 301-08 (1994) (discussing the theories underlying the relationship between economic incentives and the behavior of physicians); Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 22-41 (1993) (discussing utilization review, financial risk-shifting, and effects of cost containment on quality of care).

4. A PHO, or physician-hospital organization, "is a generic term used to describe any type of joint venture entity among hospitals and physicians . . . formed for the purpose of collective hospital/physician activities in the managed care contracting arena." Carl H. Hitchner et al., *Integrated Delivery Systems: A Survey of Organizational Models*, 29 WAKE FOREST L. REV. 273, 296 n.95 (1994).

5. See Alexander M. Capron, *Containing Health Care Costs: Ethical and Legal Implications of Changes in the Methods of Paying Physicians*, 36 CASE W. RES. L. REV. 708 (1986); Hitchner et al., *supra* note 4.

lieve most cost-effectively treat their patients' maladies (and simultaneously enhance their own bottom lines by retaining any surplus), unfettered by insurer cost containment restrictions. Moreover, capitated systems supply the risk-sharing needed to insulate nonintegrated physicians from antitrust liability when they employ joint pricing strategies in contracting with powerful insurers.<sup>6</sup>

Provider capitation is marketed as a win-win strategy for coping with both cost and quality problems perennially bedeviling the world's health care systems. It gives physicians incentives to shop carefully when they exercise their economic power to order clinical treatment for patients. Only the size of their capitated budgets theoretically constrains the range of clinical choice. In addition, payors escape the headache of trying to micro-manage physician decisions,<sup>7</sup> because risk (and potential reward) has been shifted from insurer to provider. Insurers are protected further from a doctor's temptation to breach the contract between them by under-providing services,<sup>8</sup> because the doctor does not want to create an angry patient by delivering poor quality care any more than the insurer wants to lose that unhappy patient as a subscriber. Finally, patients—off the hook for purchasing each unit of medical service they consume—can relax any fears they may have about insurance bureaucrats undermining their doctors' clinical judgment by second-guessing treatment recommendations in the interest of cost containment.

Is this glowing scenario too good to be true? Might there not be a dilemma or two lurking in capitation's implementation? As in most situations, that depends—most specifically on the way capitation incentives are structured and regulated.<sup>9</sup> Too gen-

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6. *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332, 356 (1982) (holding that joint pricing by unintegrated physicians not sharing substantial risk is per se illegal price fixing). Cf. *FTC Staff Advisory Opinion Denying Antitrust Clearance of Nevada Orthopaedic IPA*, reprinted in 4 HEALTH L. REP. (BNA) 1128 (1995) [hereinafter *FTC Staff Advisory Opinion*] (denying IPA antitrust clearance for capitated orthopedic services because it is prohibited by Nevada law.)

7. This process is referred to on both sides of the Atlantic as akin to "trying to herd cats." Milt Freudenheim, *Physicians Are Selling Practices to Companies as Changes Loom*, N.Y. TIMES, Sept. 1, 1993, at A1. See also Simon Kuper, *Unhealthy Tension For Hospital Staff: Health Reforms*, THE LONDON FIN. TIMES, May 16, 1995, at 10.

8. The insurer is the pivotal party to two related contracts here; it has contracted with the subscriber to pay for a defined range of medical services in return for the premium and with the provider to furnish those services in return for a set level of payment.

9. Cf. Carol Propper, *Regulatory Reform of the NHS Internal Market*, 4 HEALTH ECON. 77 (1995) (discussing the incentives and disincentives of National Health Service regulatory

erous a level of capitation payments will undercut the stimulus for efficiency, while too parsimonious a capitated amount forces providers to stint quality in order to retain income.

Setting the capitated payment at the optimal level required to balance societal cost and quality objectives is a feat worthy of Houdini's best efforts.<sup>10</sup> Since perfecting that trick on a moving target like health care seems well-nigh hopeless, the theory of the second best dictates that some degree of monitoring over clinical decision making probably is inevitable. The question is, who should exercise it? Employers and employer groups have recently displayed more purchasing muscle<sup>11</sup> and this, combined with rapidly improving information technology in the health care field, may make market forces a more effective regulator of both cost and quality than they have been in the past. Can insurers or providers themselves be entrusted to monitor quality in response to market-consumer pressures, or should the government intervene?<sup>12</sup> Undoubtedly some combination of market and regulatory forces will be most effective, but where should the balance be struck? Can an incentive system for delivering cost-effective care of reasonable quality be devised that still will preserve sufficient physician autonomy to satisfy doctors' sense of professionalism?

## II. FORMS OF U.S. PROVIDER CAPITATION

Experiments with various forms of capitation are now being undertaken by all types of U.S. health insurers.<sup>13</sup> Closed staff health maintenance organizations (HMOs) like the Kaiser Permanente plans are among the most well-known instances of

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reform); David M. Frankford, *Managing Medical Clinicians' Work Through the Use of Financial Incentives*, 29 WAKE FOREST L. REV. 71 (1994) (asserting that financial incentives in clinical practice will increase conflict, not control).

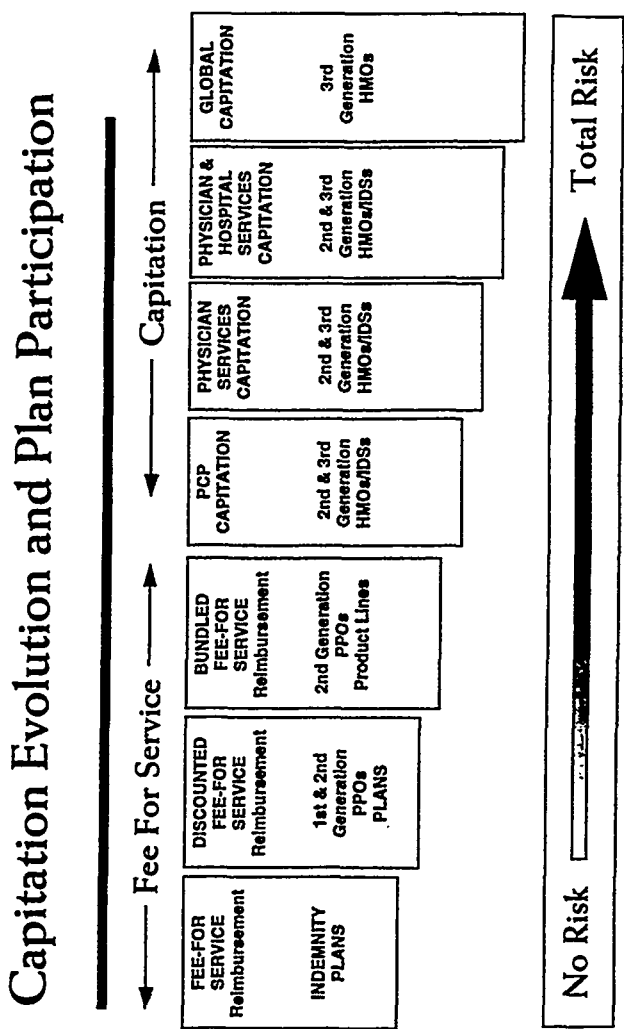
10. Cf. Glenn Lohrmann, *Capitation: Implications for Provider Cost Structures*, HEALTHCARE FIN. MGMT., July 1995, at 36 (arguing that operating managers should be held accountable for the full costs of their products); Arnold M. Epstein & Edward J. Cumella, *Capitation Payment: Using Predictors of Medical Utilization to Adjust Rates*, HEALTH CARE FIN. REV., Fall 1988, at 51 (summarizing studies of predictors of medical utilization among the elderly).

11. Frances H. Miller, *Health Insurance Purchasing Alliances: Monopsony Threat or Procompetitive Rx for Health Sector Ills?*, 79 CORNELL L. REV. 1546 (1994).

12. Cf. WARREN GREENBERG, COMPETITION, REGULATION, AND RATIONING IN HEALTH CARE 97-109 (1991) (arguing that competition may improve resource allocation).

13. See generally DAVID LEE, CAPITATION: THE PHYSICIAN'S GUIDE (1995) (available from the American Med. Ass'n, Chicago). Cf. Louise Kertesz & Joanne Wojcik, *Risky PHOs Winning Bet*, 25 MODERN HEALTHCARE 44 (July 25, 1994).

global capitation for patient care, but Kaiser historically has integrated both insurer and provider functions within the same entity. The capitated amount takes the form of a single comprehensive insurance premium payable to Kaiser. The newer wrinkle is for insurers to use premium income to capitate unintegrated providers *secondarily*, but directly. In that way risk is shifted down to the smaller independent provider units that actually deliver medical care. One version of the evolution in capitated systems is depicted in the accompanying diagram.



The federal and various state governments have been experimenting with capitating Medicare<sup>14</sup> and Medicaid<sup>15</sup> services for some time, originally through traditional HMOs. The Medicare diagnosis-related group (DRG) payment system, in effect for more than a decade, is another method of directly capitating providers. Under the DRG system, the government pays hospitals a lump sum, specified in advance, on the basis of each Medicare patient's discharge diagnosis, rather than reimbursing for that patient's actual health care costs. DRG financial incentives have been a significant contributor to the declining length of hospital stays in the United States because a discharged patient ceases to be costly to the hospital, but little evidence of any accompanying decline in clinical quality stemming from DRG use has been documented.

Governments now are toying more adventurously with permitting capitated Medicare and Medicaid insurers to re-capitate their contracting providers secondarily. Private insurers of all stripes also are playing around with provider capitation concepts, top-slicing administrative fees and profits, and then shifting significant risk to doctors, hospitals, and integrated provider networks.<sup>16</sup> Recent controversies over compensation for officers of some managed care insurers, however, have focused damaging attention on the possibilities for corporate exploitation in this area.<sup>17</sup> They also have sharpened the long-simmering debate over whether rationing is inherent in managed care, particularly where closed-end financing like direct provider capitation is involved. If provider capitation fees are squeezed too tightly, the quality of patient care inevitably will appear on the casualty list.

Provider capitation concepts can take a wide variety of forms contractually, but local law limits the range of possible arrangements in some states.<sup>18</sup> At the simplest level, physicians can

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14. Approximately 250 HMOs now participate in Medicare. Sharon McIlrath, *HCFA Estimates 10% Rate Hikes for Medicare HMOs*, AM. MED. NEWS, Aug. 14, 1995, at 7. See, e.g., *Partial Capitation Holds Promise for Expansion of Medicare Managed Care*, Health Care Pol'y Rep., (BNA) 14d22 (Apr. 3, 1995).

15. See, e.g., John K. Iglehart, *Health Policy Report: Medicaid and Managed Care*, 332 NEW ENG. J. MED. 1727 (1995); *Georgia Allows Managed Care Plans to Provide Services for Capitated Fee*, Health Care Pol'y Rep., (BNA) 30d36 (July 24, 1995).

16. See Kertesz & Wojcik, *supra* note 13.

17. Milt Freudenheim, *Penny-Pinching H.M.O.s Showed Their Generosity in Executive Paychecks*, N.Y. TIMES, Apr. 11, 1995, at D1 (illustrating that for-profit HMOs are "rewarding their chief executives with sizable pay packages.").

18. See, e.g., Kurt Fernandez, *Industry Says Texas Lawmakers Adopt Conflicting Laws*

be capitated solely for delivering their own services. In such situations, they usually contract with insurers to provide whatever care (within their medical competence) patients require during a given period of time, in return for a set total fee. A more complex arrangement would capitate a primary care doctor for *all* physician services needed by a particular patient, whether provided personally or by other professionals. In that case, the primary care physician would channel those patients needing more sophisticated care to the appropriate specialist, and then pay the specialist's fees from a larger initially capitated amount.

Primary care or other physicians also can be capitated for any and all other medical services their patients may need, including hospitalization, drugs, nursing home care, free-standing clinic services, home care, and/or anything else that conceivably could be categorized under the label of health. Alternatively, any insurer can capitate any and/or all of the secondary players listed above directly for their own services or products. Some commentators contend that such direct specialist capitation may be necessary in order to align the financial incentives properly.<sup>19</sup> Finally, any of these players can receive a prescribed annual fee in combination with any of the other providers, in return for delivering a contractually defined smorgasbord of health care to insureds. This Article focuses exclusively on those arrangements sharing one salient characteristic: a shift of some degree of underwriting risk from insurer to provider.<sup>20</sup>

### III. RISK-SHIFTING IN THE UNITED STATES

Risk-shifting can be tricky business, particularly with respect to capitating physicians. Individual doctors generally lack the actuarial skills critical to assessing what their true exposure to financial risk and benefit may be at given levels of payment. They may be relatively safe, however, when it comes to agreeing on a capitated rate covering only their own professional services,

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on *Global Capitation*, 3 HEALTH L. REP. (BNA) 1306 (Aug. 14, 1995); FTC Staff Advisory Opinion, *supra* note 6.

19. Cf. Paul R. DeMuro, *Paying Specialists and Subspecialists on a Capitated Basis*, HEALTHCARE FIN. MGMT., July 1995, at 33 (discussing the need for and difficulty in instituting specialty capitation).

20. Any of these arrangements can incorporate a separate insurance component also, but this Article focuses only on direct provider capitation rather than on providers who are vertically integrated with insurers.



for they ordinarily have a pretty good idea about the care likely to be needed by their usual patient base. Even an unexpected liver transplant candidate<sup>21</sup>—or a surge of costly HIV or AIDS patients<sup>22</sup>—need not prove financially disastrous, for these doctors are only required to supply their own knowledge, skill, and judgment to patients for the agreed capitated sum. They may have to work harder than expected if unanticipated catastrophic illness strikes their enrolled populations, but they will not be financially responsible for the other (presumably expensive) therapy any unforeseen transplant candidate or HIV or other costly patients might require.

Once capitation payments for a larger share of patient medical needs becomes involved, however, individual physicians enter more dangerous fiscal territory; physicians rarely have accurate information about the *total* costs of patient care. In such situations, monetary obligations for those same unanticipated HIV, AIDS, or liver transplant patients could prove financially ruinous to them. Primary care doctors conceivably might take on the financial burden of paying for whatever specialist care such loss-generating patients might need, but shouldering sole pecuniary responsibility for the additional costs of facility-based care would be downright foolhardy.<sup>23</sup> Thus, insurers usually place global capitation contracts only with physician, hospital, or combined physician-hospital *groups*; by informed U.S. estimates a 1000-patient base is required for minimal actuarial stability when primary care doctors are capitated directly for total patient care.<sup>24</sup> It would be highly unlikely to find an individual physician taking care of 1000 patients covered under capitation contracts with the

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21. The average cost of a liver transplant in mid-1995 was \$153,000. Stephen Baker, *Caught in the Organ Grind*, BUS. WK., Aug. 21, 1995, at 32.

22. The lifetime costs of treating HIV patients range from \$60,000 to more than \$100,000. Fred J. Hellinger, *The Lifetime Cost of Treating a Person with HIV*, 270 JAMA 474, 477-78 (1993).

23. A capitated physician provider group may or may not be considered an insurer for purposes of state insurance regulation, including reserve requirements. See *Jordan v. Group Health Ass'n*, 107 F. 2d 239 (D.C. Cir. 1939) (holding that insurance statutes do not necessarily regulate all arrangements for assumption or distribution of risk). This is a matter of some concern to state governments, see *Overwhelming Opinion of NAIC Group That Provider Networks Be Licensed*, 4 Health L. Rep. (BNA) 1264 (Aug. 17, 1995); Jeannine Mjoseth, *NAIC Bulletin to Address Application of Insurance Laws to Provider Groups*, 4 Health L. Rep. (BNA) 1177 (Aug. 3, 1995).

24. Interview with Joseph Gerstein, HMO Medical Director of Tufts Associated Health Plans, in Waltham, Mass (June 6, 1995).

same insurer now, let alone caring for even more of them.<sup>25</sup> When specialists are capitated directly for the full costs of secondary and tertiary care in their own specialty areas, much larger numbers of covered lives ordinarily must be involved for the costing predictions to have any meaning.<sup>26</sup> At present the marked shift of physicians from solo into group practice models of organization accelerates, and thus facilitates, the capitation trend.

#### IV. PHYSICIAN AUTONOMY ISSUES INHERENT IN CAPITATION

Although capitation theoretically "empowers" physicians by giving them control over budgets for varying amounts of patient care, at least three autonomy issues always are involved when physicians are capitated directly. In taking on more risk-reward potential through capitation, doctors may nevertheless find their professional autonomy circumscribed concerning their own clinical skills and with regard to their ability to make referrals. Their economic latitude to secure other health care services that they believe could benefit their patients, but which they do not provide themselves, could also be compromised if the capitated sum is calculated too closely to the line for reasonable accommodation to patient medical needs.

##### A. Professional Clinical Autonomy

Although capitated payments theoretically free physicians from insurer cost-containment encroachments on their clinical autonomy, insurers still keep a watchful eye on the clinical quality of the care their contracted providers deliver. After all, if quality standards for insured patients fall, the affected subscribers eventually will defect to other insurers. Thus, insurers develop varying methods of quality oversight. Some rely on random retrospective review, while others require providers to submit dummy bills for each patient encounter, charting them exactly as they would were they submitting bills for fee-for-service reimbursement. The only difference is that those doctors already have been paid a lump sum in advance for delivering the care.

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25. However, if current insurance industry consolidation continues apace patients will have fewer choices among insurers, so that possibility might not seem so far-fetched in the long run.

26. DeMuro, *supra* note 19.

These oversight methods can be more or less onerous, depending on the plan, so that doctors may or may not find that capitation at least lets them escape the curse of insurer red tape. The real threat from insurer quality oversight, however, is to the doctor's continuing contractual relationship with the capitating insurer, which is an increasingly significant source of physician income. Capitation contracts usually are written on an annual basis, and a physician ordinarily is vulnerable to nonrenewal for *no* cause, let alone for problems associated with quality. In any event, capitation's seductive promise of clinical autonomy for physicians may well prove slippery, if not rather hollow. Doctors may be free from second opinion requirements and pre-admission review, but they could well end up wishing they had those devices to validate their medical judgment and thus protect their contractual relations with the insurer.

### B. Referral Autonomy

For those physicians controlling budgets covering care other than what they deliver themselves, capitation theoretically permits them to order whatever additional services they believe will help their patients. The potential fly in the ointment, however, may be that the provider pool to which they are permitted to refer for other services may be severely circumscribed. In other words, in the interest of the most cost-effective care, the insurer may have limited the doctors' clinical freedom contractually in another indirect manner. (Those capitated for just their own services also often find that their insurer only permits referrals to certain preferred providers.) In some situations, referrals are limited to certain forms of treatment, or no referrals at all will be permitted for patients with certain diagnoses.<sup>27</sup> Doctors in these circumstances must refrain from giving full rein to their treatment preferences unless the patient is prepared to pay for them out-of-pocket. When physician referral autonomy is thus sharply constrained, the referring doctor's clinical autonomy undeniably is circumscribed. It is as simple as that. Physicians should, therefore, analyze with extreme care whatever contract restrictions may be imposed on their referral powers.

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27. Typical limitations might relate to infertility and certain forms of terminal illness.

### C. Economic Autonomy

The third major area of concern with regard to physician autonomy under capitation concerns the doctor's economic freedom to secure more sophisticated or ancillary patient care. Characterizing capitation as a breakthrough enhancement to physician autonomy is highly misleading if the capitated budget allocated to doctors will not stretch to cover the full range of other medical services they believe their patients need. The whole point of provider capitation is to shift decision making—and financial responsibility—"down to the coal-face" where providers quite literally must confront patient medical problems in flesh and blood. However, inadequate capitation payments can make a mockery of purported clinical autonomy. Thus, the actuarial skills of insurers are critical to reasonable capitation, as are the analytical skills of physicians in deciphering what the capitated amount translates into in terms of patient care. Some sort of stop-loss coverage for treatment outliers undeniably should be built into any reasonable capitated payment system.

## V. CAPITATION UNDER BRITAIN'S NATIONAL HEALTH SERVICE

Although most U.S. physicians at least are hazily familiar with capitation concepts, the idea of provider capitation is relatively new and vaguely threatening to many of them because of the administrative burden and financial uncertainties associated with risk-shifting. The methodology itself has been around for decades, however. The British have been capitating general practitioners (GPs) for their own professional services since 1948 when the National Health Service (NHS) first came into existence. This system has worked remarkably well.<sup>28</sup> Great Britain spends about seven percent of its gross domestic product to cover the health needs of its entire population, while we spend more than twice as much, still leaving out at least fifteen percent of our citizenry.<sup>29</sup> For all that impressive expenditure, the public

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28. See generally DAVID TAYLOR & KAREN BLOOR, *HEALTH CARE, HEALTH PROMOTION AND THE FUTURE OF GENERAL PRACTICE* (1994).

29. Joyce Price, *How Health Plans Work in Other Countries*, WASH. TIMES, Sept. 13, 1994, at E4 (citing U.K. NHS statistics). See also Katharine R. Levit et al., *National Health Expenditures, 1993*, HEALTH CARE FIN. REV., Fall 1994, at 247 (placing share of GDP devoted to health care at 13.9% in 1993); *Growth In Health Spending Projected To Reach 36 Percent In Next Five Years*, Health Care Daily, (BNA) d8 (June 14, 1995) (projecting share

health basic indices in the United States are no better than those in Britain, and in many cases, such as infant mortality, generally are worse.<sup>30</sup>

From the beginnings of the NHS, British GPs have been paid a set amount each year for delivering primary care to each patient registered on their rolls.<sup>31</sup> The current annual capitation amount of £14.80 per patient under the age of sixty-five (about \$22.00 at current rates of exchange) indeed seems modest in comparison with American standards; it probably amounts to less than the charge for a single office visit in most parts of this country.<sup>32</sup> However, when combined with other NHS fees GPs can earn,<sup>33</sup> and income from the private practice that all British physicians are permitted to do,<sup>34</sup> it has been sufficient to keep British doctors well-ensconced in the highest income brackets in their country over the past half-century.<sup>35</sup>

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of GDP devoted to health care will rise to 16% by the year 2000).

30. Five years ago the United States spent 200% more per capita on health care than did the United Kingdom. Leslie M. Greenwald, *Meaning in Numbers*, HEALTH MGMT. Q., Third Quarter 1992, at 6, 7, tbl. 1.

31. British GPs also can receive incentive bonuses for achieving public health objectives, such as reaching targeted percentages of their patient populations with cervical screening and immunizations. See generally HOWARD GLENNERSTER ET AL., IMPLEMENTING GP FUNDHOLDING 13-19 (1994).

32. The amount rises to £19.55 for patients between 65 and 74 and to £37.80 for those over age 80. DEPARTMENT OF HEALTH, GREAT BRITAIN NATIONAL HEALTH SERVICE GENERAL MEDICAL SERVICES: STATEMENT OF FEES AND ALLOWANCES PAYABLE TO GENERAL MEDICAL PRACTITIONERS IN ENGLAND AND WALES (1994).

33. For example, GPs earn from £16.15 to £48.45 for each night visit they make and from £715 to £2145 for reaching targeted percentages of their pediatric patients with immunizations. GPs also are paid on a fee-for-service basis for performing certain minor surgical procedures. *Id.*

34. GPs generally do not realize significant income from seeing patients in private practice, but consultants in private practice averaged £40,000 above their NHS income in the early 1990s. KAREN BLOOR, HOW MUCH IS A DOCTOR WORTH?, University of York Discussion Paper 98 (1992). See also JOHN YATES, PRIVATE EYE, HEART AND HIP: SURGICAL CONSULTANTS, THE NATIONAL HEALTH SERVICE AND PRIVATE MEDICINE (1995) (attacking the dual status of NHS consultants engaging in private practice to the detriment of their NHS responsibilities); MONOPOLIES AND MERGERS COMMISSION, HMSO PRIVATE MEDICAL SERVICES: A REPORT ON AGREEMENTS AND PRACTICES RELATING TO CHARGES FOR THE SUPPLY OF PRIVATE MEDICAL SERVICES BY NHS CONSULTANTS, 2452 (1994).

35. Consultants (specialists) are salaried physicians employed directly by hospitals. Their earnings, supplemented by private practice income and distinction award payments, generally have been higher than those of GPs. KAREN BLOOR & ALAN MAYNARD, REWARDING EXCELLENCE? CONSULTANTS' DISTINCTION AWARDS AND THE NEED FOR REFORM, Discussion Paper 100, 1 (1992).

### A. Purchaser-Provider Separation

In 1991, the NHS was re-structured to introduce competition principles under the umbrella of socialized medicine.<sup>36</sup> The internal markets initiated when the reforms were implemented essentially divorced the British government's health service purchasing function from its traditional provider role, and relatively abruptly compelled hospitals and other NHS facilities to compete for contracts to deliver patient care. Local hospitals, routinely accustomed to receiving annual budgets (on the basis of past workload) from the Department of Health for providing care to area residents, now are required to vie for cash-limited funding from newly designated purchasers for the government instead.<sup>37</sup> Institutions have to compete to serve patients who used to be channeled to them as a matter of course by local GPs. They must compete for patient referrals not only with rival institutional providers from neighboring districts, the private sector, and from abroad, but also with newly innovative outpatient providers of services formerly found only in association with an inpatient setting.

In 1991, the government began capitating GP-fundholder groups,<sup>38</sup> permitting them to purchase (from an enlarged capitated sum) a broader range of their patients' consultant (specialist), hospital, pharmaceutical, and other health needs. These GPs get separate budgets for their patients' drug needs, and for their non-urgent specialist and inpatient care,<sup>39</sup> in addition to the basic capitation payment covering their own services. Fundholders also have their administrative budgets augmented to cover the in-

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36. For a general description of the reforms, see Patricia Day & Rudolf Klein, *Britain's Health Care Experiment*, HEALTH AF., Fall 1991, at 3, 39; Frances Miller, *Competition Law and Anticompetitive Professional Behaviour Affecting Health Care*, 55 MOD. L. REV. 453 (1992) [hereinafter *Competition Law*]. For an analysis concluding that the 1991 reforms are basically incompatible with "the ideals of a public, free and comprehensive health service," see JOHN MOHAN, *A NATIONAL HEALTH SERVICE? THE RESTRUCTURING OF HEALTH CARE IN BRITAIN SINCE 1979*, 233 (1995).

37. For a description of these new purchasers and their functions, see *infra* nn. 40-46 and accompanying text.

38. The government originally required these groups to have a minimum of 11,000 patients on their rolls, but that number was later reduced to 9000, then 7000 and most recently to 5000. See GLENNERSTER ET AL., *IMPLEMENTING GP FUNDHOLDING*, *supra* note 31, at 9-10.

39. Jennifer Dixon, *Can There Be Fair Funding For Fundholding Practices? Funding of Large Practices Under Britain's National Health Service*, 308 BMJ 772 (1994). Some fundholders recently have complained that budgets no longer are keeping up with rising costs. See also HEALTH SERV. J., Mar. 23, 1995, at 4.

creased expense of taking on the purchasing function.<sup>40</sup> GPs practicing alone were excluded from fundholder status at the start, because their typical patient base is considered too small for effective risk-spreading, but they now can participate through cooperatives.<sup>41</sup> Very small practices cannot support the administrative and information infrastructures deemed essential to efficient purchasing.<sup>42</sup>

This year more than half of all NHS patients are registered in fundholder practices,<sup>43</sup> and the Conservative government has strongly urged more GPs to become involved in fundholding. It has encouraged them to form groups and purchasing consortia with other fundholders if necessary to achieve minimum fundholding size. In addition, the District Health Authorities (DHAs), which purchase specialist and hospital services for non-fundholding GPs, have involved primary care doctors much more closely in their purchasing decisions.<sup>44</sup> After early opposition to internal markets, the British Medical Association has come around to supporting GP purchasing as "the key to ensuring change and efficiency in the NHS," reflecting the enthusiastic embrace of the purchaser role by a growing number of GPs.<sup>45</sup>

Most recently, a pilot project in total practice budget fundholding has provided selected fundholder practices with financial control over virtually the full range of whatever government-funded health services their patients may need, including emergency care, but it is too early yet for analysis of the ef-

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40. For basic structure of the 1991 reforms, see Miller, *Competition Law*, *supra* note 36, at 455-63.

41. More than half of British patients now are enrolled with fundholding GPs. David Fletcher, *Fundholder GPs Treat More Than Half of Patients*, LONDON DAILY TELEGRAPH, Apr. 2, 1996, at 16.

42. B. J. Crump et al., *Fundholding in General Practice and Financial Risk*, 302 BMJ 1582 (1991). Informed commentators suggest that at a 7000-patient fundholding minimum, "small risk pools will become a serious problem in the future." Manos Matsaganis & Howard Glennerster, *The Threat of "Cream Skimming" in the Post-Reform NHS*, 13 J. HEALTH ECON. 31, 56 (1994). The small-pool problem presumably has been exacerbated by the reduction in minimum practice numbers for fundholding to 5000.

43. David Fletcher, *More GPs Take Over Budget*, DAILY TELEGRAPH, Aug. 30, 1995, at 6.

44. *Perspectives on Purchasing: Think Globally Act Locally*, HEALTH SERV. J., Jan. 13, 1994 at 27, 28. The Labour Party has said that, when elected to a Parliamentary majority, it will abolish fundholding but will keep the purchaser-provider split. Dolly Chadda, *Managers Breathe Again as Labour Reveals Plans*, HEALTH SERV. J., June 22, 1995, at 6.

45. Patrick Butler, *Give GPs Buying Power, Says BMA*, HEALTH SERV. J., Apr. 20, 1995, at 4 (citing HEALTH POL'Y AND ECON. RESEARCH UNIT, BRITISH MED. ASS'N, *FUTURE MODELS FOR THE NHS: A DISCUSSION PAPER*).

fects.<sup>46</sup> As U.S. health insurers begin pursuing similar financing methodologies with physician group practices, Britain's capitation experience still can be instructive to anyone seeking to evaluate the impact of capitation payments on U.S. physician behavior.<sup>47</sup>

Fundholding groups, and the DHAs purchasing health services for patients of those GPs not choosing fundholder status, became far more powerful once the reforms were instituted.<sup>48</sup> Purchasers' decisions now have the potential to spell survival or demise for hospitals, including for their formerly untouchable hospital consultant staffs.<sup>49</sup> Analogies obviously can be made to the predicament of U.S. specialists and hospitals encountering the power of managed care insurers. Hospitals and specialist providers now are forced to negotiate with hard-bargaining insurers offering subscribers preferred-provider plans, and must attempt to woo those primary care physicians who control referrals as well. British GP-fundholders in particular stood to gain personally from their new strength as purchasers, because although they have always served as gatekeepers to NHS specialist care,<sup>50</sup> never before have they had the opportunity to derive indirect profit as individual doctors from making their referrals more cost-effective.

## B. Professional Advantages of GP-fundholder Status

To begin, merely having more economic leverage to secure an improved service for patients carries obvious professional satisfactions for GPs.<sup>51</sup> Fundholder control over purchasing deci-

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46. The King's Fund Institute in London currently is putting together a study to "investigate the efficiency" of total fundholding. *Total Fundholding is Put to the Test*, HEALTH SERV. J., June 29, 1995, at 6; Rod Smith, et al., *Room at the Top: How Can All Patients Eventually Join the Top Tier of the NHS?*, HEALTH SERV. J., Nov. 24, 1994, at 28; *Fundholders to Take Over All Purchasing*, 308 BMJ 360 (1994) Cf. *Fundholding Practices: The Provision of Secondary Care*, 14 NHS Management Executive (Health Service Guidelines HSG) (1993).

47. See also Alan Maynard, *Can Competition Enhance Efficiency in Health Care?: Lessons from the Reform of the U.K. National Health Service*, 39 SOC. SCI. & MED. 1433 (1994) (concluding that "competition . . . needs to be used with caution and recognised as a means and not an end in itself.").

48. *Developing NHS Purchasing and GP Fundholding*, NHS Management Executive 79 (1994).

49. Consultants historically have received lifetime appointments to NHS hospitals. Although trust hospitals are theoretically free to employ new consultants on a different contractual basis, change has been slow.

50. BRITISH MED. ASS'N, THE HANDBOOK OF MEDICAL ETHICS 17-18 (1984).

51. One enthusiastic fundholder described the psychic satisfactions as follows: "I have



sions entails the opportunity for GPs to "do it better" than the more bureaucratic DHAs may be able to accomplish. Moreover, fundholders can tailor their purchases to the special health needs of the individual patients on their lists. In addition, fundholder purchasing muscle helps to redress the historic imbalance of power between primary care physicians and British hospital consultants, which often has been exacerbated by Parliament's closed-end and relatively tight-fisted funding of the NHS. Now consultants and their hospitals are more directly dependent on GPs for referrals, and therefore income, and in their own self-interest must pay more attention to GP wishes and concerns. Cash-limited local hospital budgets often had left GPs at a disadvantage in their attempts to secure hospital-based services for certain patients. They also have helped give rise to the widespread perception that Britain "rations" medical care.<sup>52</sup> British GPs usually have incorporated whatever local resource shortfalls that may exist into their treatment recommendations, and Britain's more physician-centered (and less patient-rights-oriented) law of informed consent tends to reflect (and deflect criticism from) any local resource limitations.<sup>53</sup>

Britain does limit health care, of course, as do all countries, including the United States. The United States just does it more covertly than other nations do. They simply exclude many of the increasing number of their uninsured citizens from the delivery system altogether for non-emergencies.<sup>54</sup> The NHS, by way of contrast, has delivered excellent primary health care services over the years, and has offered more or less reasonable secondary and tertiary care access to everyone for decades. Britain does ration non-urgent services for everyone more or less forthrightly, by way of its waiting lists.<sup>55</sup> However, the time patients

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been a GP for 23 years but I have never been so excited and turned on as I am now . . . This is megalomania isn't it? Fundholder, then total practice budget. Next year we want the defence budget." *Soundbites*, HEALTH SERV. J., June 30, 1994, at 10 (quoting David Colin Thomé, Runcorn GP fundholder).

52. See generally HENRY J. AARON & WILLIAM B. SCHWARTZ, *THE PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE* (1984) (emphasizing the trade-offs made in the British health care system with a global budget).

53. Frances H. Miller, *Denial of Health Care and Informed Consent in English and American Law*, 18 AM. J. L. & MED. 37 (1992).

54. Oregon is the only state that explicitly rations medical services and only for its expanded Medicaid population. See generally Howard M. Leichter, *Political Accountability in Health Care Rationing: In Search of a New Jerusalem*, 140 U. PA. L. REV. 1939 (1992).

55. Not coincidentally, long waiting lists create demand for private care, which NHS

must spend on those lists reportedly has shrunk significantly in the five years since the government implemented internal markets.

### C. Potential Financial Advantages of Fundholder Status

In addition to the professional satisfactions accruing to fundholder status, a GP's own financial position can be enhanced considerably through astute purchasing choices for patients. One of the first evaluations of the reforms even entitled its chapter on fundholding, "GP Fundholding: Wild Card or Winning Hand?"<sup>56</sup> The government, in order to persuade GPs to become purchasers and advance the government's internal market agenda, initially set generous fundholding budgets and promised to bail out fundholders should they overspend. Therefore, in reality, GPs took little downside financial risk when they assumed the more entrepreneurial stance involved in purchasing.<sup>57</sup> The chapter title thus was directed more toward the government's gamble in offering fundholder status to GPs than to any financial windfall or hazard a GP might have encountered in accepting it.

The British government does not permit any financial surplus accruing from more efficient prescribing patterns, better preventive care, or more cost-effective referrals to inure directly to GPs as individuals, but these savings can be plowed right back into the GP's own fundholding practice to improve its amenities and augment its services.<sup>58</sup> By luring patients with services perceived as superior to those available from other GP surgeries,<sup>59</sup> such as shorter waiting lists, fundholders hope to attract additional patients. As a result, they can garner an increased number of basic capitation payments for their own services to put in their own pockets. Moreover, to the extent the practice itself is enriched from surpluses generated by savvy purchasing, its goodwill—which can be recouped monetarily when the GP leaves practice—will be increased correspondingly. All in all, these financial incentives for GPs to engage in fundholding are signifi-

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consultants then can deliver wearing their private practice hats. The economic incentive for consultant foot-dragging with regard to appointments for NHS patients is plain.

56. Howard Glennerster et al., *GP Fundholding: Wild Card or Winning Hand?*, in *EVALUATING THE NHS REFORMS 74* (Ray Robinson & Julian Le Grand eds. 1994).

57. See *infra* part V.E.1.

58. GLENNERSTER ET AL., *IMPLEMENTING GP FUNDHOLDING*, *supra* note 31, at 13.

59. GP offices are referred to as surgeries.

cant, notwithstanding the prohibition on *direct* financial gain to doctors from effectuating savings through shrewd purchasing decisions.

#### D. Efficiency Gains from Fundholding

Once fundholding took hold in 1991, GP-fundholders showed considerable ingenuity in devising ways to improve the efficiency and "user-friendliness" of their patients' care.<sup>60</sup> They struck deals with hospitals for faster service and better amenities for their patients, and often got a more favorable price in the bargain by threatening to refer their charges (with their all-important financial reimbursements) elsewhere. However, fundholders have been even more hesitant than U.S. insurers about getting into the business of specifying standards of clinical quality, let alone expected outcomes from treatment. They apparently have concluded that given the current state of British information systems and their own technology, accompanied by professional skepticism about establishing performance indicators and doing outcome analysis, those issues are too difficult for small purchasers, let alone larger ones, to grapple with.<sup>61</sup> But fundholders have been creative in obtaining direct patient access to services that usually were hospital-based only, such as physiotherapy. These now are often delivered through fundholders' user-friendly outreach clinics, with a minimum of patient dislocation and delay.<sup>62</sup>

NHS waiting lists for consultant appointments and non-urgent hospital care have been legendary, but some fundholders have hired NHS consultant physicians in their private practice capacity to run clinic sessions on GP premises, rather than routinely referring patients to those same busy specialists in their hospital consultant roles.<sup>63</sup> Thus, long waits for initial appoint-

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60. The King's Fund, London, a British health policy think tank, has established a nationwide data base to track fundholder purchasing innovations. *Purchaser Notes*, HEALTH SERV. J., July 14, 1994, at 8.

61. The District Health Authorities, who purchase larger blocks of services for the patients of GPs not engaged in fundholding, have done no better at getting into issues of clinical quality.

62. *Fundholders Are Not Putting Cash Before Care*, HEALTH SERV. J., Mar. 16, 1995, at 6 (asserting that "[r]esearchers have debunked the popular image of fundholders as business-minded penny-pinchers who are reluctant to spend money on patient care.").

63. Jacqueline Bailey et al., *Outreach Clinics: The Special Branch*, HEALTH SERV. J., July 28, 1994, at 30 (reporting on 96 outreach clinics covering medical and surgical special-

ments were neatly averted, and many fundholder patients joined the queue for any inpatient treatment that might be necessary at earlier dates than otherwise would have been the case. Moreover, by negotiating aggressively with hospitals to place contracts for inpatient services, some fundholders were able to extract guarantees that their patients would receive faster hospital-based treatment than the larger and more cumbersome DHAs were able to secure. Although the Department of Health officially discourages such "fast-track" hospital service for fundholder patients, and the British Medical Association has publicly condemned it as creating a two-tiered NHS, fast-tracking nonetheless continues to exist in some cases.<sup>64</sup> Fundholders also become creative in achieving savings through their prescribing patterns, through such methods as switching to generic drug formularies.<sup>65</sup>

## E. Socially Undesirable Side-Effects of Fundholding Incentives

### 1. Adverse Selection

"Cream skimming" of the healthiest subscribers is a well-recognized competitive strategy among U.S. managed care insurers, whose marketing schemes often are designed to select against older and more chronically ill patients.<sup>66</sup> Regardless of whether incorporated in a for-profit form, U.S. health insurers usually will seek to increase or at least retain market share in order to survive. Economic theory teaches that the healthier the risk pool insured, the more surplus will accrue to an insurer at any given premium rate. Such striving for profit-maximization always drives competitive insurance markets, whether it inures to shareholders or enables the insurer to reduce premiums in order to capture more subscribers. The same economic analysis, at least in theory, applies to capitated providers.

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ties). Some charge that consultants deliberately manipulate NHS waiting lists in order to generate demand for their services in the private sector. YATES, *supra* note 34.

64. David Brindle, *Minister Rejects Consultants' Two-Tier NHS Treatment Claim*, MANCHESTER GUARDIAN, Dec. 10, 1993, at 5.

65. Jon S. Dowell et al., *Changing to Generic Formulary: How One Fundholding Practice Reduced Prescribing Costs in the United Kingdom's National Health Service*, 310 BMJ 505 (1995).

66. Donald W. Light, *The Practice and Ethics of Risk-Rated Health Insurance*, 267 JAMA 2503 (1992). See also Harold S. Luft & Robert H. Miller, *Patient Selection in a Competitive Health Care System*, HEALTH AFF., Summer 1988, at 97.

Some feared that once the NHS competitive reforms were introduced GP fundholders would engage in adverse selection, seeking to insulate their practice budgets from patients predicted to be actuarially costly, because fundholders would seek greater financial surpluses with which to upgrade their practices.<sup>67</sup> Thus far, those fears have gone largely unrealized for a number of reasons.<sup>68</sup> Among them are a strongly articulated and more service-oriented British professional ethos, particularly among NHS physicians, than is generally found in the United States. This promotes the kind of patient loyalty one would not expect to find in the more impersonal insurer-subscriber relationship.<sup>69</sup> In addition, although fundholders now compete more or less overtly with other GPs for patients, their initial fundholding budgets were set on the basis of their own historic practice costs.<sup>70</sup> Thus, the extra financial burden of caring for their more expensive patients was built into their spending power from the beginning. This created perverse incentives, however, for it blunted the economic stimulus to efficiency and perpetuated then-existing resource inequalities. Any existing inefficiencies in the fundholder's practice effectively were subsidized.

Since 1993, however, fundholder budget allocations have been partially tied to a weighted capitation formula, and eventually historic costs could be phased out altogether as a factor in setting fundholder budgets.<sup>71</sup> The temptation to engage in adverse selection nonetheless will remain attenuated for British physicians in comparison with the financial incentives facing capitated U.S. doctors. Fundholders still are prohibited from *directly* pocketing whatever savings could be generated by eliminating costly patients from their rolls, while their American counterparts currently are not. Moreover, the British government has provided stop-loss coverage above £5000 to fundholders at no charge to encourage more GPs to become involved in purchasing. Thus far, the government generally has financially bailed out the few fundholders who have overspent their budgets.

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67. Richard Scheffler, *Adverse Selection: The Achilles Heel of the NHS Reforms*, 1 LANCET 950 (1989).

68. Matsaganis & Glennerster, *supra* note 42.

69. See generally JOSEPH M. JACOB, DOCTORS AND RULES (1988).

70. GLENNERSTER, ET AL., IMPLEMENTING FUNDHOLDING, *supra* note 31, at 116-34.

71. *Id.* at 133-49. Weighted capitation, however, has been criticized as slighting inner-city needs. See, e.g., Steve Mayner, *Funding Fails to Meet Needs of Inner Cities*, HEALTH SERV. J., June 23, 1994, at 7.

## 2. Self-Referral

Although fundholders personally cannot keep surpluses generated by efficient purchasing, GPs can benefit financially from astute purchasing decisions in ways other than attracting more patients. When the reforms were first introduced in 1991, innovative fundholders immediately devised strategies to generate secondary income through their purchasing in ways that are excruciatingly familiar to observers of the U.S. health sector. For example, some fundholders set up partnerships or private corporations with themselves and/or family members as owners. These companies then provided ancillary services to fundholding and other patients, if requested. As purchasers, fundholders could sow the seeds of demand for their own products, from which they could profit as investor-owners, and use their newly expanded NHS practice budgets to satisfy the demand created. In essence, they were able to buy from themselves using public funds, with no middleman to ask awkward questions about whether they really were getting value for money. Some fundholders reportedly harvested "a windfall" in the process.<sup>72</sup> All of this is reminiscent of the kind of physician self-dealing that has occurred in the United States in all too many guises, from ordering unnecessary testing in doctor-owned imaging centers<sup>73</sup> to physician kickbacks for hospital referrals and cardiac pacemaker installations.<sup>74</sup>

The British government moved very quickly to curb this type of conflicted practice among fundholders. By April of 1993, within two years of the time the reforms went into effect, the Department of Health had implemented a regulation that prohibits fundholders from contracting with companies providing health services if those fundholders are in a position to receive income, directly or indirectly, from those services. This parallels enactment in the United States of the recent Stark I and Stark II legislation, also designed to curtail physician conflicts of interest.<sup>75</sup>

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72. Alan Pike, *Government May Curb Spread of GPs' Companies*, FIN. TIMES (London), Dec. 10, 1992, at 8.

73. See MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST* 57 (1993).

74. *Id.* at 57-59.

75. Ethics in Patient Referrals Act (Stark I), 42 U.S.C. § 1395nn (1994) (effective Jan. 1, 1992) (prohibiting certain physician referrals for Medicare patients); Comprehensive Physician Ownership and Referral Act (Stark II), 42 U.S.C. § 1359nn (1994) (effective Jan. 1,

Significantly (particularly in light of its professed interest in discovering the full range of innovations fundholders could devise with competition as a spur to creativity), the Department chose to regulate perceived abuses directly rather than to change the incentive structure which had elicited the censured professional conduct in the first place. Fundholders still can plow back all savings from purchasing into the practice itself, increasing other services and amenities to attract more patients, and consequently, more capitation payments to keep for themselves. However, they do not yet have to remit fundholding savings back to the government for redeployment to areas with lesser resources. GP fundholders simply cannot profit directly from any surpluses generated by savvy purchasing.

### 3. Miscellaneous Gaming Problems of Fundholding

Several other alleged abuses of fundholder status have been reported, but none seems either extensive or wide-spread at this stage. For example, because fundholder budgets were originally set on the basis of the GPs' historic practice patterns, inequities were built-in from the beginning.<sup>76</sup> There is some evidence that GPs increased their referrals in the data collection period just prior to embarking on fundholding to jack up their fundholding budgets.<sup>77</sup> The opportunity to engage in such manipulation is a one-time phenomenon, however, and the gradual shift toward weighted capitation has ameliorated the problem. In another example of profit-maximizing gaming, fundholders in Wales allegedly made "vastly more emergency referrals to hospital than non-fundholders," indicating that these GPs may have engaged in cost-shifting,<sup>78</sup> a practice well-honed by U.S. hospitals and exemplified in its most extreme form by patient-dumping.<sup>79</sup>

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1995) (prohibiting physician self-referrals for designated services). See also RODWIN, *supra* note 73, at 126-28.

76. See Patricia Day & Rudolf Klein, *Variations in Budgets of Fundholding Practices*, 303 BMJ 168 (1991) (discussing spending patterns in fundholding practices); Jennifer Dixon et al., *Distribution of NHS Funds Between Fundholding and Non-Fundholding Practices: United Kingdom's National Health Service*, 309 BMJ 30 (1994) (suggesting that the methods of allocation result in inequitable funding practices).

77. Dixon, *supra* note 39, at 773.

78. Dolly Chadda, *Fundholders Account for Most Emergency Referrals*, HEALTH SERV. J., Mar. 30, 1995, at 5.

79. Maria O. Hylton, *The Economics and Politics of Emergency Health Care for the Poor: The Patient Dumping Dilemma*, 1992 B.Y.U. L. REV. 971 (explaining that "dumping" occurs when a hospital illegally transfers an emergency patient to another hospital, or refuses

Fundholder budgets cover patients' expenses for *non-urgent* hospital care only. However, subsequent data has indicated that other factors probably explain those increased emergency referrals.<sup>80</sup>

## VI. CONCLUSION

What autonomy lessons can be drawn from the U.S. and British experiences with capitation? To begin with, capitating primary care physicians for services they alone provide should work well for both physicians and payors in the United States, if the British example is any guide. Both insurers and primary care providers can make actuarial calculations on the basis of relatively small numbers, and few diagnostic surprises can upset their projections dramatically. Moreover, capitation should work reasonably well for patients, so long as continuing relationships are contemplated; this is usually the case when patients select primary care doctors. Economic temptations to under-provide primary care are unlikely to subvert doctors' clinical judgment significantly when they will presumably be interacting with their patients on a long-term basis. Realistically calculated primary care capitated payments do permit doctors to exercise the full range of clinical judgment for their own services, and to cross-subsidize the care requirements of their more clinically needy patients from the costs generated by their more healthy ones.

More troublesome difficulties can arise in both the United States and the United Kingdom when providers are capitated for more than their own expertise, although that is precisely the area where the greater potential for efficiency exists. The fact that few British fundholders have overspent their budgets for specialist and hospital care thus far indicates that the government probably set their original capitation payments too high to induce GPs to make cost-effective choices that truly maximize efficiency. The government no doubt financed fundholders generously to secure their cooperation for advancing its internal market political agenda, just as it granted the medical profession *carte blanche* clinical autonomy in 1948 when the NHS first was instituted.<sup>81</sup> The U.S. government engaged in a similar strategy in

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treatment when the patient cannot pay).

80. Patrick Butler, *High Emergency Admission Levels Here to Stay*, HEALTH SERV. J., Sept. 14, 1995, at 3.

81. RUDOLF KLEIN, *THE NEW POLITICS OF THE NATIONAL HEALTH SERVICE* 166 (3d ed.



1983 when it switched to prospective payment for Medicare hospital services, and fixed the first DRG payment amounts. When budget pressures mount, however, governments inevitably tighten the financial screws on providers in lieu of incurring voter wrath by significantly increasing taxes. Provider resistance to such financial squeezes is equally inevitable. Attempting to reduce a financial advantage already enjoyed by a powerful physician interest group is guaranteed to generate stiff political opposition, regardless of whether patients advocate the overall finance strategy.

The Conservative government banks on such fundholder commitment to the purchasing concept, and on British GPs' reluctance to give up their newly recovered economic power, to keep primary care doctors wedded to purchasing, and thus sustain the NHS's competition initiatives. Labour has pledged to end fundholding once in office, but it may find that pledge quite difficult to keep politically because the British Medical Association is every bit as powerful in the United Kingdom as the American Medical Association is in the United States. In any event, fundholders probably will remain deeply attached to maintaining a fair degree of control over where their patients go for hospital and specialist care now that they have begun to enjoy that power, whether it be through their own purchasing or through a much larger influence on DHA contracting for patients care than GPs have been accustomed to wielding in the past. Clinical autonomy over referrals once regained will not be relinquished lightly.

The referral autonomy issue in the United States is now perhaps less problematic for primary care physicians than it is for their patients who are beginning to understand that their choices for specialists have narrowed considerably under many managed care plans.<sup>82</sup> However much those physicians may resist restrictions on their freedom to send patients wherever they choose for specialist care, primary care doctors at least have their own financial incentives to keep referrals from going out-of-network. The British experience has demonstrated that GPs can be quite

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82. The autonomy issue is complicated further in the United States because our doctrine of informed consent is more patient-centered than that prevalent in the United Kingdom. See generally Miller, *supra* note 53 (contending that limitations of local resources play a role in informed consent and treatment recommendations).

innovative in creating efficiencies when allowed to make their own referral arrangements, and to benefit financially thereby. However, they are not as yet at personal financial risk if they overspend their capitated practice budgets. The lessons to be taken from their experience must, therefore, be tempered by the understanding that the whole tenor of capitation in this country is to force more hard-edged economic choice than is the case in the United Kingdom. Stop-loss insurance coverage could perform some of the same protective functions for doctors in this country as government bail-out does in the United Kingdom, but presumably, the expense of such coverage will be borne more immediately by U.S. physicians in the form of either direct costs or discounted capitation fees.

The biggest potential for incursions on clinical autonomy posed by the trend toward provider capitation stems from the size of the capitated payment. A miscalculation of that sum can spell disaster for physician and patient alike, and in the longer run, for the insurer as well. Economic autonomy thus becomes the pivotal issue when evaluating capitation proposals, and few providers acting on their own or in small groups possess the skills necessary to analyze capitation initiatives realistically — be they their own or those of third-party payors — against hypothetical future patient needs. Stop-loss coverage again could function to cushion any financial blows, but the same costs would be borne by providers as were delineated in the discussion of referral autonomy. Thus, an investment in expert consultant advice is critical to any provider, insurer, or government decision about whether to go forward with capitation.

Capitation is no fail-proof panacea for physician autonomy and health care cost-containment dilemmas, but neither is it an inevitably flawed approach to the daunting quality and cost-containment problems of health care delivery systems. In order for the right balance to be achieved between the professional and financial satisfaction of physicians and a society's interest in patient welfare accomplished with a reasonable balance of cost-effectiveness, both doctors and patients must sense a commitment to fairness and equity on the part of payors who utilize capitated payment systems, be they governmental or private insurers. In other words, all must approach capitation as a win-win rather than a zero-sum game proposition if it is to bear out its potential promise. A perception of commitment to that objective should help to offset a scramble for short-term gain on all sides.

The key is to build in incentive structures that are at the same time sufficiently accurate to return adequate compensation to providers when they deliver good quality care at a reasonable price, and sufficiently difficult for insurers, providers, and patients to manipulate detrimentally. Both the United States and the United Kingdom have had experience observing all players as they gamed our respective health care delivery systems for financial advantage. Unfortunately, no country seems to have enjoyed unqualified success in implementing strategies in which the economic and professional incentives *accurately* reinforce the health care quality and cost objectives that the society values.