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Guide to Prospective  
Capitation with Illustrations  
from Latin America



# Guide to Prospective Capitation with Illustrations from Latin America

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## ACRONYMS

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<b>ARS</b>	<i>Administraciones del Régimen Subsidiado</i> (Subsidized Regime Authorities, Colombia)
<b>CB</b>	Capitated budget
<b>DDM</b>	Data for Decision Making
<b>EBAIS</b>	<i>Equipo Básico de Atención Integral de Salud</i> (Basic Team for Integrated Health Care, Costa Rica)
<b>EPS</b>	<i>Entidades Promotoras de Salud</i> (Health Promotion Organizations, Colombia)
<b>EPS</b>	<i>Entidades Prestadoras de Salud</i> (Health Care Provider Organizations, Peru)
<b>FPMD</b>	Family Planning Management Development
<b>HMO</b>	Health Maintenance Organization
<b>IAMC</b>	<i>Instituciones Médicas Colectivas</i> (Collective Institutions of Medical Assistance, Uruguay)
<b>HIS</b>	Integrated health system
<b>IMSS</b>	<i>Instituto Mexicano del Seguro Social</i> (Mexican Social Security Institute)
<b>IPS</b>	<i>Instituciones Prestadoras de Servicios</i> (Health Service Provider Organizations, Colombia)
<b>ISAPRE</b>	<i>Institución de Salud Previsional</i> (Prospective Health Institutions, Chile)
<b>LAC</b>	Latin America and the Caribbean
<b>MCO</b>	Managed care organizations
<b>MoH</b>	Ministry of Health
<b>OS</b>	<i>Obras Sociales</i> (Sickness Funds, Argentina)
<b>PAHO</b>	Pan American Health Organization
<b>PC</b>	Prospective capitation
<b>PHR</b>	Partnerships for Health Reform
<b>PMPM</b>	Per-month-per-member (rate of payment)
<b>Pop</b>	Population
<b>POS</b>	<i>Plan Obligatorio de Salud</i> (Mandatory Health Plan, Colombia)
<b>POSS</b>	<i>Plan Obligatorio de Salud Subsidiado</i> (Subsidized Mandatory Health Plan, Colombia)
<b>UPC</b>	<i>Unidad de pago por capitación</i> (Capitated payment unit, Colombia)
<b>USAID</b>	United States Agency for International Development



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# 1. INTRODUCTION AND BASIC CONCEPTS

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Prospective capitation is a method of financing under which health care providers receive a pre-determined payment for each patient who registers with them. In return, the providers agree to supply specified services to any member of the defined population, on an as-required basis during a period of time stipulated by a contract.

Prospective capitation exposes providers of care to the risks and consequences of spending in excess of the predefined and prepaid budget. To manage such risks, providers receiving payment through this mechanism seek clinically effective and cost-efficient ways of delivering their services by strengthening prevention and other primary care, favoring hospital-substituting clinical strategies, limiting referrals to higher levels of care, and controlling resource utilization by subcontracting providers.

International recognition of prospective capitation has grown in the past 15 to 20 years. Currently, it is used by health care systems that range from market-driven, such as the U.S. system, to government-dominated, such as the system in the United Kingdom. Under provider payment reforms in these trend-setting health systems, prospective capitation has produced important systemic effects, including increased emphasis on prevention and continuity of care, decline in admission rates, and decline in length of hospital stay. Because both positive and negative experiences have been widely documented, prospective capitation has become an accessible option for trial application in the LAC countries.

Capitation contains three crucial elements:

- 1) Payment is tied to a defined patient population, i.e., the money follows the patient;
- 2) Care is prepaid at a predetermined rate, hence, capitation is a method of prospective provider reimbursement;
- 3) The recipient of the capitated payments may be at financial risk if expenditures exceed payments and is therefore influenced by an incentive to manage care in a cost-effective manner.

Prospective capitation strongly supports the following health policy goals:

- ? Increase participation of general practitioners in determining clinical strategies, referral patterns, and allocation of resources among levels of care;
- ? Improve coordination of services among the primary, secondary and tertiary levels;
- ? Broaden access to care and liberalize consumer choice of provider while, at the same time, restricting indiscriminate “doctor shopping”, resulting in too many office visits, tests and prescriptions;
- ? Raise professional and economic satisfaction of health care providers;
- ? Increase cost efficiency in the health care sector.

## 1.1 PARTIAL CAPITATION

Depending on whether capitation as a method of funding applies to some or all types of services, a distinction is made between partial or full (total) capitation.

Under the 1992 U.K. National Health Service Regulations, general practitioners are paid a capitation fee per enrolled patient, supplemented with "fees for items of service" that apply to contraceptive and maternity services, immunizations, cervical cytology, and minor surgeries.

*Partial capitation* implies that prospectively determined per capita rates and budget only apply to some services provided by a given medical facility or a network of facilities. All other services are reimbursed outside the capitated budget, even though their rates may also be agreed upon in advance. In the United Kingdom, beginning in 1990, 45% of services provided by general practice were reimbursed using capitation. This share has grown ever since.

Because partial capitation includes elements of both capitated and fee-for-service reimbursements, two sets of diverging incentives emerge. When managing capitated services, the provider tends to contain costs in two ways. Firstly, the provider seeks to control its cost per unit of a service to make sure cost does not exceed a predetermined price by which the service is integrated in the capitation rate. Secondly, the provider seeks to prevent over-utilization of that service, since the service-specific component of the prepaid capitated budget is fixed to a predefined utilization rate. Excessive utilization would lead to financial strain.

When managing non-capitated services, providers will still actively work to control unit costs in order to stay within the fee-for-service rates that are usually set in the purchaser-provider contract. At the same time, the incentive to prevent over-utilization is reversed here since revenue is directly proportionate to the number of units of services provided.

A prudent payer would apply a variable approach to cost-containment by combining prospective capitation with fee-for-service. Most medical care would be reimbursed by capitation, thus, strongly encouraging a provider to adhere to cost-efficient strategies in maintaining patients' health. However, providers may be tempted to achieve across-the-board savings by limiting patients' access to services, including those of particular relevance for public health, rather than seeking creative strategies for cost-containment. To minimize this risk, a prudent purchaser would stimulate production of services that match public health priorities with the fee-for-service method of reimbursement.

## 1.2 FULL CAPITATION

Dental care is a relatively rare component of capitated funding. Since 1993, dentists in the U.K. have been paid on a capitation basis for providing most office care to children less than 18 years old. They also receive a monthly capitated payment for continuing care of adults, including emergency services and replacement of restorations that failed within a year. In addition to these payments, doctors may charge patients regulated fees.

*Full (total) capitation* implies that the capitation payment covers the entire package of services negotiated between a purchaser and a provider. Such packages may be comprehensive enough to include acute hospital stays, planned hospitalization, day hospitals and surgery care, outpatient office and home visits, immunizations, family planning and health promotion, drug prescriptions, and dental care.

In practice, purchasers can utilize full and partial capitation payment methods simultaneously. For example, all services of a general practice could be funded by prospective capitation, while nearby providers of secondary and tertiary care operating under contract from the same purchasing agency would be reimbursed on the basis of fee-for-service per episode of care or patient discharge. If the purchaser organizes all contracting providers into

one referral network, the provider network would cover all levels of care, thus forming an integrated health system. Resources for this type of system would be planned and allocated on the basis of full capitation – i.e. the total resource requirement is the product of annual per capita health expenditure and the number of enrollees or local residents. From the standpoint of financial planning, an integrated health system is a fully capitated system. In the case of general practice, funds are disbursed on a full capitation basis, whereas other methods of fund disbursement are utilized in the case of secondary and tertiary providers. From the perspective of fund disbursement and budget execution, the system exhibits the features of a partially capitated provider network.



*SUBCONTRACTORS*