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Group Practice under Capitation versus Individual Practice under Fee-For-Service

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Objectivos (Objectives):

It is common, in countries where publicly-subsidized private medicine is the norm (non-NHS), that general practitioners (GP) voluntarily practice in partnership. They have several reasons to do so: reduce their costs through economies of scale, share the financial risks, distribute the workload or facilitate the exchange of information and knowledge. In the Belgian case under scrutiny, joint work has also been motivated by the shared wish to promote higher access to underprivileged populations.

Though, there is poor evidence about the consequences of group practice on efficiency. In particular, the impact of financing incentives remain largely unexplored as regards group practice. There are however good reasons to believe that financial incentives do not equally bear on partnerships. Economic theory postulates, e.g., that the revenue sharing associated to partnerships creates an incentive to free ride on the effort of others. Hence, we may expect the incentives of fee-for-service (FFS) and capitation to be attenuated under a partnership, as physicians share the benefits of higher productivity (in the case of FFS) and cost-containment (in the case of capitation).

The organization of primary care in Belgium offers a framework to compare individual and group practice under different payment schemes. Indeed, all physicians working in group practices are paid by capitation while most physicians practicing individually are paid by FFS. The present study is devoted to comparing the impact of financing incentives on health care use and expenditures between individual and group practices.

Metodologia (Methodology):

We use a large data base with individual observations (n=66,631) between the 1st January 2002 and the 31st December 2004. The data base includes detailed expenditures on primary care consultations, prescriptions, lab tests and exams, and referral to specialist and hospital care. In addition, our data base includes a large array of individual's socio-demographic characteristics (age, sex, low-income beneficiaries of reduced co-payment rates, long-term unemployment, disability benefits recipient) and clinical characteristics (disability, dependency, chronic diseases). Finally, individual data were merged with area-

based socio-economic information through individuals' area of residence (median income, ownership, assets, education level, inequality index).

Resultados (Results):

As already mentioned, group practices were originally motivated by equity concerns and generally receive a population that is poorer on average. In addition, the choice of provider in Belgium is free, so that the decision about which GP to visit is likely to be influenced by the expected health care use. In order to control for this bias, data are matched on the basis of the probability of choosing to be treated in group or individual practice.

Our findings indicate that differences in expenditures between group practice under capitation and individual practice under FFS are rather negligible (predicted values are of 1,285€ versus 1,297€ respectively). Group practice have a 98% higher primary care expenditures, related to GP visits, physiotherapy consultations and nursing. However, these differences are largely compensated by their lower referral to specialized care and hospitalizations, leading to lower expenditures (-12%). In terms of lab tests, higher expenditures are also observed among individual practitioners, although differences are statistically non-significant.

Conclusões (Conclusions):

This study shows the relevance of comparing individual and group practice when measuring the impact of financing incentives. We observe that capitation payment in partnership settings leads to higher primary care expenditures but is associated to lower referral and specialized care expenditures. Hence, the commonly mentionned incentive of capitation to cost-containment and higher referral seems to be attenuated under group practice.