
Commentary

Reins Or Fences: A Physician's View Of Cost Containment

by Kevin Grumbach and Thomas Bodenheimer

The days when American physicians could practice medicine unfettered by concerns of cost are rapidly vanishing. The emphasis of health policy debate is no longer, "Should we attempt to contain costs?" but, "How should we control costs?" In this context, the medical profession's traditional resistance to the setting of limits in any form is unlikely to remain a credible position. Far more productive will be physicians' engagement in the selection of cost containment strategies that best preserve professional integrity and minimize disruption of patient care.

Expenditure targets and utilization review exemplify markedly different approaches to cost containment. Congress, following the recommendations of the Physician Payment Review Commission (PPRC), recently adopted expenditure targets for the Medicare program despite a highly visible campaign of opposition by organized medicine. Expenditure targets and expenditure caps are prominent cost containment strategies in other nations, most notably Canada and Germany. In contrast, strict utilization review linked to payment decisions is a singularly American approach to cost control. Nearly 60 percent of private health insurance plans in the United States, in addition to Medicare and Medicaid, now feature some form of utilization review.¹ Yet, compared with expenditure targets, the rapid growth of utilization review appears to have provoked far less organized opposition from American physicians.

In this Commentary, we discuss the different implications of expenditure targets and utilization review from the point of view of practicing physicians. One of our principal considerations is the extent to which these measures impinge on physicians' clinical freedom. The analogy of the medical commons provides an illustrative context for understanding how physicians may experience the growing tension between pressures to limit resources and desires for clinical freedom.

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The Medical Commons

The predicament of limited resources, both in health care and other areas, has been likened to a herd of cattle grazing on a common pasture of finite capacity.² Adapting the analogy of the commons to the contemporary cost containment setting, the total grazing area may be regarded as the entirety of economic resources in the United States. The smaller pasture dedicated to health comprises a portion of that grazing area. The herd represents the nation's physicians, grazing on the financial resources of the commons in the process of providing services to patients.

Physicians, guided by medicine's moral imperative to "do everything possible for the individual patient," continually attempt to extend the borders of the medical pasture.³ As health care costs as a percentage of U.S. gross national product (GNP) rose from 5.2 percent in 1960 to 11.1 percent in 1988, the boundaries of the pasture dedicated to health care steadily expanded within the overall societal commons.

But communities outside the medical pasture increasingly view the herd as encroaching on resources needed for other pursuits. The organized payers-government and employers-who plant much of the "green" on the medical commons, are intent on protecting their larger commons from what they see as the relentless expansion of the medical herd. Conflict is intensifying between the contrary drives of physicians, seeking maximum care for their patients in an era of scientific breakthroughs, and the cost containment impulses of the payers planting the commons. The unencumbered open range, like the American doctrine of manifest destiny, is a thing of the past.

There are two fundamentally different manners of restraining resource use on the commons: placing individual reins on each member of the herd to control grazing on the open range (utilization review), or building a fence around the medical pasture to limit the total area of grazing available but leaving the individual cattle unharnessed (global budgetary controls such as expenditure targets). Which form of restraint, reins or fences, least threatens physicians' clinical freedom?

Professional autonomy. It is important to define exactly what we mean by "clinical freedom." Physicians frequently wave the banner of professional autonomy with great rhetorical flourish and lack of precision. In our view, clinical freedom is the ability of the physician to deliver medical care to a patient without the *uninvited imposition* of outside influences whose purpose is not the optimal health of the patient. Clinical freedom allows physicians to fulfill their role as the patient's agent in performing those services believed beneficial to the patient's well-being. It follows that quality-assurance peer review conducted within hospitals and group

practices should not be construed as a loss of autonomy; it is (or should be) invited by the physician, with the goal of improved patient care.

Nor is clinical autonomy linked with the fees a physician receives. Negotiation and regulation of fees by third-party payers is clearly warranted; it is the exceptional physician who expects to be paid whatever he or she chooses to bill. But to the extent that cost-control mechanisms wrest away from the physician the ability to determine the type and quantity of services, physicians' autonomy is reduced. Organized medicine frequently confuses freedom to set fees with clinical freedom. In Canada, one member of the Ontario Medical Association testified in opposition to the province's policy to prohibit extra-billing of patients above the government fee schedule: "It is our duty to ourselves, to medical students now in training, and to those yet unborn who will carry on our profession in the 21st century, to resist, in any and every possible way, this mortal attack on our professional freedom."⁴

The "professional freedom" defended so assiduously in this case has little to do with the notion of clinical autonomy we have proposed. In their analysis of the controversy surrounding Canada's extra-billing ban, a Canadian physician and his colleagues concluded that "the end of extra billing did nothing to interfere with clinical practice."⁵ Unfortunately, appeals about professional autonomy, when the issue is really economic gain, simply create confusion in instances when clinical autonomy or the health of patients is genuinely at risk. True clinical freedom is important to patients as well as physicians. Patients should have the right to consult, and make decisions with, their physician under conditions of privacy, free from the interference of outside parties whose primary interest in the patient/physician interaction is to reduce the costs of that interaction.

Economic realities dictate that the era of absolute clinical autonomy is over. Whether by reins or fences, physicians will have to consider costs when making clinical decisions. Different cost containment strategies may, however, impinge on clinical freedom in very different ways.

Reins And Fences: Cost Control And Clinical Autonomy

Utilization review. Let us now return to the medical commons and explore the impact of two contrasting cost-control methods on clinical autonomy. Utilization review ("reins") is the surveillance of and intervention in the clinical activities of physicians through such methods as preadmission authorization for hospital care, concurrent review of length-of-stay, mandatory second opinions, and retrospective claims review. Holding the reins are agents of the payers-peer review organizations (PROs) or cost management firms—who tighten them whenever physi-

cians are perceived to be grazing outside the perimeter of practices found acceptable to the payer. The most stinging forms of utilization review employ the prod of payment denial for services received. (Total payment denial for legitimate services, in contrast to fee schedules, does have an impact on clinical freedom because it provides a 100 percent negative incentive for providing certain services.)

Supporters of utilization review might argue that this cost-control method selectively eliminates unnecessary services and is thus justified as a clinical intrusion on quality-of-care grounds. There is evidence that physicians in the United States perform large numbers of inappropriate procedures and suspicion that much of what constitutes "appropriate" standards of practice lacks proven efficacy.⁶ But does utilization review really catch the "stray cattle" grazing unnecessarily, apart from the accepted standards of the herd, without restricting the clinical autonomy of more conscientious physicians?

Tarnishing such an ideal vision of utilization review is a pervasive uncertainty about exactly what constitutes appropriate care. In one study of the utilization review decisions of Arizona's Medicare PRO, two community physicians conducted a blind review of hospital admissions previously evaluated by the PRO. The community physician reviewers would have denied 28 percent of the admissions approved by the PRO and would have allowed 39 percent of the admissions denied by the PRO. Worse yet, the two community reviewers disagreed with each other in 48 percent of the cases.⁷ In another study, The RAND Corporation convened a panel of experts to review detailed medical records of Medicare patients receiving coronary angiography, upper gastrointestinal endoscopy, or carotid endarterectomy. Even among these experts, there was "substantial disagreement" about the appropriateness of 25 percent of the endoscopies and 32 percent of the endarterectomies.⁸

A physician writing in *The New York Times* described making daily visits to a patient terminally ill with lung cancer during the last eighteen days of her life. The patient was increasingly short of breath, weak, and unable to eat; decisions on her care had to be made daily. The physician was told by Medicare that the visits were medically unnecessary.⁹ The 73 percent of American physicians who have experienced Medicare claims denials no doubt could add many examples of the difficulty distinguishing between appropriate and inappropriate care.¹⁰ Even strict practice guidelines, currently under development, will likely be unable to eliminate the gray areas of uncertainty that color so much of what William Osler called "an art which consists largely in the balancing of possibilities."

The harness and prod of utilization review have turned American physicians into the most "second-guessed and paperwork-laden physi-

cians in western industrialized democracies.”¹¹ Utilization review also requires a large bureaucratic force to ride the herd, holding the reins of the many individually harnessed cattle. It is no wonder that the United States has the highest ratio of health care bureaucrats to health caregivers in the developed world, causing the administrative costs of the American health system between 1980 and 1986 to grow at more than double the rate of overall health cost increases.¹² Proposals to expand current utilization review practices into the ambulatory sector (as currently planned by public and private payers) are daunting. Former Health Care Financing Administration head William Roper admitted that “the task of monitoring 11 million admissions from 7,000 hospitals for 475 DRGs [diagnosis-related groups] pales in comparison with that of reviewing 350 million bills from 500,000 physicians for 7,000 different procedure codes.”¹³

Expenditure targets. An alternative to the rein is the fence: a global boundary that surrounds the medical commons, setting clear limits on the amount of money budgeted for the health system. “Fences” are exemplified in expenditure targets; global budgeting of hospitals, as occurs in Canada and many European nations, is a related strategy. International experience suggests that fences are far more effective than individually placed reins in controlling costs, since they set defined budgetary limits and avoid the bureaucracy factor required by utilization review.¹⁴ But what is the impact of fences on clinical autonomy?

In contrast to utilization review, global limits such as expenditure targets focus on the collective behavior of large groups of doctors and patients, rather than on individual physician/patient encounters. If physicians as a group provide so many services that budget targets are exceeded, fees are adjusted downward, creating a general incentive for more judicious use of resources. While strict global limits delineate boundaries on the common that circumscribe the ultimate clinical freedom “to do everything possible,” these boundaries distance the cost-control process from day-to-day clinical decisions. Without the constant intrusion of external utilization review, clinical autonomy is enhanced.

If the physician community finds that certain members of the herd are growing fat by consuming too much greenery at the expense of others, it becomes the responsibility of the profession to discipline such greedy members. With the development of medical practice parameters operating within global expenditure controls, collegial action against the errant individual is possible, making use of quality assurance bodies within medical societies and hospital staffs.¹⁵

Naturally, the construction of fences will create difficulties. Where to place the fence will occasion negotiation and strife.¹⁶ The locus of the battle will shift from the bureaucratic conflict of utilization review to the

political conflict of global budgeting—in the words of Canadian economist Robert Evans, from “diffuse distress” to “orchestrated outrage.”¹⁷ Nonetheless, global budgetary methods allow physicians to exercise internal professional review against a few outliers, while utilization review requires outside agents to scrutinize the daily decisions of all physicians.

Fences such as expenditure targets and caps also may compel physicians to recognize an additional fact: the medical commons becomes increasingly crowded as the physician-to-population ratio grows. While most industrialized nations are experiencing increases in physician supply, this trend is particularly dramatic in the United States. Global budgetary strategies may give the medical profession a greater incentive to collaborate with government and teaching institutions to exert greater “population control” over the physician herd.

Conclusion

Traditionally, organized medicine in the United States has been most vigorous in lobbying against fee controls and budgetary limits and, in particular, against vesting in a publicly administered universal health care system the authority to erect fences in a global fashion. Uwe Reinhardt has commented on the irony of this political strategy:

The less tightly society controls the overall capacity of its health system and the economic freedom of providers to...price their services as they see fit, the more direct appears to be the private or public payer’s intrusion directly into the doctor-patient relationship- the less clinical freedom at the level of treatment will payers grant the providers. In fighting as tenaciously as they have for the principle of free enterprise in medicine.. .American physicians seem unwittingly to have surrendered much of their clinical freedom—a freedom still enjoyed to a much greater extent by their colleagues abroad.¹⁸

In the absence of fences around aggregate costs, payers will have no recourse but to tighten individual harnesses on physicians in an attempt to better restrain expenditures.

No cost containment approach will be entirely free of discomfort for physicians. As our nation continues to experiment with different cost containment measures, we believe physicians and policymakers should carefully consider factors such as clinical autonomy when evaluating these measures. American physicians are likely to experience continuing erosion of their clinical freedom as long as utilization review remains a prominent feature of U.S. cost containment policy. Global budgetary strategies represent a more effective and less cumbersome alternative.

NOTES

1. P.R. Lee and L. Etheredge, "Clinical Freedom: Two Lessons for the U.K. from U.S. Experience with Privatisation of Health Care," *Lancet* (1989): 263-265.
2. G. Hardin, "The Tragedy of the Medical Commons," *Science* 162 (1968): 1243-1248; and H.H. Hiatt, "Protecting the Medical Commons: Who Is Responsible?" *The New England Journal of Medicine* 293 (1975): 235-241.
3. Hiatt, "Protecting the Medical Commons."
4. Cited in J.K. Iglehart, "Canada's Health Care System," *The New England Journal of Medicine* 315 (1986): 778-784.
5. H.M. Stevenson, A.P. Williams, and E. Vayda, "Medical Politics and Canadian Medicare: Professional Response to the Canada Health Act," *The Milbank Quarterly* 66 (1988): 65-104.
6. Regarding inappropriate procedures, see M.R. Chassin et al., "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services?" *Journal of the American Medical Association* 258 (1987): 2533-2537; and A.M. Greenspan et al., "Incidence of Unwarranted Implantation of Permanent Cardiac Pacemakers in a Large Medical Population," *The New England Journal of Medicine* 318 (1988): 158-163. Regarding practice standards, see J.E. Wennberg, "The Paradox of Appropriate Care," *Journal of the American Medical Association* 258 (1987): 2568-2569; and W.L. Roper et al., "Effectiveness in Health Care: An Initiative to Evaluate and Improve Medical Practice," *The New England Journal of Medicine* 319 (1988): 1197-1202.
7. SE. Dippe et al., "A Peer Review of a Peer Review Organization," *Western Journal of Medicine* 151 (1989): 93-96.
8. R.E. Park et al., "Physician Ratings of Appropriate Indications for Three Procedures," *American Journal of Public Health* 79 (1989): 445-447.
9. *The New York Times*, 12 September 1988.
10. P. Cotton, "Internists Blast Medicare Carriers," *Medical World News*, 11 April 1988.
11. Lee and Etheredge, "Clinical Freedom."
12. U.E. Reinhardt, "The Medical BFactor: Bureaucracy in Action," *The Washington Post*, 9 August 1988.
13. *Internal Medicine News*, 14 August 1988.
14. R.G. Evans et al., "Controlling Health Expenditures-The Canadian Reality," *The New England Journal of Medicine* 320 (1989): 571-577.
15. B.L. Kirkman-Liff, "Physician Payment and Cost-Containment Strategies in West Germany: Suggestions for Medicare Reform," *Journal of Health Politics, Policy and Law* 15 (1990): 69-99.
16. See J. Lomas et al., "Paying Physicians in Canada: Minding Our Ps and Qs," *Health Affairs* (Spring 1989): 80-102, for a discussion of the political conflict over physician expenditure targets and caps in Canada. Most functioning systems of expenditure targets or caps are predicated upon health care systems that either are a public monopsony (for example, Canada) or feature explicit government coordination of a multipayer universal insurance system (for example, Germany. See Kirkman-Liff, "Physician Payment and Cost-Containment Strategies"). Both the success and political volatility of America's venture into expenditure targets for Medicare may be tempered by cost shifting in response to an expenditure target instituted for only a single (though major) payer among many.
17. Evans et al., "Controlling Health Expenditures."
18. U.E. Reinhardt, "Resource Allocation in Health Care: The Allocation of Lifestyles to Providers," *The Milbank Quarterly* 65 (1987): 153-176.