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CONTAINING HEALTH CARE COSTS: ETHICAL AND LEGAL IMPLICATIONS OF CHANGES IN THE METHODS OF PAYING PHYSICIANS

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Economic pressures are constantly changing the delivery of and access to health care in America. In examining changes in physician payment mechanisms and effects of business-orientation organization of the health care system, and in evaluating those effects along the ethical dimensions of fidelity, fairness, and access, Professor Capron concludes that the changes and effects must be justified ethically, not simply as the results of marketplace forces.

INTRODUCTION

ARE THE MEDICAL profession's ethical precepts about fairness and fidelity to patients adequate to meet the challenges facing health care today? Signs of change abound in the American health care system. Although these changes are certain to have profound effects on the ways in which people receive health care and on their relations with physicians, patients and physicians have not been the moving force behind the changes. Rather, the changes are largely being driven by the financial concerns of the "third parties" who pay most health care bills—the government and employers. Those who witnessed the initiation of third-party payment more than a half-century ago could have predicted the inevitability of changes in health care.[1] However, the extent and nature of those changes

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1. P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 299-310 (1982) (describing organized medicine's resistance to health insurance because of the poten-

probably would have surprised anyone in the 1920's and 1930's, so remarkably has health care been transformed in the intervening decades. There is no question that certain changes in the health care system were necessary; some changes may even be provoked by the current alterations in the financing of care and the resulting increase in competition among providers. Other needed changes are unlikely to occur as a result of the financing alterations, while some of the likely changes are ethically worrisome. With foresight and determination it should be possible to avoid undesirable consequences and achieve better results along such dimensions as the fairness of the system, patients' access to care, and physicians' fidelity to patients' interests, including the receipt of quality health care.

Hospitals and similar institutions have experienced most of the recent changes in health care financing. Representative of this change is the prospective payment system (PPS) which determines the fee paid for the care of a hospitalized Medicare patient according to the Diagnosis-Related Group (DRG) into which the patient falls rather than by the charges incurred in caring for the particular patient. Even though addressed to institutions, the changes in payments for hospitalized patients instituted both by the government and by private firms have forced physicians to adjust the way they practice.

Public and private payors' cost-containment efforts have already changed the means by which physicians are paid for outpatient services. These changes will continue in the future. For example, strong pressures are building to adopt one or more alternative payment mechanisms in place of the Customary-Prevailing-Reasonable (CPR) fee-for-service program now used to pay physicians for treating Medicare patients. Likewise, physicians are now competing with one another—in a manner that has not been seen since the early years of this century. At stake are contracts with employers and health insurance companies to care for large blocks of patients on a prepaid or reduced-fee basis. Further, competitive business pressures are leading increased numbers of physicians to seek employment with hospitals and other health care organizations rather than entering the traditional professional medical practice.

American health care is increasingly shaped by market focus driven by the changes in payment mechanisms and other factors

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tial for insurers to place themselves between patients and physicians). *See, e.g., Minutes of the Eighty-Fifth Annual Session of the American Medical Association*, 102 J. A.M.A. 2191, 2201 (1934) (recommending that there be "no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession").

such as the growth in large multi-institution health care providers, especially investor-owned facilities. The efforts by third-party payors to contain costs by changing the means through which physicians are paid significantly adds to this alteration. These simultaneous and closely interrelated developments are the topic of this Artice. The growing perception of medicine as a business has encouraged the public (especially governmental and corporate officials with financial responsibilities for health care) to be more skeptical about exempting medical professionals from economic regulation. At the same time, the growth of market-oriented providers has offered those who wish to reduce the cost of medicine an opportunity to use "the discipline of the market" in familiar ways.

This Article will describe and classify changes in physician-payment mechanisms and then analyze the changes and some of their likely effects, in light of the existing legal and institutional mechanisms.[2] The Article next sketches some potential effects of the medical profession's business orientation on the organization of the American health care system.[3]

Finally, the effects are evaluated along several ethical dimensions, described as fidelity, fairness, and access. The fidelity dimension focuses on the physician-patient relationship; in the Hippocratic tradition, the actions of medical practitioners are supposed to promote the interests of patients above all others, including the physician. The fairness and access dimensions arise at the societal level. Due to the ethical importance of health care, a just society will endeavor to develop an equitable system for the distribution of health care that treats providers fairly, that ensures everyone access to an adequate level of care, and that prevents anyone bearing excessive burdens in the process.

I. CHANGES IN PHYSICIAN PAYMENT

The system of third-party payment on a retrospective fee-for-service basis is dominated by incentives for excessive intervention with overpriced procedures. Indeed, it is unlikely that any other

2. *See infra* notes 4-73 and accompanying text. In evaluating the changes—both those already occurring and those likely to result from some of the proposed means of paying physicians—their interactive nature, and sometimes ironic effects, must be borne in mind. For example, changes that restrict a physician's income from fees, which might seem to *deemphasize* the financial side of practice, could actually increase financial pressures on the practice and thereby accelerate the tendency to treat medicine as a business. Practitioners may feel compelled to make up for lower fees and tighter controls by organizing their practices so as to find new means of generating income.

3. *See infra* notes 74-92 and accompanying text.

system of paying health care providers could offer greater incentives for excessive interventions with overpriced procedures than that which has dominated third-party payment, both private and federal, for the past twenty years. Proposals for reforming those incentives arose virtually as soon as the present insurance system was created. When implemented, as in prepaid health maintenance organizations (HMOs), reforms were usually justified by improving the quality and the appropriateness of services delivered to patients. Yet, the vested interests of insurance companies, physicians, and hospitals, and the basic satisfaction of most patients kept extensive reforms at bay. However, the current season of health care cost awareness has revived the movement towards health care payment reform.

This Article will describe those changes being considered that bear directly on physician payments. Not considered are those changes that alter physicians' incentives indirectly, by changing the way hospitals are paid[4] or the degree to which patients are required to pay a portion of their bills.[5]

A. *Current Predominant Methods of Payment*

1. *Insurance in the Fee-for-Service Context*

a. *Payment and Compensation.* The United States is unusual among developed nations today in that the dominant method by which consumers pay for health services and by which physicians are compensated is the fee-for-service method. Most of the reforms generated by the governmental and private sectors in their roles as insurers are aimed at altering the payment method, while reforms aimed at changing the compensation method are impelled by mar-

4. *See* Capron & Gray, *Between You and Your Doctor*, Wall St. J., Feb. 6, 1984, at 24, col. 3.

5. The failure of this Article to address changes in enrollee co-payment and deductible formats is not because they are insignificant in terms of either extent or impact. Indeed, such changes have occurred in both private and public programs: the number of employers who have added deductibles to their health benefits in the past several years has multiplied ten-fold. Increasing the cost to beneficiaries has been, and will continue to be, a major avenue for federal cost and expenditure containment. Cost increases can cause enrollees to make use of fewer services, even to the point of adverse health impacts among the most vulnerable populations. Furthermore, making patients more aware of the costs of care will contribute to the general increase of market-sensitivity in health care, which will, in turn, affect physicians' behavior and their relationship with patients.

Despite such effects, including the general effect on the income of physicians and on the success of the overall cost-containment efforts, changes in coinsurance and deductibles are not evaluated in this Article. Instead, this Article addresses only direct alterations in the methods used by third parties to pay for physicians' services.

ket forces and regulatory changes which result in structural alterations in the health system.

Although changes in methods of compensation are the primary subject of this section, it is important to remember that changes in the method of payment may not translate directly into changes in incentives to physicians because of different compensation methods.

> [A]pproximately half the active physicians, excluding residents, were compensated by fee-for-service. This figure includes all solo practitioners, seven percent of physicians in group practice, and sixty percent of hospital-based physicians. Just under twenty percent were salaried. The remainder of U.S. physicians—roughly thirty percent—received a mixed form of compensation, with a fixed component analogous to salary and an incentive component analogous to fee-for-service.[6]

Thus, although a physician's total income is not directly correlated with the type of compensation, but varies with specialty, years in practice, geographic location, and hours worked,[7] it is a rare physician whose income is unaffected by the quantity of service he or she provides. This may be true even for salaried physicians, depending on their relationship to the institution in which they work.

b. *The Dominant Third-Party Mode.* The present fee-for-service mode of payment originated at a time when patients paid physicians directly for services provided. Today, however, two-thirds of payments to physicians ultimately come from either public or private insurance.[8] Because of the profession's resistance to direct relationships between insurance companies and physicians, most payment plans developed in the indemnity format. Under this format, physicians bill patients directly for services provided and the patients are subsequently reimbursed by their insurance carrier, sometimes for the full amount they paid or for only a lesser "allowed" amount. Over time, however, many insurance programs adopted the service approach to insurance, in which enrollees' premiums guarantee them certain services such as a specified number of days of hospital care, and those providing the services agree to accept the program's allowed payment as full compensation.[9]

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6. Yoder, *Physicians Payment Methods: Forms and Levels of Physicians Compensation*, in INSTITUTE OF MEDICINE, REFORMING PHYSICIAN PAYMENT: REPORT OF A CONFERENCE 87, 88 (1984) (based on published data for 1980).

7. *Id.* at 95-96.

8. Gibson, Waldo & Levit, *National Health Expenditures, 1982*, 5 HEALTH CARE FIN. REV., Fall 1983, at 1 (third parties, comprised of private health insurers, governments, private charities, and industry, financed 68% of the $287 billion in personal health care in 1982).

9. In Medicare parlance, physicians can either bill patients directly or "accept assign-

Insurers determine their allowance using a "fee screen," under which they pay the lower of a physician's *actual* charge or a *reasonable* charge calculated according to one of several formulae.[10] In Medicare programs, the formula is called CPR because a physician's own *customary* charge and the area's *prevailing* charge[11] are used to calculate the figure that will be compared to the actual charge in deciding what is *reasonable*.[12]

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ment," meaning that they agree to bill the program and accept its determination of the reasonable charge (less 20% for patients' co-insurance) as full payment. OFFICE OF TECHNOLOGY ASSESSMENT, MEDICAL TECHNOLOGY AND COSTS OF THE MEDICARE PROGRAM (July 1984). Under either payment method, the enrollee is liable for an annual deductible of $75. *Id.* Although assignment is mandatory for Medicaid beneficiaries, physicians had until recently been free to decide whether to accept assignment on a bill-by-bill basis for most Medicare patients; in 1982 only about one-third accepted assignment in all Medicare cases, and voluntary assignment averaged only about 40% of Medicare claims. *Id.* Through the Deficit Reduction Act, 42 U.S.C. §§ 1395-96 (Supp. 1984), and the Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, 98 Stat. 1061 (codified as amended in scattered sections of 5, 26, 29, 42 and 45 U.S.C.), Congress tried to increase the number of physicians who would accept assignment in all cases by offering inducements to those physicians who would accept assignment for all services to Medicare patients (termed Medicare Participating Physicians or MPP), while still permitting "non-par" physicians to decide on the payment method on a bill-by-bill basis. The incentives to become a MPP include Health Care Financing Administration (HCFA) compiling and distributing MPP directories to senior groups, to social security offices, and (at a charge) to the public; establishing toll-free information lines for MPPs and beneficiaries; publicizing the MPP program; providing MPP emblems. 42 U.S.C. § 1395u(i)(1-4). The incentive of exemption from the current price freeze on physician services was also offered to participating physicians, HCFA MEDICARE AND MEDICAID GUIDE, INSTRUCTION (1984), although continuing Federal budgetary problems may render this incentive illusory. Were such a plan to be implemented, MPPs would be allowed to submit bills for higher amounts to update their customary charges, although the actual fee received would be based on the frozen CPR level.

Perhaps because of physician skepticism about the value of the incentives that actually would be provided, the new system did not raise participation rates significantly, but it did increase the rate of claims assigned. In the first year (Fiscal Year 1985, beginning Oct. 1, 1984), 30.4% of practitioners signed participation agreements with Medicare; in the second year, the rate fell to 28.4%. The rate of claims assigned stood at 68.2% in December of 1985, which is a decline from the initial spurt early in the new program (increased from the level of 59.6% for voluntary and involuntary assignments in 1984). McIlrath, *Medicare Participation Rates Decline*, Am. Med. News, Feb. 28, 1986, at 1., col. 1.

10. In certain circumstances, the actual charge will be deemed the reasonable charge even though it exceeds the customary or prevailing charges, provided that the reasonable charge may not be higher than the charge for comparable services provided to a carrier's non-Medicare subscribers. *See* 42 U.S.C. § 1395x(v) (1982).

11. In addition to using a state or contiguous region within a state as the "locality" for collecting data to calculate the area's prevailing charge, insurance carriers may configure the charge area in other ways, such as separately grouping noncontiguous urban and rural localities that have similar charging patterns. The HCFA now recognizes 240 geographic charge localities. U.S. DEPT OF HEALTH & HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION, MEDICARE CARRIER MANUAL (1984).

12. In Blue Shield and comparable plans, the fee screen formula is called UCR, in which the first screening level is the physician's *usual* (rather than customary) fee, and the second

Although the prevailing Medicare charge has been limited by statute since 1971 to the seventy-fifth percentile,[13] physicians can obviously inflate the CPR rate for a procedure, simply by raising the amount they charge for it. This not only will increase their actual charge to the particular patient and their own customary charge for all patients but will also inflate the prevailing charge for the locality. Moreover, the usual market restraints on sellers' ability to increase their prices do not operate very effectively for medical prices because patients usually lack comparative information about physicians' charges and have only a small incentive to select physicians based on the prices they charge.[14]

To limit this inflationary pressure on the Medicare program, Congress included provisions in the Social Security Amendments of 1972 under which the annual increases in prevailing charges since 1976 have been capped by a Medicare Economic Index (MEI) based on increases in general earnings levels and increases in physicians' practice costs.[15] Nonetheless, Medicare Part B expenditures (three-quarters of which go for physician services) increased at an annual twenty percent rate from 1980 to 1983.[16] Beyond the inflation in unit prices that typically occurs in a CPR system, expenditures are also inflated because physicians lack incentive to provide the most economical or efficient treatment, rather, the incentive with insured patients is to base the particular treatment-selection option on the relative rate of reimbursement among the medically acceptable al-

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level is typically set at the 80th to 90th percentile of the *customary* (rather than prevailing) charge for the same service in the local area. *See generally* Yett, Der, Ernst & Hay, *Physician Pricing and Health Insurance Reimbursement*, 5 HEALTH CARE FIN. REV., Winter 1983, at 69, 70-71; Showstack, Blumberg, Schwartz & Schroeder, *Fee-for-Service Physician Payment: Analysis of Current Methods and Their Development*, 16 INQUIRY 230, 234-35 (1979).

13. *See* 42 U.S.C. § 1395x(v)(1)(L) (1982). The 75th percentile means the lowest charge for the service that was greater than or equal to 75% of the customary charges submitted by physicians in the locality in the previous calendar year.

14. This insensitivity to comparative prices among insured patients does not mean that the demand for medical service is totally price-inelastic, as recent studies of the role of patient co-payments and deductibles have shown.

15. The prevailing rate is either the lesser of the unadjusted prevailing charge or the MEI-adjusted rate, which is derived by multiplying the charge for the service that prevailed in the 1973 fee screen by the current MEI.

16. "[M]edicare's rate of increase has been significantly greater than national average trends—and the difference has been widening." SENATE SPECIAL COMMITTEE ON AGING, MEDICARE: PAYING THE PHYSICIAN— HISTORY, ISSUES AND OPTIONS 4 (Comm. Print 1984). The 20.9% rate for Medicare in 1980-82 was six points higher than the 14.9% rate for physician services generally during that period. But the existence of *any* large increase (14.9 or 20.9%) in the face of the recession that gripped the rest of the American economy at that time is itself remarkable testimony to the inflationary tendencies built into third-party fee-for-service payments.

ternatives. Although insurance carriers increasingly have made vigorous attempts to identify inappropriate interventions for which they will not pay, the wide variations in acceptable practice restrict the effectiveness of such review processes.[17] In any event, such efforts are much more effective in removing a particular treatment for a condition from the reimbursable category than in eliminating payment in a particular case on the ground that the physician could have achieved equal results less expensively using another approved treatment method. Despite third parties' greater power in today's environment, an insurer who routinely second-guessed physicians in this manner would meet considerable market resistance.

A CPR-type system, in addition to its potential for disserving patients (such as the detriment to quality of care that can occur through overuse of a medical procedure), may create other ethical problems for the medical profession itself. First, the amount paid for the same procedure varies, not only between localities, but also among specialists within the same locality, creating inequities among physicians. Second, CPRs emphasize procedures; thus, the financial rewards to practitioners in procedural fields such as pathology, anesthesiology, surgery, and obstetrics are much greater than those in the so-called "cognitive services" such as internal medicine, psychiatry, general practice, and pediatrics.[18] Yet, as suggested above, it was the financial concerns of payors and not the ethical needs of enrollees that have led to the current proposals to replace the CPR fee-for-service system. We turn now to consider several strategies for containing the costs of physicians' services.

B. *Cost-reduction Proposal Objectives*

1. *Limiting Unit Prices for Medical Services*

The primary motivation for seeking new methods of paying physicians is to gain control over expenditures both by achieving predictability and by restraining the rise in total health care spending. Consequently, all proposals share the common characteristic of an expected reduction in the amount a physician would otherwise receive for the average patient's care. It is important to distinguish

17. *See, e.g.*, Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action*, 3 HEALTH AFF., Summer 1984, at 6; Wennberg & Gittlesohn, *Small Area Variations in Health Care Delivery*, 182 SCI. 1102 (1973).

18. *See, e.g.*, AMA, 2 SMS REPORT NO. 4 (July 1983) (estimating physician's 1982 average net practice income as follows: radiologists, $137,000; anesthesiologists, $131,400; surgeons, $130,500; obstetrician/gynecologists, $115,000; internists, $86,8000; psychiatrists, $76,500; general practitioners, $71,900; and pediatricians, $70,300).

those restraints on expenditures that reduce the *price* of individual units of care (i.e., examinations, diagnostic tests, surgical operations, etc.) from those that attempt to reduce the *number* of units employed.

A physician's treatment charges reflect several factors: principally, return on investment in equipment and other property, profit for efficiently managing workers in the physician's employ, and rewarding his or her own work, including investment in education and specialized training. The present CPR fee-for-service system gives physicians a great deal of leeway, collectively and individually, to set the prices on these items because the market does not operate very effectively in this area. Two possible methods to reduce the excess profits that providers can now extract are regulation (e.g., the proposals discussed below for modifying the fee-for-service system and for a fee schedule) or "bidding" and other price-competitive behaviors designed to create more of a market. Successful reforms would result in physicians receiving a reasonable reward as entrepreneurs (e.g., a reasonable return on investments in equipment and property, payments as employers of nurses and assistants, and reward for the risks of running a business), as well as payment for their own labor commensurate with other professionally educated people in the marketplace. The monopoly profit, however, would be removed from the service unit price.

a. *Refinement of Current Payment Methods.* The least radical changes in third-party reimbursement involve modifying the calculation of the fee paid. For example, the current payment system could be changed by establishing a uniform fee for a particular procedure. The fee could be standardized based upon the physician's specialty, the service site, the type of visit, the locality, or the region. Standardization would eliminate the inequity of payment for the same service in the same area by removing the "customary" factor from the equation.

Reimbursement could also be changed by altering assignment procedures. The option to reject assignment has been viewed as a license to overcharge.[19] If Medicare made assignment mandatory, patients would be protected from these charges. However, mandatory assignment could result in several problems. Historically, a substantial number of non-"participating physicians" nonetheless accept assignment as full payment for treating some of their

19. Conversely, some physicians view the option to reject assignment as necessary to avoid being locked into a payment structure that underpays them for some procedures.

patients. If these physicians refuse to participate under a mandatory assignment program, they would become unavailable to patients who rely on Medicare payments for physicians' care. Thus, there might be a decrease in physician participation in the Medicare program and/or reduction in both access and quality of care; the result would be equal access only to participating physicians rather than equal access to all physicians with "reasonable charges."[20]

Another option would be to increase Medicare's percentage payment on assigned claims, thereby guaranteeing a higher proportion of the fee to the physician. One way to fund the increased payment would be to discount payment on non-assigned claims.[21] A desirable side effect of this option would be to create an incentive for patients to seek care from physicians who accept assignment because the required co-payment would be lowered and uncovered costs would be avoided.

Periodic reassessment of the fees charged for procedures would also produce a change in payment.[22] Typically, a new technology is introduced at a high price due to the specialized knowledge possessed by its developers and the limited supply of equipment available to implement it. As the procedures become routine the costs decline. The current system does not routinely monitor declines or adjust the prices downward.

Limiting physicians' fees charged for services provided outside of their practice would further change Medicare payment. Instead of allowing the physician to determine these charges independently, a set handling charge could be established by Congress, as has been done for laboratory tests.[23]

Payment could also be changed by modifying the fee limit calculation in either of two ways. First, the rate at which physicians are paid could be changed by lowering the percentile of the allowable

20. Jencks & Dobson, *Strategies for Reforming Medicare's Physician Payments: Physician Diagnosis-Related Groups and Other Approaches*, 312 NEW ENG. J. MED. 1492, 1497 (1985).

21. Hadley, *How Should Medicare Pay Physicians?*, 62 MILBANK MEMORIAL FUND Q. 279, 295 (1984):

> To finance the reduction in cost-sharing for beneficiaries treated on assignment, Medicare could discount its payment for nonassigned claims. This would further increase the difference in beneficiary cost-sharing between assigned and nonassigned claims. Percentage reductions could be set so that the impact on taxpayers is neutral, with users of nonassigned services subsidizing reduced cost-sharing for users of assigned services.

22. *Id.* at 295.

23. Pub. L. No. 98-369, 98 Stat. 1061 (codified as amended in 42 U.S.C. 1395 (1982)).

charge. Second, the economic index calculation for annual increases could be changed.

Payment could also be controlled by routing all services through a primary-care physician. The growing number of people who circumvent the primary-care physician and deal directly with the specialists has increased the cost of care in two ways.[24] First, the provision of specialty services itself generates higher bills. Second, the specialist lacks incentives to provide cost-effective care.[25] Requiring the primary-care physician to screen patients not only reduces the cost of unnecessary service, but provides the opportunity for alternative, less expensive treatement forms such as patient education and non-surgical interventions.

b. *Explicit Fee Schedules.* Fee schedules are widely used in private health plans' basic medical expense policies, under which subscribers are paid the lesser of the physician's actual fee or the scheduled amount for the service, without regard to medical specialty or geographic location.[26] It has been noted that HCFA could likewise construct an explicit fee schedule for Medicare beneficiaries, as a means of controlling prices and eliminating the CPR system variations.[27]

Fee schedules differ from current reimbursement method refinements because they are based on independent value assessments of a medical intervention rather than on mere variations in the existing pattern of charges. This could eliminate the wide range of charges for the same service in the same area (such as specialist versus generalist, and urban versus rural) depending upon how the fee schedule was implemented. The adoption of a national fee schedule would eliminate regional variation. The most rigorous type of fee

24. *See* E. FRIEDSON, PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE 93 (1970).

25. *See id.* at 306-07. The specialist is primarily colleague dependent. Consequently, he or she does not have to compete in the patient market for clients and is less concerned with controlling costs. The primary care physician is primarily patient-dependent. As a result, *if* there is sufficient competition for clients, the primary-care physician may be more cost-conscious.

Specialists appear to be providing an increasing amount of primary care to patients. Additionally, the percentage of self-referrals by patients to specialists ranges from a low of 11.4% for neurosurgery to a high of 87.2% for pediatrics. ROBERT WOOD JOHNSON FOUNDATION, MEDICAL PRACTICE IN THE UNITED STATES 26 (1981).

26. *See* Showstack, Blumber, Schwartz & Schroeder, *supra* note 12, at 233, 236 (discussing "maximum benefit" schedules).

27. OFFICE OF TECHNOLOGY ASSESSMENT, PAYMENT FOR PHYSICIAN SERVICES: STRATEGIES FOR MEDICARE 20 (1986) [hereinafter cited as PAYMENT FOR PHYSICIAN SERVICES]. A fee schedule would also remedy one problem for patients, the unpredictability of the actual out-of-pocket cost of a physician's services.

schedule would require a "relative-value scale" to be developed for all reimbursable medical procedures, based on: (a) all resource costs; (b) charges; (c) physician time; and/or (d) consensus.[28] The degree of difficulty of the procedure could also be incorporated; however, this would increase the incentive to perform "difficult" procedures, resulting in increased costs. Consensus could be determined through the use of medical experts or through competitive pricing, with the aim of finding the minimum prices at which physicians are willing to provide services. Although this would prevent access barriers, it would tend to maintain the current distribution of physicians and specialists.

All of these measures are actually based on input-costs comparison and might better be described as "relative-cost scales." The construction of an actual relative-value scale would require bases for measuring the outcome value of various medical services for patients—clearly a formidable task. The most likely process would involve the creation of an expert consensus, akin to the Consensus Development Conferences sponsored by the National Institute of Health since 1975.[29] A process involving only experts' views, however, would not necessarily reflect the true social consensus of informed consumers on the relative value of various outcomes.[30] The creation of relative values would be further complicated if separate values for particular procedures were calculated for different diseases and conditions. For example, the relative value of a CAT scan might differ when used for head injuries rather than for recurrent headaches because the likelihood of improving patient outcome differs.

The monetary conversion factor, which converts the relative values into fees, is critical.[31] The exact multiplier is a political determination, but it must be set with care. If budgetary concerns (i.e., attempts to hold down total Medicare spending) lead to too low a number, physicians may either refuse to treat Medicare patients or reduce the quality of care. If it is too high, Medicare will

28. *See* Jencks & Dobson, *supra* note 20, at 1494-95. "All resource costs" could include physician services, overhead, training expenses, etc. "Charges" could be based on prevailing area costs or could be standardized across the country. "Physician time" could be based on the time-cost of producing the service.

29. Mullan & Jacoby, *The Town Meeting for Technology: The Maturation of Consensus Conferences*, 254 J. A.M.A. 1068 (1985).

30. Pauly, *What is Unnecessary Surgery?*, 57 MILBANK MEMORIAL FUND. Q. 95, 98-99 (1979).

31. As with refinements in current payment mechanisms, yearly increases could be limited by an economic index to prevent excess inflation of rates.

increase reimbursement, resulting in excess delivery of less needed services (along with a corresponding increase in physician income).[32]

The relative-value scale system could be further strengthened by incorporating a utilization review process. In order to control costs, the use of services could be systematically reviewed. Information feed-back could be used to make appropriate adjustments in the relative value scale and the monetary conversion factor. Thus, fee schedules are more likely to control costs than to ensure that a particular level of use is targeted toward the most appropriate patients.

Fee schedules do not, by themselves, control the rate usage. One means to control this factor is to incorporate an expenditure cap under which a total sum of money would be allocated for each service, using the relative-value scale as a guide. Physicians would then bill for services according to a fee schedule, but payment would be discontinued as the charges approached the cap.[33] Alternative controls on the rate at which services are provided include: (a) allowing a full fee for the most expensive service provided and a discounted fee (or no fee) for additional services performed at the same time; (b) decreasing fees over time for follow-up visits; (c) paying fees only in packages; (d) paying full fees for a service until it has been performed a certain number of times, and then discounting payment for subsequent performance.[34]

c. *Bargained Prices.* The technical difficulties in establishing fee schedules have led to bargaining as a more feasible means of reducing the prices of physicians' services. In most situations, health care consumers do not participate in a real "market" for the services they receive; hence, there is little opportunity for them to bargain over prices. Rather than simply play a passive role as payors of the charges incurred by consumers, some major payors (such as insurance carriers, unions, and employers) have entered directly into fee negotiations with physicians. Preferred provider organizations (PPOs) are a major example of this development. PPOs are agreements between a payor and a group of physicians (and other health

32. *See* Hadley, *supra* note 21, at 291-92.

33. *See* W. GLASER, HEALTH INSURANCE BARGAINING: FOREIGN LESSONS FOR AMERICANS (1978). Though this would eliminate incentives for over-treatment, it could cause access problems as physicians who have met their service cap refuse to treat patients who need the service.

34. *See* W. GLASER, PAYING THE DOCTOR: SYSTEMS OF REMUNERATION AND THEIR EFFECTS 145-150 (1970). Such schedules could also create problems of quality of care and access to services if certain procedures are discouraged due to low fees, or if physicians feel that the amount of time needed for the service is disproportionate to the remuneration.

care professions) to provide medical services to a specific patient group based upon negotiated (and generally discounted) fees.[35] PPOs are primarily sponsored by hospitals and physician groups. Independent entrepreneurs and service purchasers such as insurance companies, union and employee groups, and employers also sponsor PPOs.[36] Providers' incentives to join include access to a pool of patients and more rapid payment of bills. Reduced rates are negotiated based on insurance companies' considerable economic clout. If Medicare were placed on a PPO footing, many of the incentives currently being utilized in the MPP program could be included to enhance the desirability of physicians' participation.

Although services are provided at a discounted rate, thereby lowering the cost of individual treatment procedures, most PPOs provide no incentives to contain the number of services provided.[37] Like other fee-for-service systems, a PPO provider's income rises with increased volume of services; thus, the payor bears the major risk. PPOs are also vulnerable to antitrust law violation charges[38] and may be precluded by state laws.[39]

2. *Limiting the Amount and Type of Services Used*

The payment methods discussed above offer hope of restricting the price of physicians' services, but, to varying degrees, they all share a cost-containment strategy weakness. They shift physicians' incentives from increasing the charge per treatment unit to increas-

35. Present PPOs provide patients such incentives as lower co-payments or deductibles to use participating providers, but still allow patients to choose other providers.

36. *See* Gabel & Ermann, *Preferred Provider Organizations: Performance, Problems, and Promise*, 4 HEALTH AFF., Spr. 1985, at 24, 26.

37. To avoid the over-treatment problem, utilization review could be used to monitor the provision of services, evaluate provider performance, and deny payment for unnecessary treatment. If such denials failed to provide a sufficient disincentive, the insurance carrier could cancel or refuse to renew the PPO contract. Since such an action would result in disrupting patient services and general confusion as to which physicians are in a PPO, a fee cap might be a better means to control over-treatment.

38. *See* Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982) (maximum-fee setting by physicians who were members of two medical foundations was held to be a per se violation); Blue Shield v. McCready, 457 U.S. 465 (1982) (patient has standing to sue for an anti-trust violation when Blue Shield refused to reimburse for psychological services provided by a clinical psychologist which would be covered if provided through a physician or by a psychiatrist). *See generally* Blacker, *Preferred Provider Organizations*, 6 WHITTIER L. REV. 691, 694-95 (1984).

39. Nine states (California, Florida, Indiana, Louisiana, Michigan, Minnesota, Nebraska, Virginia, and Wisconsin) have enacted laws permitting prepaid health plans that potentially or actually limit choice of provider. Fifteen states have pending legislation. Congress also has considered legislation that would override state laws inhibiting these health plans. *See* Gabel & Ermann, *supra* note 36, at 28-29.

ing the number of units employed. Thus, reducing the price of units of service may merely cause an increase in the number of units provided.[40] Plainly, such an increase has different connotations if it results from physicians' providing service to a larger number of patients,[41] than if it results from physicians' providing the same patients with more services for the same diseases that merely yields the same health outcomes.

Several proposals have been set forth to overcome or ameliorate this problem.[42] One payment method involves the packaging or "bundling" of services for reimbursement purposes. This method seeks to avoid excessive treatment because it is directly aimed at overcoming the present incentives to "unbundle" services.

The current Medicare coding system identifies 7,040 individual services for which physicians may bill HCFA.[43] Similar rules are followed in many private plans. Consequently, physicians are motivated to bill for treatment based upon individual services rather than as a package or "bundle." This "unbundling" results in higher costs. Physicians also are motivated to code procedures as if they were more complex than they actually are resulting in "Code Creep" with corresponding higher expenditures.[44]

A broad spectrum of packages could be developed to eliminate these practices. At one end of the spectrum is fee-for-each-individual-service. At the other extreme is totally capitated payments requring a physician to provide all services needed by an enrolled patient. Ambulatory care packages could be designed to combine physician and ancillary service costs; similarly, diagnostic and therapeutic procedures could be combined in the same package. A package might cover a single office visit or encompass a single illness or episode of care extending over several visits, thus reducing both cost and paperwork.

In-patient packages could likewise be developed to cover all physician services for a particular hospitalization. More compre-

40. *See* J. KRONEFELD & M. WHICKER, U.S. NATIONAL HEALTH POLICY: AN ANALYSIS OF THE FEDERAL ROLE 120-22, 131-33 (1984); Newhouse, *A Model of Physician Pricing*, 37 S. ECON. J. 174 (1970).

41. *See* Feldstein, *Hospital Cost Inflation: A Study of Nonprofit Price Dynamics*, 61 AM. ECOM. REV. 853 (1971); Evans, *Supplier Induced Demand: Some Empirical Evidence and Implications*, in THE ECONOMICS OF HEALTH AND MEDICAL CARE (M. Perlman ed. 1974).

42. Several programs operate by exposing physicians to financial penalties if they overutilize services. These are discussed under the heading of financial risk. *See infra* text accompanying notes 52-73.

43. *See* 42 U.S.C. § 1395x(V)(1)(A) (1982).

44. Jencks & Dobson, *supra* note 20, at 1495.

hensive packages could be developed to combine physician, ancillary, and hospital services. In order to prevent unnecessary hospital-based services, a "service window" could be imposed to cover services before admission and after discharge.[45] This would encourage outpatient provision of services, removing any incentive to keep the patient hospitalized longer than necessary.

The combination of packaging physician services and prospective payment has been characterized as physician diagnosis-related groups (MDDRGs).[46] MDDRGs would establish a single fee for all physician services provided during one hospital stay. The MDDRG rates could be determined on a competitive basis or by using a relative value scale, based initially on current allowable charges and later nationally standardized charges. Three different payment methods for MDDRGs have been identified: (a) paying the physician; (b) paying the medical staff; and (c) paying the hospital.[47]

Under the first method, the carrier pays the attending physician who is then responsible for paying all other consultants. This method motivates the attending physician to reduce the use of consultants (and the provision of services generally) in order to increase the retained share of the fee.

The second payment option credits the medical staff with the insurer's share of average allowable charges. The medical staff then pays its physicians at a rate which reflects the difference between the total MDDRG credits and the total allowable charges by the staff.[48] Alternatively, the medical staff could be given the MDDRG payments to distribute. The medical staff might also be subdivided to increase the incentives to contain costs within each subdivision.[49]

The final method of implementing an MDDRG program links the payment to the amount paid to hospitals under the DRG program for Medicare patients. The hospital could then allocate funds for physician services. Funds could be distributed through a medi-

45. *Id.*

46. MDDRGs would extend the Diagnosis-Related Groups (DRGs) system currently employed by Medicare for prospective payment of hospital services. DRGs are diagnostic related categories, grouped by body area into approximately 468 DRGs. The average price and weight of the procedure are multiplied to determine payment. Tichon, *Current Issues in Reimbursement: Medicare and Medicaid*, 6 WHITTIER L. REV. 851 (1984).

47. Jencks & Dobson, *supra* note 20, at 1496.

48. If the charges exceed the credit, the dollar value could be discounted; if charges were less than the credit, the dollar value could be inflated.

49. Special care is required in designing and administering a subdivision of a program or individual physicians will not be motivated to limit provision of services, since their individual income would increase with increased billing. Utilization review and group performance rewards could provide such an incentive.

cal staff model (as previously described) or through a physician contract. The contract could require a base salary for routine medical duties and a scheduled fee for non-routine medical duties and a scheduled fee for non-routine services.[50] Base salaries could be determined by negotiation or bid, or adjusted based on specialty, experience, or seniority (years of Medicare service). Physician salaries could be further manipulated by providing incentives based on the number of cases seen, hours worked, profits generated, or revenue produced.

Like other types of prospective payment schemes, the packaging of services in a MDDRG, while avoiding certain overutilization problems, has certain potential risks. First, the plan rewards ingenuity in dividing patient problems into separate parts, each treated as a distinct episode and requiring a separate set of office visits or hospital admission. Second, since the most seriously ill patients require the heaviest use of physician time and other resources, these patients would face the greatest problems in obtaining care. However, this is less of a problem when the physician group is large. A plan that pays the medical staff or hospital, rather than a single physician, offers greater opportunity to distribute the burdens imposed by one or more patients who need an unusually large amount of medical attention. Finally, the plan encourages the payment recipients to find some means to shift costs to others. For example, an individual physician might use the resources available in the hospital (such as ordering lab tests instead of paying for a consult, or using hospital-based physicians instead of outside consultants) even though such choices are inefficient from a systemic viewpoint, unless charges are imposed.

The greatest barrier to the use of payment packages, however, is technical. Although similar to the single fees paid to obstetricians for childbirth, or to surgeons for all their services still treating a particular problem, the packaging of all services would be quite novel. It has been noted that "because of the lack of experience and, in some cases, usable payment categories, the options with this strategy call for research to develop categories or demonstrations to evaluate the effects of packaged payment."[51]

50. Reduced access to individual physicians could result if physicians try to obtain exclusive contracts with a hospital that is the area's sole funding source. Additionally, quality of care could suffer in a bidding war as the physicians attempt to stay within their agreed-upon budget.

51. PAYMENT FOR PHYSICIAN SERVICES, *supra* note 24. Simulated MDDRG payments using Medicare claims from four states suggest that while *surgical* in-patient costs may

3. *Shifting Financial Risks to Physicians*

Employers, insurance companies, and the federal government have used capitated payments as a means to shift risks to others. Physicians receiving direct payments are financially exposed; however, if the payments are to organizations, they may forge various links with physicians to share the risk.[52]

Thus far, organizations have indirectly exposed physicians to financial risks in two ways: (1) by providing financial incentives and disincentives through organizational arrangements, and (2) by placing restrictions on physicians' decisionmaking power. Financial incentives and disincentives arise in a variety of arrangements; a physician with an ownership interest in a group practice will attempt to avoid extravagant treatment choices, as would a physician who has a joint-venture with a hospital[53] or who has a "bonus" arrangement with an HMO, where the surplus from "cost-effective" care is shared with the physician.[54]

Programs restricting a physician's decisionmaking power have developed over the past few years to control hospital costs. Such programs allow hospitals to

> monitor physicians' spending patterns over time and, where high-spending physicians refuse to curtail their ordering habits, revoke their privileges to practice at that hospital. It can identify its most expensive products, services, and technologies, and place restrictions on their use. Physicians, for instance, might be required to apply to a utilization committee for specific approval each time they wish to order an expensive test. Or where a phy-

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be quite similar, *medical* admissions costs vary substantially. The differences found were systematically related to specialties: medical and some surgical specialists would lose money while general practitioners and ophthalmologists would gain. Mitchell, *Physician DRGs*, 313 NEW ENG. J. MED. 670 (1985).

52. Alternatively, the capitated payment may become one of the means of cost-containment of physician's fees if the organization uses its large number of enrollees as clout to negotiate favorable rates with physicians and other providers.

53. A joint venture may in many ways be the most advantageous arrangement for both the physician and the hospital.

> The hospital is the organization the doctor is most familiar with. It offers a capital-generating capacity that most groups of physicians would find hard to match. It already has in place mechanisms physicians need to operate effectively—systems for quality assurance and utilization review, in particular . . . joint ventures facilitate cooperation in three major areas: payment schemes, ambulatory care net working, and professional integration.

Elwood, *When MDs meet DRGs*, 57 HOSP. 62, 62-63 (1983). *See also* Morreim, *The MD and the DRG*, 15 HASTINGS CENTER REP., June 1985, at 30, 34-35.

54. *Cf.* Capron & Gray, *supra* note 4 ("[I]ncreasing attention is being paid to arrangements by which hospitals would offer economic rewards to physicians whose patient-care decisions help restrain the hospital's expenses.").

> sician is judged to overuse a particular technology, the hospital might monitor or restrict his privilege to use that particular technology.[55]

Some of these strategeis may be ineffective or even legally questionable[56] in attempting to influence physicians to help control institutional expenses. However, in the context of changing the methods of paying for physicians' services, some payment methods offer considerable scope for such influences to work, either indirectly, such as physician-employees in hospital-based programs and HMOs or directly for ambulatory services provided by physicians participating in a capitated program.

The organization of physicians most associated with capitation is the form of prepaid group practice (PGP) known as a health maintenance organization.[57] All HMOs share certain characteristics: voluntary enrollment, which defines the population served by the HMO, and premiums not tied to the patient's actual use of services. Consequently, HMOs assume part of the financial risk.[58]

PGPs are health practices which employ physicians (staff model) or contract with physician groups (group model) to provide health care services to enrollees in exchange for prepaid premiums.[59] The physicians are generally salaried, and may be rewarded or penalized for their performance with respect to HMO targets.[60] Physicians work full time for the PGP and primarily serve the prepaid enrollees.[61] A PGP generally owns its facilities, and the physi-

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55. Morreim, *supra* note 53, at 34.

56. Hall, *Hospitals and Doctors Clash Over Efforts by Administrators to Cut Medicare Costs*, Wall St. J., Jan. 19, 1984, at 33, col. 3 ("Revoking hospital privileges for economic reasons is controversial and legally largely untested.").

57. A second type of HMO is the independent practice association (IPA). IPAs are similar to PGPs in that most of an IPA enrollee's health care costs are covered by prepaid premiums. They differ, however, in several ways. IPAs seldom involve insurance type risks for their physician participants. Physicians are paid on a fee-for-service basis, according to a schedule of fees negotiated by the IPA administrators. L. BROWN, POLITICS AND HEALTH CARE ORGANIZATIONS: HMOS AS FEDERAL POLICY 34 (1983). IPAs rarely own facilities. Patients are seen in physicians' private offices and are sent to private clinics and hospitals. *Id.* Generally, only a small amount of an IPA-participating physician's practice will consist of prepaid HMO patients. *Id.* If a patient discontinues enrollment in an IPA, the patient may continue to see the physician on a fee-for-service basis. *Id.* Although IPAs have the potential for effective utilization review and control—and can operate like PGPs—they generally operate like fee-for-service practice. *Id.*

58. H. LUFT, HEALTH MAINTENANCE ORGANIZATIONS: DIMENSIONS OF PERFORMANCE 2-3 (1981).

59. BROWN, *supra* note 57, at 33; Wolinsky, *The Performance of Health Maintenance Organizations: An Analytic Review*, 58 MILBANK MEMORIAL FUND Q. 537, 546 (1980).

60. BROWN, *supra* note 57, at 33.

61. *Id.*

cians therefore usually work in the PGP's clinics and hospitals.[62] Physicians in PGPs may make less money then fee-for-service providers, but are attracted by other benefits such as fixed schedules, guaranteed income, fewer administrative burdens, and fringe benefits including malpractice insurance, retirement plans, sick days, time off, and funds for continuing education.[63] However, negative aspects of PGP practice have been identified as loss of the physician's freedom to schedule and manage care, patients who demand care for trivial complaints, and lack of acceptance by community fee-for-service physicians.[64]

HMO income accrues from prepaid premiums. Consequently, HMOs are able to budget provision of services in advance. As total income is generally limited by premium payments, HMOs have strong incentives to control costs and no incentives to provide unnecessary or marginal care. Costs can be controlled by giving physicians an economic stake in the HMO's success, utilization review of physicians, limiting access to hospital beds and consultants, the use of allied health professionals, and controlling enrollment. Studies of HMOs suggest that overall costs for care are ten to forty percent lower than conventional insurance;[65] hospitalization rates are up to forty-five percent lower;[66] and quality of care appears to be as good as conventional insurance.[67] However, there appears to be no agreement on how these savings are achieved. This is largely due to the diversity among HMO programs and the variety of factors that have been evaluated.

Furthermore, HMO proponents contend that HMO physicians are better informed, more motivated, regularly monitored, lack the administrative and business distractions of private practice, and are free to "simply practice medicine."[68] HMO critics note that HMO policies can lead to under-provision of needed services, increased caseloads, and extensive queuing for services.[69] Physicians may hesitate to recommend expensive lab tests and treatment procedures

62. *Id.* This particular feature is often considered essential to the "pure" PGP. *Id.*

63. *Id.* at 51.

64. Potential fee-for-service physician responses to HMO physicians include: abusive phone calls and mail; denial of hospital privileges; cut-off of referrals; disappearance of patients' files; harassment at meetings. *Id.* at 54.

65. Luft, *supra* note 58, at 387. *See also* Wolinsky, *supra* note 59, at 544.

66. Wolinsky, *supra* note 59, at 544.

67. *Id.*

68. Brown, *supra* note 57, at 130.

69. *See* Schneider & Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects*, 70 Nw. U.L. REV. 90, 98-99 (1975) ("[I]n practice, an HMO may, absent appropriate safeguards, seek to cut costs by reducing the amount of services provided

for fear that utilization reviews will identify them as "over-providers"—a label which may adversely affect the physician's pay raises or yearly bonuses.[70] Physicians may feel overworked and exploited when confronted with the increased caseloads necessary to make the HMO financially viable, resulting in impersonal, mechanical patient care.[71] Ironically, the decreased physician time spent with each patient can even result in failure to detect conditions in their early stages, which directly conflicts with the goals of preventive medicine.[72]

Finally, the patient may experience delays in obtaining services as a result of the physician's increased caseload. While some queuing may be desirable, extended delay may lead to failure to detect problems at an early stage, and ultimately to more costly care. Queuing has also been used as a method to encourage disenrollment of high risk patients; when needed care is hard to obtain, the patient is likely to seek it elsewhere.[73] HMO advocates insist that these problems are monitored and remedied by the peer review process.

II. CHANGES IN ORGANIZATION OF HEALTH CARE

A. *Pressures on Hospitals and Physicians to Change*

In addition to directly changing the physician-payment methods, cost-containment efforts also alter the organizational framework in which care is provided. The resulting changes in the patient-physician-hospital relationship are likely to have pronounced effects on "physician autonomy." Because of this "autonomy" and the fractionated character of the health care "system," the medical profession has maintained its dominance. For the past half-century, physicians have used their authority as health care gatekeepers (particularly of hospital admissions) to resist hospitals' and insurers' efforts to influence the type and extent of patient

through such rationing devices as low physician-patient ratios, underbedding, or unduly restrictive prior authorization procedures.") (footnotes omitted).

70. Brown, *supra* note 57, at 140.

71. Since a HMO physician's salary is fixed there is no incentive to work "overtime." In contrast, the fee-for-service physician's income increases in direct proportion to the patient caseload. While the fee-for-service physician may view increased caseload as a sign of confidence and a reward for good work, the HMO physician is likely to feel exploited by the administratively increased caseload. *Id.* at 146-48.

72. *Id.* at 147.

73. *Id.* at 139. Control methods have included: restoring fees for some services; requiring primary care physician referrals; use of physician's assistants and nurses to provide care or screen patients; requiring telephone consultations before granting appointments; and simply telling members not to waste physician's time. *Id.* at 16-64.

treatment.[74]

Today, the relative balance of authority is dramatically shifting. While once, "the profession's authority [put] at its disposal the purchasing power of its patients,"[75] that power is increasingly wielded by large organizations, driven by the perceived need to hold down health care costs, an objective proven impossible so long as physicians controlled the system. In particular, in this increasingly competitive environment, insurers with large subscriber bases are able to exert considerable influence over physicians' practice patterns, and many physicians are willing to comply with restrictions so they do not lose substantial numbers of patients.

Recent actions by a large HMO in Minneapolis illustrate the changes that an insurer can bring about when it holds a strong position in a competitive market for health care services.[76] The Minneapolis experience is particularly interesting because it also illustrates the greater competitive potential that arises when physicians' traditional collective control is challenged.

The Physician Health Plan (PHP), the HMO in question, is of the IPA type.[77] Beginning in March of 1986, the 58,000 Medicare enrollees of its 326,000 enrollees are covered by a "risk" contract with the federal government. PHP receives a fixed monthly fee to provide the enrollees' medical and hospital care. In order to control hospital as well as physician expenses, PHP selected nine hospitals, geographically distributed in the service area, which could offer comprehensive services. The hospitals agreed to share the risk of providing care within the predicted cost limits, thereby motivating them to control costs. Medicare enrollees were told that if they selected one of the nine preferred hospitals they would obtain extra benefits (such as a private room, preventive dental care, and subsidized eyewear, which are not usually covered by Medicare) and

74. P. STARR, *supra* note 1, at 26.

75. *Id.*

76. Scheier, *Twin City MDs fight IPA hospital contracts*, Am. Med. News, Feb. 28, 1986, at 1, col. 4.

77. *Id.* Because such groups are comprised of affiliated, rather than employed, physicians, they are usually more deferential to physicians' wishes, and the PHP itself was created by the Hennepin County Medical Society in 1976. *Id.* Had it remained a creature of the Medical Society, its recent actions probably would not have occurred, but the Society was forced by the Federal Trade Commission to relinquish control several years ago. *Id.* The importance of the present example is magnified because PHP is one of 36 HMOs managed nationwide by United HealthCare. They may introduce select-hospital plans under other Medicare-risk contracts if the markets for HMO-enrollment in other locales become as competitive as Minneapolis, which is "more mature from a competitive and price competition standpoint." *Id.* at 24, col. 3.

would pay a premium of only $15.00 per month. If enrollees wished to obtain care at one of fifteen other hospitals, their premiums would be $22.50 per month. The third option—freedom to select among all fifty-nine hospitals statewide—required a $29.10 monthly premium.[78]

Managers of excluded hospitals not only protested their exclusion from the selection process, but also advertised in newspapers, not only to retain the Medicare business but to combat any public impression that the preferred hospitals are generally "better" institutions. Hospitals in the region have reason to be concerned about losing market share, since occupancy levels are already just forty-five percent.[79]

PHP's new Medicare plan puts even greater pressure on physicians than on hospitals, since many hospitals were already being pushed by general market forces to consider closing or merging.[80] The nine hospitals already accounted for about half of PHP's Medicare enrollees admissions.[81] Physicians who are not primarily affiliated with one of these nine hospitals must decide whether to switch their affiliation or to stop treating patients who choose the low-premium option.[82]

B. *Medicine and the Marketplace*

The changes in health care organization and relationships brought about by cost-containment efforts illustrated by the Minneapolish PHP situation should not be surprising. Altering the way physicians are paid obviously affects their incentives to employ particular procedures, including the services of health care colleagues and institutions.

Moreover, the effects of current efforts to contain physicians' services expenditures are likely to be magnified because health care is an increasingly business-oriented activity. This is largely due to the rising importance of for-profit institutions in this field. Clearly, for-profit activities have long been an important part of health care, from the manufacture and marketing of drugs and medical equipment to the traditional physician's fee-for-service practice. Yet the field as a whole has retained a not-for-profit aura, largely due to the visible role played by hospitals, most of which are not-for-profit in-

78. *Id.*
79. *Id.*
80. *Id.*
81. *Id.*
82. *Id.*

stitutions. In the past decade, however, "a vigorous and varied for-profit sector has developed in the predominantly not-for-profit world of medical care."[83] This sector is made up of independent medical facilities, such as ambulatory surgery centers, often owned by local investors (including physicians), and of large publicly traded hospital and nursing chains.

The emergence of the for-profit institutions since the late-1960's has had profound, though not yet widely recognized, effects. The first is the creation of a number of powerful companies with the potential for significant effects on health care policy. Interestingly, the growth of the for-profit chains has only slightly increased the number of for-profit hospitals, since much of this growth has come through acquisition of existing proprietary hospitals (typically "Doctors' Hospitals," owned and operated by local physicians).[84] The *structure* of the new investor-owned organizations is more significant than the *numbers*. Today, the chains own about ten percent of United States hospitals and manage another four percent, while independent for-profit hosptials account for another five percent.[85]

Second, the growth of the for-profit chains has accelerated the move toward a greater role for management (instead of physicians) in health care decisionmaking. The apparent success of the investor-owned companies in mapping profitable strategies, combined with the pressures to reduce costs throughout health care, has led many not-for-profits to form chains of their own and to give managers greater control in running the institutions.[86] Even a not-for-profit facility must be profitable to survive, a realization that has led many hospitals to implement tighter controls over physicians and to establish profit-making subsidiaries and joint-ventures with physicians.[87]

Third, in subtle ways the world of health care has fundamentally changed. "Market shares" and "profit centers" mark a new vocabulary which "would have seemed foreign in the health policy world only a few years ago."[88] The business-medical care mixture is bound to increase as the major hospital chains continue to expand recently developed integrated health care programs. These pro-

83. Gray, *An Introduction to the New Health Care for Profit*, in THE NEW HEALTH CARE FOR PROFIT: DOCTORS AND HOSPITALS IN A COMPETITIVE ENVIRONMENT 1 (B. Gray ed. 1983).

84. *Id.* at 2.

85. *Id.*

86. *Id.* at 3.

87. *Id.*

88. *Id.*

grams provide everything from routine outpatient care to hospitalization at specialized facilities owned by the company, all encompassed within a health-insurance program.[89]

The rise of independent treatment and diagnosis centers in which physicians are often major investors, as yet a less widely recognized effect, is an important ethical change.

> Free-standing investor-owned ambulatory surgical centers are springing up everywhere. To increase the use of their facilities, which are often in competition with similar units in the community hospitals, these companies offer local surgeons a share in the profits. Some ambulatory surgical centers are owned by the surgeons who use the facility, and they share in the profits from its use.[90] The partnership of physicians and venture capitalists is not limited to surgery; it extends to radiologists establishing CAT scanning and magnetic resonance imaging centers,[91] and ophthalmologists holding stock in intraocular lense companies.[92]

III. THE ETHICAL DIMENSIONS OF PAYMENT CHANGES

Two strategies are advisable based on the absence of any means for making reliable and quantifiable predictions about the impact that changes in third-party payments to physicians might have on the quality of care and on patients' access to care.[93] The first strategy requires the creation of research programs to establish the means of measuring such effects. This step is recognized as essential by health care planners and economists.[94]

The second strategy, which is the object of this Article, proposes other, nonquantitative criteria to evaluate the implications of the various ways third parties could pay physicians. Three such criteria, described in ethical terms, are physicians' fidelity to patients,

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89. *See, e.g.*, Special Report, *Competition Grows as Increasing Number of Providers Enter Insurance Business*, 19 FED. AM. HOSP. REV. 18 (1986).

90. Relman, *Dealing with Conflicts of Interest*, 313 NEW ENG. J. MED. 749 (1985).

91. *Id.* at 749-50.

92. *Id.* at 750.

93. *See* PAYMENT FOR PHYSICIAN SERVICES, *supra* note 27, at 33-35 (summarizing the advantages, disadvantage and uncertain ramifications of four strategies to change Medicare payment for physician services: present payment arrangements, fee schedules, packages of services, and capitation payment).

94. *See, e.g.*, Hammons, Brook & Newhouse, *Evaluation of Effects of the Quality of Care Of Selected Alternatives for Paying Physicians under the Medicare Program* (OTA Background Paper) 70-71 (1985) (concluding that not enough is known to quantify the effects of changing the physician payment system on quality of care, especially since relatively little is known about the quality of our present system of care. Given the inability to predict the effects of change on quality of care, the authors recommend that when changes are implemented or tested in demonstrations, the quality of care be carefully monitored).

fairness of the system to physicians, and fairness of the system to patients.

Although these variables do not exhaust the ethical implications of the various payment systems, these particular variables have been carefully selected. Thus, a discussion of the ethical dimensions themselves is appropriate before analyzing their relationship to various payment options.

A. *Physician Fidelity To Patient Interests*

Medicine is grounded on ethical premises and probably could not operate without the articulation of those premises. Ethical strictures are necessary because of the subject matter of medicine involves the human body and its functioning. One author has noted that "professionally imposed restrictions on deed and speech grow out of the recognition that illness is inherently degrading and dehumanizing, and that it exposes and threatens the sick person's body, soul, and intimate relationships."[95]

Western ethical traditions, which rest on respect for persons, value privacy, bodily integrity, and personal autonomy.[96] Touchings of others are permitted only with their permission, and bodily intimacies are usually limited to members of one's own family.[97]

Physicians and other health care professionals are exceptions to this rule. By seeking medical treatment a person gives implied permission for manipulation of his body by someone who is otherwise a stranger and shares with this person many private facts, both those discovered through examination and those conveyed verbally by the patient.[98] Moreover, procedures used by physicians may involve grave risks to patients' life or health. Misuse of these powers by persons who do not adhere to standards of decency and dedication to the welfare of those they treat could cause suffering or death.

As a result, the medical profession has always requried its members to keep patient information confidential. Furthermore, the very precept of professionalism[99] is rooted in ethics because bodily sanctity can only be interfered with when the actor is a qualified

95. L. KASS, TOWARD A MORE NATURAL SCIENCE: BIOLOGY AND HUMAN AFFAIRS 222 (1985).

96. *See generally* T. PARSONS, THE SOCIAL SYSTEM (1951).

97. *Id.*

98. *See id.* at 453 ("[T]he situation of medical practice is such as inevitably to 'involve' the physician in the psychologically significant 'private' affairs of his patients.")

99. *See generally* E. FREIDSON, *supra* note 24. One definition of professionalism is self-regulation by a group that meets standards of knowledge and training and adheres to standards of conduct.

member of a professional group, with the requisite skill, learning, and dedication to patient welfare. The sensitive aspect of medical care is closely connected to the second relationship of ethics to medicine, namely, the physician-patient relationship. The nature of the material over which the physician has control is both personal and technologically sophisticated, which creates an imbalance between physician and patient. Although many patients have and use the power to choose one physician over another, once involved in a physician-patient relationship, the physician's technical superiority endows him or her with significant power over the patient. Furthermore, patients are understandably less knowledgeable than physicians about their health care needs and about alternative means of meeting those needs. Indeed, patients are relatively more ignorant in choosing who, where, how (and often, when) health care will be supplied than they are about most other choices affecting their lives.[100]

Although the "doctor knows best" rhetoric is no longer as forceful as it once was,[101] and despite "consumerism" and the legal requirements of informed consent, physicians remain remarkablely resistant to sharing information—much less authority— with their patients.[102]

The primacy of the patient's interests lies at the heart of the physician-patient relationship. In the Hippocratic tradition, this was expressed as *primum non nocere* ("first do no harm"), which was largely a reflection of the limited value of available medical interventions, rather than an affirmative limitation on the physician. That traditional ethical code's central tenet was protection of the patient. Physicians have recognized the need since early times— for principled as well as practical reasons— to establish a professional standard of *fidelity* to individual patient's interests. Duties of fidelity may stem from the generation of expectations through words, gestures, or silence. Promises or contracts—whether made explicitly, implicity, or tacitly—are binding for physicians, other health care professionals, and researchers, except when they are

100. Feldstein, *Research on the Demand for Health Services*, 44 MILBANK MEMORIAL FUND Q. 128, 138 (1966).

> The physician, not the patient, combines the components of care into a treatment. In other markets the consumer, with varying degrees of knowledge selects the goods and services he desires from the available alternatives. In medical care, however, the patient does not usually make this choice directly . . . . [H]e selects a physician who then makes . . . choices for him.

101. *See* C. CHAPMAN, PHYSICIANS, LAW, AND ETHICS (1984).

102. *See* J. KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984).

overridden by stronger duties or obligations.[103]

1. *Appropriate Care*

Unfortunately, there is no guarantee that physicians are as perfect as their ideals. Thus, it would be naive to assume that physicians' behavior under existing reimbursement methods fully adheres to the principle of fidelity. Were perfect fidelity the case, the question would simply be the degree of deviation resulting from alternative reimbursement procedures. But such an assumption would be mistaken. The historical record makes clear that the medical profession has taken many steps aimed to promote the interests of the profession.[104] Indeed, even third-party payment mechanisms— and especially the limitations on the methods of payment under such mechanisms—are directed toward enhancing the well-being and authority of the profession.

In light of the recognized risk that physicians may not behave ideally, how is one to know whether a particular physician is faithful? Clearly, one cannot look to outcome alone, otherwise, the physician whose patients' natural good health (or self-limiting illnesses) creates little need for the physician's ministrations would appear to be providing the best care. Conversely, the physician who attempted to save the lives of the sickest patients would falsely appear to be doing the greatest disservice. Nor is it possible to permit patients to be the sole judge of fidelity, because they lack expertise and may be impressed by the "bedside manner" of a physician who is doing them no good or may reject the care of someone else who is actually employing the appropriate means.

Yet it is exactly on this point that the technical difficulties intrude. The practice of medicine is characterized by large differences in the rates at which various techniques are utilized.[105] Rather than reflecting variations in individual competence or personal idiosyncracies, technical differences vary by locality, even after adjusted for differences in the patient mix. Moreover, no marked variations have been found in the mortality rate or reported disease incidence in the areas studied.[106] Some of the differences in frequency are so great (up to eight or nine-fold) as to render the notion of "standard, accepted practice" of dubious value. This means that for some pro-

103. T. BEAUCHAMP & J. CHILDRESS, PRINCIPLES OF MEDICAL ETHICS 239 (2d ed. 1983).

104. *See generally* P. STARR, *supra* note 1, at 79-144, 235-334.

105. *See* Wennberg & Gittlesohn, *supra* note 17.

106. *See* Wennberg, *supra* note 17.

cedures it is apparently professionally acceptable to have many times as many surgical procedures of a particular type per capita compared to a neighboring community. Furthermore, the authors of one recent study of this phenomenon pointed out that even the *lowest* current rate may not be the appropriate rate because physicians in all geographic areas in the state may be doing too much of the procedures.[107] Conversely, even the highest rate may be too *low*.

Thus, individual judgment, and a corresponding degree of arbitrariness, underlies the central ethical principle of fidelity. Although the choices made are often subsumed under the heading of "professional judgment," this term is misleading. It suggests that a highly individualized application of generally accepted norms of practice is involved, when in fact the profession has left large areas of "proper practice" largely undefined.[108] Moreover, to the extent that more than personal judgment is involved, decisions may be guided by informal protocols that have grown up without careful examination or scientific basis.[109] Outside of medical schools and teaching hospitals, such informal and unproven medical habits spread from colleague to colleague, probably accounting for the wide variations from one community to the next in the frequency of common procedures like Cesarean section, hysterectomy, and tonsillectomy.

Of course, there are means to identify practitioners whose efforts are so adverse to the best interests of their patients (though usually from lack of skill or attention instead of conscious choice) as to be "negligent." These means exist both within the profession and through the courts. But these methods are cumbersome and are usually invoked only after a very bad result has occurred.[110]

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107. Barnes, O'Brien & Comstock, *Report on Variations in Rates of Utilization of Surgical Services in the Commonwealth of Massachusetts*, 254 J. A.M.A. 371, 374 (1985).

108. *See* Komaroff, *The Doctor, the Hospital, and the Definition of Proper Medical Practice*, in 3 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIROAL RESEARCH, SECURING ACCESS TO HEALTH CARE 225, 232-34 (1983) [hereinafter cited as SECURING ACCESS TO HEALTH CARE].

109. Wong & Lincoln, *"Ready! Fire! . . . Aim!"*, 250 J. A.M.A. 2510, 2511 (1983) (*"[a]d hoc* routines develop and subsequently acquire authority and autonomous lives as informal protocols. Without any apparent critique or review, they are passed on from resident to resident and to medical student as a kind of folklore").

110. This mode of selection may be very biased. It may include some cases of bad outcome that are not in the least due to physician negligence and may exclude other cases in which an outcome was, fortuitously, not as bad as was risked by the physician's conduct.

2. *Trust*

Fidelity to the patient's interests means more than simply providing care of acceptable quality, even assuming that the contours of "acceptable quality" were clearly discernible. Patients expect their physician to respect their moral limits, promote their welfare, and favorably balance the prospective benefit and harm in prescribing care.[111] In seeking medical care, a patient selects a physician whom she can "confide in." One author has interpreted this to mean "that the relationship is expected to be one of mutual trust, of the belief that the physician is trying his best to help the patient and that conversely the patient is cooperating with him to the best of his ability."[112]

The trust relationship has been described as a covenant or contractual relationship. "The structure of the contract has tended to increase not only the physician's technical authority, but also his 'moral' influence."[113] The physician's authority is clearly undermined when he fails to honor this contract, either by violating an explicit ethical rule or by departing from the implicit purpose of the relationship (as by providing inadequate treatment because of cost constraints or providing excessive treatment to increase income). Breach of this contract violates the patient's trust.[114]

Conversely, when physicians demonstrate their commitment to the trust relationship, the patient feels comfortable in seeking treatment. It has even been found that many patients experience thera-

111. T. BEAUCHAMP & J. CHILDRESS, *supra* note 103, at 120.

112. T. PARSONS, *supra* note 96, at 464. The patient's trust derives, in part, from the special role which has been created for the physician. *See also* Gaylin, *The Psychiatrist as Double Agent*, HASTINGS CENTER REP., Feb. 1974, at 12, 13.

113. Mechanic, *Therapeutic Relationship; Contemporary Sociological Analysis*, in ENCYCLOPEDIA OF BIOETHICS 1668 (W. Reich ed. 1978) (citing J. FRANK, PERSUASION AND HEALING (rev. ed. 1973)):

> Implicit in such a contract is that the physician can be trusted to treat the patient's health needs and interests as central, thus minimizing the need for the patient to be defensive or to withhold information. Both the status of the physician and the ethical bases of his practice facilitate the patient's willingness to put his health in the hands of the physician with little demand for detailed explanations or monitoring of the physician's decisions. This is not to imply that physicians have always conformed to these ethical mandates or that patients have generally been docile, but only that the physician's authority has been assumed to be part of the ordinary understanding of relationships between physicians and patients and their respective responsibilities.

114. C. FRIED, CONTRACT AS PROMISE: A THEORY OF CONTRACTUAL OBLIGATION 16 (1981). An individual is morally bound to keep promises because he or she has intentionally invoked a convention whose function it is to give grounds—moral grounds—for another to expect the promised performance. To renege is to abuse a confidence one was free to invite or not, and which was intentionally invited. *Id.*

peutic benefits resulting from trust in their physician and her judgment.[115]

The legal underpinnings of this trust relationship was recognized in *Canterbury v. Spence*.[116] In articulating a physician's duty to disclose material information to a patient before seeking the patient's consent, the court stated:

> The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject. . . . [L]ong before the instant litigation arose, courts had recognized that the physician had the responsibility of satisfying the vital information needs of the patient. More recently, we ourselves have found in the fiducial qualities of [the physician-patient] relationship the physician's duty to reveal to the patient that which in his best interests it is important that he should know.[117]

Fulfilling the medical interests of patients, as they themselves define them, is the criterion for successful medicine. Patients' expectations of the promotion of their interests through medicine, indeed, the very definition of those interests, depend on the quality of the patients' trust relationship with their physicians.

Issues of patients' trust in the health care system, rather than solely in their individual physician, may be particularly important in the current cost-containment environment. These issues take on a special twist in light of another aspect of "trust" in health care.

> "Trust" is an ambiguous word in medical ethics. It is touted as the moral basis of the patient-physician relationship, yet is also the foundation of the collegial relationship of one physician to another and of physicians to other members of the health care team. The Hippocractic oath is first of all an oath of secrecy and loyalty to one's medical colleagues.[118]

To the extent that peer review of the adequacy and appropriateness of diagnosis and treatment plays a significant role in the success of a particular Medicare reimbursement system, "trust" may assume contradictory meanings. Patients trust that they will learn everything medically important about the care being received including the ways in which the care may have been inadequate or inappropriate; physicians trust that their medical colleagues will not

115. E. FRIEDSON, *supra* note 24, at 263-68.

116. 464 F.2d 772 (D.C. Cir. 1972).

117. *Id.* at 782.

118. R. VEATCH, CASE STUDIES IN MEDICAL ETHICS 113 (1977).

harm their relationships with patients by revealing their errors or professional inadequacies.

This problem is not unique to new forms of reimbursement and can also arise in fee-for-service medicine. However, the growth of formal review mechanisms accompanying prospective and capitated payment systems is likely to increase not merely the recognition of instances of medically improper or inadequate care, but also patients' understandable sense of being misled if they do not learn of these inadequacies. It appears that HCFA's recent decision to release data on hospitals that have unusually high (or low) mortality rates was provoked by public pressure. It is likely that the public's perception is that it was wrong for people not to know what the review mechanisms had allegedly discovered about the quality and safety of various hospitals.

B. *Fairness Among Physicians*

Trust between physicians is only one dimension by which to evaluate the reimbursement system's effects on providers. Fairness of the rewards provided to different physicians for their professional services is another, more central, issue. Defining equitable treatment of physicians in the reimbursement system is difficult because there is no simple appropriate "equal treatment" formula. A reward standard based on a complexity of interventions may seem appropriate, but the implementation of this standard creates its own complicating distortions. Similarly, a formula based on the predicted value of an intervention to a patient's life rewards medical "heroics." Such a standard leaves little incentive for many interventions that patients need and desire though their quantifiable value is relatively slight or has simply never been demonstrated by controlled studies.

An even more difficult issue is whether the focus should be the procedure or the physician who performs it. The patient is primarily concerned with the procedure and its outcome. From the patient's perspective, if an operation can be performed effectively by either of two physicians, any skill, training, or other differences between them are irrelevant. A standard based on the procedure and not the physician more closely resembles the usual market transaction, and hence achieves an air of ethical neutrality.

Nonetheless, the medical system desires highly skilled pratitioners who operate at the frontiers of their field. If the extra investment of time and expense necessary to achieve an advanced level of

proficiency and knowledge requires an extra reward, it may be desirable. By overpaying for a simple procedure (that could be performed equally well but for a lower fee by a nonspecialist), the system subsidizes the development of specialists.

Such an arrangement may be ethically unobjectionable since the nonspecialist's time is admittedly "less valuable" than that of the specialist or subspecialist. Yet the extra financial reward seems unjustified because (a) the reimbursement system is supposedly geared to the value of procedures performed for patients, and (b) reimbursement should be a reflection of appropriate input costs (including the costs of extra training, etc.). The specialist who performs a procedure that a less highly trained individual could do for a much lower cost is *choosing* to follow a nonefficient use of his or her own resources. The system ought to discourage such a choice.

Different financial rewards to physicians who live in different locales or who provide different types of medical services, unlike differences in the "quality" of medical care, can be reliably determined. However, assigning ethical significance to these differences is an unresolved problem.

C. *Patients' Access To Health Care*

Patients' access to health care has characteristics that place it somewhere between the other two criteria for evaluating alternative payment methods in ethical terms. Similar to the fairness among physicians criterion, it should be possible to generate quantitative access data, although predictions regarding the impact of particular payment methods on access are merely guesses about *probable directions*, not quantitative conclusion about *end points*. Conversely, although there is considerable disagreement as to its defintion, the basic value of access, like the value of fidelity to patients' interests, is not in question.

1. *Patterns of Access to Care*

Many Americans are surprised that despite enormous expenditures of public and private funds, everyone is not encompassed by this nation's health care "system." Access problems are not limited to residents of rural or inner-city communities, nor are they limited to the very poor, but even extend to low or middle income families.[119] Compared to people who are insured, people not covered by

119. 1 SECURING ACCESS TO HEALTH CARE, *supra* note 108, at 92-100 (At any one time 22 to 25 million Americans lack health insurance, which amounts to 11 to 12.6% of the

any form of private or public health insurance are less likely to seek prompt medical care and are more likely to face substantial obstacles in obtaining adequate care, particularly for chronic or other nonemergency conditions.[120]

Is it significant that uninsured individuals use substantially fewer health services, even though they are no less in need of care.[121] Despite skepticism about the efficacy of many medical procedures and the lack of agreed upon methods to evaluate the cost effectiveness of medical techniques and practices, having access to adequate health care can have dramatic results. Advances in health care capabilities in this century have been accompanied by notable increases in longevity and reductions in morbidity. More particularly, recent reports demonstrate that utilization of medical care leads to a marked reduction in mortality rates.[122]

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noninstitutionalized population. An even larger number, about 16%, are without insurance at some point over the course of the year because some people lose their coverage due to change in employment status or change in income (which determines eligibility for some public programs)). *Id.*

120. *See* Davis & Rowland, *Uninsured and Underserved: Inequities in Health Care in the U.S.*, in 3 SECURING ACCESS TO HEALTH CARE, *supra* note 108, at 55-76.

The absence of health insurance is not evenly distributed across income groups. 1 SECURING ACCESS TO HEALTH CARE, *supra* note 108, at 103-08 (of families with incomes below $10,000, 27% lacked health insurance for all or part of the year). Among like families with incomes exceeding $32,000, 90% were insured, and the uninsured 10% would clearly be better able to meet health care costs using their own funds. *Id.* Indeed, in 1977, poorer members of the population not only spent a larger proportion of their income for out-of-pocket health care expenses than higher income people, but also spent more in actual *per capita* dollars. *Id.* This ironic situation may have altered somewhat in the past several years as private insurance programs have markedly raised their co-payment requirements. Crozier, *Data Watch: National Medical Care Spending*, 3 HEALTH AFF., Fall 1984, at 108.

121. Walensky & Berk, *Data Watch: Health Care, the Poor, and the Role of Medicaid*, 1 HEALTH AFF., Fall 1982, at 93-106.

122. *See* J. HADLEY, MORE MEDCIAL CARE, BETTER HEALTH? (1982).

It would be a mistake to equate the levels of hospital and physician services used by insured, white middle-class patients with the optimum level. The fact that insured whites under age 65, in fair to poor health, averaged 7.2 physician visits per year does not prove that uninsured whites in similar health (who saw physicians only 4.5 times per year) or uninsured nonwhites (who averaged only 2.6 visits per year), were necessarily receiving too little medical attention. 1 SECURING ACCESS TO HEALTH CARE, *supra* note 108, at 66-70. However, other facts substantiate the adverse effects of lack of access to health care. Indigent patients who lost Medicaid coverage because of changes in eligibility rules experienced clinically significant worsening health status. For example, one 1983 study of such patients in California found that six months after termination of benefits, patients with hypertension had experienced a 10 mm Hg rise in diastolic blood pressure (which increased their relative risk of dying by 40%). Lurie, Ward, Shapiro & Brook, *Termination from Med-Cal: Does it Affect Health?*, 311 NEW ENG. J. MED. 480, 484 (1984). The study associated this result with the unavailability of care for this indigent population.

> Fewer medically indigent adults could identify a usual source of care (50 percent after termination vs. 96 percent before termination), fewer thought that they could

2. *Ethical Implications of Lack of Access*

Currently Americans' health care access disparities take many forms: "variations in the level of financial protection against health care costs, in the financial impact of health care expenses, in the use of services, in the availability of health resources, and in the use of different settings offering varying levels of quality of care."[123]

Inadequate health care and the imposition of excessive burdens to obtain health care are included as problems resulting from a lack of insurance and resources. The issue becomes: to what extent are these ethical problems? This issue has been addressed by recognizing that in American society many goods and services are distributed unevenly without concern that an injustice is being done.[124] Yet health care is regarded differently, and its distribution is governed by principles of fairness that dictate equitable access to an adequate level of care.[125] The reasons that health care is particularly subject to the dictates of justice can be briefly summarized.

First, philosophers termed good health a "primary good," since one need not know another's peculiar preferences and goals to know that the person will value health, which is necessary for fulfilling those preferences and goals.[126] Although all people do not place equal value on health (or even on life), the connection between health care and the opportunity to enjoy life and pursue one's other objectives is self-evident. Moreover, the need for health care varies widely among individuals, and cannot be anticipated like other "necessities" of life.[127]

Of course, a large proportion of health services are not necessary to save life or even to relieve suffering and restore functioning. Physicians and other health care personnel often deal with the "worried well" and with patients whose medical problems are naturally self-limiting. Even when this is so, the information-giving facet of health care endows it with special ethical significance. Health care in these circumstances can relieve patients' worries and allow them to anticipate and adjust to the future course of their condition. Moreover, reliable information supplied by a physician or other health care professional can help a patient avoid a fruitless (and

obtain care when needed (38 percent vs. 83 percent), and fewer were satisfied with their care (60 percent vs. 91 percent).

123. 1 SECURING ACCESS TO HEALTH CARE, *supra* note at 108.

124. *Id.* at 12.

125. *Id.*

126. *Id.* at 16.

127. *Id.* at 23.

possibly painful and expensive) search for further diagnostic or therapeutic procedures. Finally, health care has symbolic significance: a person receiving it will feel cared for, a person deprived of it—in a society where it is generally available under like circumstances—will probably feel excluded from the human community. Thus, "health care has a special interpersonal significance: it expresses and nurtures bonds of empathy and compassion."[128]

Three criteria have been suggested to judge the fairness of health care distribution: equality, benefit, and equity.[129] The application of an equality standard to health care could have very odd results. It could mean that each person would be entitled to an equal amount of care over the course of a year or perhaps over the person's lifetime. Yet the need for care varies widely. If the guaranteed amount of care were set high enough to provide adequate care for those with chronically poor health status, an enormous drain would be imposed on resources that could be used to meet other non-health care needs. Conversely, if the level was calibrated to meet the needs of people in average or better health, services that could preserve life or restore health would be unavailable for some sick people.[130]

Alternatively, a fair distribution of health care could be interpreted to mean that everyone should have access to health care that will be beneficial to them. Yet, since there is virtually no end to the funds that could be used to achieve some possible medical benefit, using benefit as the basis of an ethical theory of health care distribution would open the door to unlimited spending on this one good, to the potential exclusion of many other individual and social goods. Health care is of special importance, but not sole importance. A just health care system can weigh the benefits of care against the costs of achieving those benefits in comparison with the other goods and services on which the resources might be spent.[131]

The President's Commission concluded that the correct standard for judging the fairness of health care distribution is one that ensures everyone equitable access to care, defined as access to "an adequate level of health care."[132] The commission concluded that equitable access to care requires that people not face "excessive burdens" in obtaining care—such as out-of-pocket expenses, travel and

128. *Id.* at 17.
129. *Id.* at 18-20.
130. *Id.* at 18.
131. *Id.* at 19.
132. *Id.* at 20.

waiting times, and the like.[133] Adequate care is "enough care to achieve sufficient welfare, opportunity, information, and evidence of interpersonal concern to facilitate a reasonably full and satisfying life."[134] Rather than being open-ended, the obligation created by the adequate care standard recognizes that society's resources are limited and have to be available for uses other than health care.

This view of equity in health care has major implications. Above all, it treats health care as a complex *system* in which physicians, institutions, and patients participate with others, such as employers, insurance companies, and governments, each having rights and obligations vis-a-vis the others. For example, if the federal government changed the methods used to reimburse physicians, the change cannot be judged solely by its effect on physicians or the federal treasury. Rather, it must be scrutinized for the effect on how well the *system* is fulfilling society's obligation to ensure that each person has access to an adequate level of health care.[135]

3. *Weighing Access Against Other Ethical Goals*

Ethical theories are intended to provide means for examining and resolving value conflicts. Value conflicts are not simply conflicts of good (better health) versus evil (decreased access to needed health care). Instead, they are often conflicts of one good (increased access to health services) versus another (better schools, safer neighborhoods, more knowledge through research). Although many physicians believe that value conflicts should never be resolved at the patient's bedside, it is now generally acknowledged that they must be addressed at the "macro" level. Resolution of value conflicts at the macro level involves a move beyond health care ethics to encompass general social ethics in the distribution of resources in society.

Because of the good-vs-good nature of some of the choices being

133. *Id.* at 21-22.

134. *Id.* at 20.

135. It is important to remember that an ethical, not legal, obligation is at issue here. To find that a society has an ethical obligation to do something is to conclude that its failure to do so is wrong and opens it to serious criticism. It does not mean that the persons who would be benefited by society's actions have a corresponding right to demand society's aid. The courts have not held health care to be a constitutionally guaranteed right. Thus, any discussion of "rights" in this context should be limited to the protection of those claims that individuals may have within the context of existing legislation. For example, under existing law, a Medicare beneficiary is entitled to have a certain payment made on his or her behalf. However, this does not answer the question of what society is obligated to provide through legislation or otherwise.

made about health policy, macro-ethical analysis must focus on more than the impact of changes in reimbursement methods on access. Ethical analysis must also take into account other effects of the changes in reimbursement, especially Medicare spending reductions which would not have occurred but for the policy changes. If such reductions preserve other important features of the program that might otherwise be dismantled or make available funds for other important uses, the allocative decisions have to be judged on their own merits. However, consistent ethical analysis will require that decisions which limit the amount of beneficial care received be disapproved if the payment system could have saved a like amount by expending its funds more efficiently. In other words, decisions must consider current knowledge about cost-effective medical care.

This concern is ethical as well as technical. Changes in the health care system (such as in Medicare reimbursement policies) are ethically desirable to the extent that they increase health care access but undesirable to the extent that they do not. In this connection, two points need to be assessed. First, it must be determined not only if the program will save money, but also whether the program will increase, or at least not decrease, access to health care. Second, means must be established for measuring the effects of the program to ascertain whether the situation is actually improved. For example, if a change in reimbursement effect makes Medicare participants so unattractive as patients that some of them lose the ability to obtain adequate care, this would plainly count heavily against such changes on fairness grounds. Conversely, if a change in Medicare reimbursement methods either frees up monies to treat other patients in public programs who lacked access to care, or otherwise encourages or induces physicians to care for more such patients, it would be evaluated as an ethically beneficial program.

By definition, scarce resources always imply rationing, and economists insist that those people who resist explicit rationing of health care seem not to realize that rationing already occurs.[136] Unlike age-related standards of the type found in Great Britain, we ration according to ability to pay.[137] There are important differences between this less formal means of *allocating* resources and explicit decisions denying a group of people necessary health services (which is connoted by the stronger term "rationing"). A process that merely allocates resources while not categorically denying

136. *See, e.g.*, Fuchs, *The "Rationing" of Medical Care*, 311 NEW ENG. J. MED. 1572 (1984).

137. *See* H. AARON & W. SCHWARTZ, THE PAINFUL PRESCRIPTION 7-8 (1984).

needed care permits society to maintain other important values, such as the sanctity of life and the equal worth of all persons.[138] Although this may exalt image over reality, it may provide social and ethical benefits sufficient to recommend it. For this approach to succeed, however, resource allocation must be perceived as procedurally fair. Otherwise, society may fear that the informality or invisibility of the decisionmaking process provides a cloak for biased choices by the decisionmakers.

IV. ASSESSING THE ETHICAL IMPLICATIONS

Precise effects of the ethical implications of the changes described in the first two sections of this Article are not susceptible to prediction.[139] In the absence of reliable quantitative predictions, it is especially appropriate for health care reimbursement policymakers to address possible ethical differences among policies. Even when medical and economic effects can be estimated reliably, ethical implications are important in their own right.

Although the ethical implications are important for policymakers in both public and private programs, special attention is accorded here to the Medicare program. This is because the limited financial ability of many members of the population involved in Medicare gives them much less freedom than participants in private health care insurance plans. This section now evaluates the consequences of several types of changes in reimbursement in terms of the three major ethical interests-fidelity, fairness, and access.

A. *Effects on Fidelity to Patients' Interests*

1. *From Limiting Physicians' Rewards*

There was a time, well within the memory of many physicians still practicing today, when physicians were expected to—and did—provide free medical care to patients with limited financial means. Such care was provided both in physicians' offices and at charitable, public and teaching hospitals. With this in mind, it might seem that limiting the amount paid to a physician for services to a Medicare patient would not adversely affect the physician-patient relationship because at least some payment would still be involved. However, physicians' practices and attitudes have changed. The remarkable growth in third-party coverage of health care costs in the past quarter-century has raised the complexity and expense of medical prac-

138. *See* G. CALABRESI & P. BOBBITT, TRAGIC CHOICES (1978).

139. *See supra* notes 4-92 and accompanying text.

tices, as well as practitioners' expectations of earnings. As a result, patients with "substandard" third-party reimbursement rates have difficulty commanding the attention, much less the loyalty, of many physicians.

Although this phenomenon has been condemned by many, including physicians,[140] it is a reality which a payment system must address. It has implications for all three of the ethical values discussed: fidelity (when patients are not treated), fairness to physicians (when some treat a disproportionate share of a certain group of patients), and in particular, patients' access to care. Thus, the more effectively a program (such as a fee schedule) contains charges for physicians' services to patients, the less likely it becomes that those patients will have their interests vigorously pursued.[141]

In some ways, it seems ironic that limitations in the level of payment could be thought to cut against physicians' fidelity to patients' interests. This is particularly true of those limitations that remove financial incentives for unlimited tests and procedures, such as capitation programs or expenditure caps in fee-for-service situations. Interestingly, the risk that physicians will *overtreat* their patients to serve their own economic interests was a traditional ethical consideration even before the advent of third-party payment.[142]

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140. Elias, *Physicians Who Limit Their Office Practice to Insured and Paying Patients*, 314 NEW ENG. J. MED. 391 (1986) (letter to editor):

> Physicians who limit their office practice to insured and paying patients declare themselves openly to be merchants rather than professionals. This mercantile approach has several consequences. First, it demeans the individual physician and cheapens the profession. Second, it puts the third-party payer, as service purchaser, in a position of greater importance than the patient. Third, it fosters the myth that physicians as a group are greedy and self-serving rather than dedicated and altruistic. And most important, it deprives a large segment of our fellow humans of care. Physicians who value their professionalism should treat office patients on the basis of need, not remuneration. Physicians who do not do so deserve the contempt and censure of their colleagues.

141. Obviously, there are mitigating factors. A program whose terms are set by the marketplace (such as a PPO plan) may not have such adverse effects, provided that it just "clears the market." In other words, the prices set permit physicians a fair return on both capital and labor, leaving the supply of physicians willing to provide acceptable, dedicated medical care sufficient to meet the demand for their services. Further, some programs, such as HMOs, offer administrative or other advantages to compensate for their lower reimbursement rates. Even when a program does not provide such off-setting benefits, patients with long-standing relations with a particular physician or group will probably continue to receive appropriate attention. This suggests that, from an ethical viewpoint, patients who believe they have such relationships should have access to a program that permits them to retain it.

142. Health insurance is often considered the cause of overtreatment. It not only insulates patients from many of the financial consequences of their medical care choices, thus distorting their attitude about the relative benefit of medical interventions, but also encourages physicians to do more, not less, since their patients' economic interest will not be harmed. This leads to "unnecessary treatment, . . . [and] uncritical use of costly adjuncts

Because of this potential conflict of interest, medical ethics cautioned physicians to put their patients' interests first and to restrain their impulses to intervene. Although this did not eliminate the conflict, at least it acknowledged the problem and elevated the ethical expectations of the profession. With the continuing growth of health facilities owned by investing physicians, the conflicts become more acute. Ethical norms need to be reiterated and strengthened if patient interests are to be protected.[143]

2. *From Exposing Physicians to Financial Risks*

Reversing the financial incentives, to make it disadvantageous for physicians to treat patients more intensively, poses the conflict-of-interest issue in a somewhat unfamiliar way. This unfamiliarity—on the part of physicians as well as patients—is itself part of the problem. Until recently, the relatively small proportion of patients and physicians in arrangements such as HMOs had selected this "reverse-incentive" situation themselves, against the background of a predominantly fee-for-service system. The ethos these programs developed established mutual expectations and provided the necessary insultation of physicians from undue conflicts of interests with their patients. If anything, physicians in such settings had difficulty demonstrating that their decisions about patient care were never influenced by the financial risk posed to their organization if they were "too successful" in maintaining a patient.

This points to the fundamental difference in evaluating the ethics of the current proposals. In the past, the weight of the societal expectations reinforced the physician's presumption in favor of offering (and sometimes imposing) anything believed to be of value to the patient. Contrarily, the reimbursement plans that place physicians and medical institutions at financial risk are intended to ally physicians with society's new position that many medical interventions are not cost-beneficial and ought to be avoided. At the very least, the cost-containment efforts presume that it is possible to reduce health care expenditures without harming patients. Some would say that it is now or soon will be routinely necessary to withhold (or decline to pay for) certain interventions that might benefit

such as hospitalization in lieu of (often preferable) ambulatory care, and an intricate battery of excess laboratory studies." C. CHAPMAN, *supra* note 101, at 146. Moreover, even before third-party payments existed, the physician's financial motivation to perform more services rather than less placed his or her interests in conflict with patients' interests.

143. *See* Relman, *Cost Control, Doctor's Ethics, and Patient Care*, 1 ISSUES IN SCI. & TECH., Winter 1985, at 103.

patients but that simply cost too much for society to justify. In either case, the collective attitude would no longer be a check on physicians' temptation to place their own interests ahead of their patients' interests. Instead, society would attempt to use physicians' selfish motivation to *restrain* full pursuit of patients' interests.

Of course, the reality of the system is not as simple as this scenario might suggest: physicians' norms are deeply ingrained. Society does not speak with one voice, and the voice of insurance officials is unlikely to actually proclaim the goal of slighting patients' interests. Finally, it is a close question whether patients would not be better served by less aggressive treatment, fewer tests and procedures.

Nonetheless, the interaction of society, physician, and patient inherent in the risk-shifting reimbursement schemes represents a subtle but definite shift of alliances. The outcome of this change cannot be fully predicted. However, it seems clear that all constraints on resources will eventually alter the perceptions and expectations of all the participants about what is "owed" to whom, what treatments are "appropriate" in what circumstances, and even what qualifies as a "disease" for which medical attention is indicated.[144]

The effects of the various risk-shifting proposals on the ethical value of fidelity can be differentiated as follows. First, proposals such as MDDRGs and capitation that involve the greatest risk (and hence generate greater pressure on the value of fidelity), would be more problematic for conditions with a wide variation in treatment and outcome (such as many chronic mental illnesses) than for conditions with a smaller range of outcomes. A second division involves the directness of the physician's financial exposure. Programs that place the risk on the organization employing the physician are less likely to interfere with a physician's pursuit of

144. In effect, this would be an extension of a phenomenon observed some time ago by Friedson:

> As the state assumes more responsibility for the welfare of the layman, professionals become members of the class of caretakers, and the possibilities increase for differences between their perspective and that of laymen. Given the official status of the profession, what happens to the layman— that is, whether or not he will be recognized as "really" sick, what the sickness will be called, what treatment will be given him, how he will be required to act while ill, and what will happen to him after treatment— becomes a function of professional rather than lay decision. . . . Furthermore, on an everyday basis [physicians] . . . serve as gatekeepers to special resources (the most obvious of which are hospital beds and "ethical" drugs) that cannot be used without their permission. Thus, the behavior of the physician and others in the field of health constitutes the objectification, the empirical embodiment, of certain dominant values in a society.

E. FRIEDSON, *supra* note 24, at 304.

patients' interests than those programs that provide fixed payment directly to physicians and thus increase their financial risk.

Finally, incentives and disincentives will probably prove more ethically problematic than explicit restrictions imposed on physicians' judgment by an institution or third-party payor for two reasons. First, incentives and disincentives that operate through the market's "invisible hand" are hard to police and, indeed, harder for patients even to know about.[145] Second, incentives (and perhaps even disincentives) would appeal to physicians to be complicit in achieving the institution's revenue-enhancing goals. Explicit restrictions, on the other hand, would be likely to generate resentment among medical professionals and therefore would be resisted (on the patient's behalf, one hopes). For example, suppose a plan discourages providing certain expensive treatments to certain patients. If the plan imposes financial risks on physicians or others with whom they share economic interests, the physician may feel constrained not to inform patients of the treatment alternatives, rendering them unavailable within the plan. To withhold such information would violate the physician's fidelity to the patient. Of course, it is up to the physician to judge the propriety of care, without obligation to mention minimally effective treatments or those only used in limited research trials for which the patient is not eligible. But the propriety of treatment should be independent of the financial aspects of care, which are for the patient to decide. It is important that patients know about limitations built into the system so that they can employ legitimate processes, both within an individual treatment setting and through broader political processes, to change them.[146]

B. *Effects on Fairness Among Physicians*

The effects of limiting physicians' financial rewards on interphysician fairness will naturally depend on the nature of the limitations. Attempts to create greater fee system rationality or to increase competition among physicians to provide services are likely

145. *See* A. SMITH, THE WEALTH OF NATIONS 456 (R.H. Campbell & A.S. Skinner eds. 1976).

146. Whether the existing common law of informed consent would compel such disclosure is open to debate. Disclosure is requried in those jurisdictions following the better, but still minority, patient-oriented standard of materiality. Traditional jurisdictions only require disclosure of those items that physicians customarily disclose. In these jurisdictions, physicians might decide not to disclose options to patients who are not eligible for such options under their insurance plan. *See* Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345, 1392-95 (1981).

to reduce the present fee-for-service inequities, which greatly overcompensates physicians for certain services. Changes that place physicians on fixed salaries are more fair to the extent that they reflect open market demand for physicians' services. Systems which artificially constrain access to medical staff privileges or force prepaid practice on unwilling practitioners in a particular field will be likely to create inequities among physicians. Even when markets operate freely, the value of physicians' services in various speciality fields may not reflect the value of those services in an ideal world because the lead time required for special training produces an imperfect market.

In systems in which illness-based or capitated payments go directly to physicians, physicians providing services for illnesses with wider ranges of severity and durational variation and physicians treating patients with higher complication rates are likely to suffer financially. Hence, increased financial exposure of physicians as individuals is likely to increase unfairness.

C. *Effects on Patients' Access to Care*

1. *From Limiting Physicians' Rewards*

Although all of the proposed changes in payment methods are intended to limit physicians' financial rewards, some proposals are more likely to achieve that effect than others. Several facts about price reductions (especially when linked with cutbacks in administrative budgets, which delay the processing of claims) should be recognized. First, price reductions are more likely to affect access to care negatively if they affect only one population segment. If different programs produce markedly different financial rewards for physicians, the specter of two-tier (or multi-tier) care is inevitable.[147] This is particularly true when the population in the effected plans is distinguishable from the general patient population. When a distinguishable population has limited financial resources, or when its members have some resources but assignment rules preclude collecting additional charges directly from them, that sector will be unable to "buy up" in the system.

Second, annual program changes (such as have occurred in Medicare in recent years as part of Congressional budget-balancing efforts) are particularly disruptive and thus likely to drive physicians out of the system. Finally, until reimbursement changes have

147. *See, e.g.*, Rosenblatt, *Dual Track Health Care—The Decline of the Medicaid Cure*, 44 U. CIN. L. REV. 643, 644-45 (1975).

percolated through the system, which will require time for physician and patient behavioral adjustments, alternative sources of care cannot be expected to fill in the gaps in access created by the withdrawal of physicians who do not believe that a particular program, such as Medicare, rewards them sufficiently for their efforts.[148]

It may seem as though all cost-controlling changes in reimbursement methods would, at least initiatlly, negatively affect access.[149] Programs having the least negative effect, or the most positive effect, are those with greater administrative simplicity (such as HMOs), special benefits to participating physicians (such as the access to a pool of enrolled patients provided under a PPO agreement), and the smallest reductions in physicians' income and freedom to practice (such as refinements in current fee-for-service payment methods).[150]

2. *From Exposing Physicians to Financial Risks*

Some of the most disturbing effects on patients' access to care could result from reimbursement methods that shift some or all of the financial risks of treating patients from the insurance fund to physicians and/or institutions with which they are associated. Physicians might overcome price-lowering efforts by increasing the number of service units,[151] but, physicians (and health care institutions) can "beat" risk-shifting efforts only by attempting to exclude high-risk patients from the pool of patients they will treat. Capitation programs, packaging of services, and prepaid arrangements such as HMOs have a built-in disincentive to accept the sickest and poorest patients, the very ones who have the hardest time obtaining health care.

148. The real difficulty for Medicare patients is the fact that, although they are an important segment of the market, they are not the whole market. Thus, reimbursement rule changes that make such patients less financially attractive—especially changes which emphasize the *competitive* aspects of health care provision—will have an adverse effect on their ability to obtain care because the best medical resources will be drawn to other market segments where they will be more generously rewarded.

149. Hypothetically, under fee-for-service methods, the adverse effects on physicians' net income exerted by lowered fees could result in *increased* access to care as physicians with "excess capacity" (i.e., time in their schedules) raised the number of interventions they initiated. This effect would result, however, only to the extent that physicians sought new patients, rather than simply doing *more* things to the *same* patients.

150. Stricter assignment requirements for physicians who wish to receive direct Medicare reimbursement for *any* patients, though perhaps a negative factor in the short run, are likely to have positive long-term impact on access. Such a requirement actually simplifies physicians' activities and removes an impediment (actual or perceived) to some patients' seeking health care.

151. *See supra* notes 40-41 and accompanying text.

It is important to recognize that greater rationing of services is not merely an unfortunate side effect of these programs—*it is their very intent*— particularly the programs that place some of the financial risks on the shoulders of physicians or the institutions in which they have employment or other interests. Historically, the financial incentives provided by Medicare and other third-party payment systems have simply reinforced physicians' professional norm of "do everything possible" for every patient. By shifting the incentives and creating the disincentive that results from having one's own finances at risk, the new methods of physician reimbursement turn physicians into gatekeepers for the health care system. Their decisions would no longer be based on medical criteria alone (i.e., "does medicine have something to offer this patient?") but would now have to take into account their own financial risk if they admit patients into the system whose care costs more than insurance will pay.

D. *What Directions to Go—and How?*

The problems involved with the various means of paying physicians are not absolute objections to any of the options. Rather, they are factors which should be considered in responding to the need to contain health care costs. With this in mind, it is relevant to consider the most desirable courses, the role of legal institutions and other means of review and control in avoiding or minimizing the potential ethical problems.

Among the suggested payment methods, capitation presents the greatest incentive for appropriate use of resources. It discourages both over-treatment (which unnecessarily expends resources) and under-treatment (which risks worsening enrollees' health and hence creating later expenses that could have been avoided). Consequently, capitated payments, by creating a strong incentive for physicians to take an interest in their patients' health, serve the value of fidelity well.[152] However, capitation exposes health care providers to great financial risks. Hence, capitated plans that permit a provider to spread the risks over a large patient base, which insulates clinical decisionmaking from anxiety over such risks, are preferable.

152. Capitated programs do, however, raise cost-containment problems if they do not include some aspect of cost-sharing (co-payments, etc.) by enrolled patients who otherwise have no financial incentive to constrain their consumption of medical resources. *See, e.g.*, Brown, *Competition and Health Cost Containment: Cautions and Conjectures*, 59 MILBANK MEMORIAL FUND Q. 145 (1981).

These features are best attained when care is provided by a clinic or group practice.

Unlike individual physician-patient contracts, group settings can also operate as markets for physicians' services; hence they are conducive to achieving fairness among physicians, provided that certain physicians or groups do not remove themselves from the arena by refusing to treat patients whose care is paid for by a plan such as Medicare.

The success of any plan in ensuring equitable access to care is largely dependent upon the funds the plan makes available to physicians to treat the plan's beneficiaries.[153] In this respect, capitation plans may be more attractive than other programs, such as fee-for-service or fee schedules, that pay equal amounts because capitated programs require less bureaucratic interaction between the provider and the third-party payor. Although a group practice or clinic may have to recreate some of the same oversight mechanisms, such internal mechanisms, may seem less burdensome to physicians than the third-party payor's.[154]

It is likely that various means will be adopted by public and private plans to contain the costs of medical care. The capitation method advantages are far from overwhelming and decrease when the unit of care is an individual physician. Regardless of any disagreement over the relative merits of one approach or another, the pressures to modify the prevailing mode of third-party payment to physicians is irresistible. Change may lead to increased use of explicit "rationing" techniques, an activity in which American society is reluctant to engage.[155] Society's disinclination towards rationing may lead to the adoption of measures that rely on physician decisionmaking, which tend to be less visible and provoke less conflict with collective norms about the equal and incalculable worth of every human life.[156]

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153. One commentator has noted that providers' disinclination to serve certain populations, such as the sickest patients, might be overcome if a higher premium is charged for those enrollees. The actuarial feasibility of designing risk-adjusted premiums and vouchers is quite another problem. Making the premium a smooth function of several factors such as age, sex, family medical history, and the like might avoid many of the problems associated with the yes/no decisions on disability eligibility. Luft, *Health Maintenance Organizations and the Rationing of Medical Care*, 60 MILBANK MEMORIAN FUND Q. 268, 299 (1982).

154. Internal mechanisms include controlling unnecessary spending and monitoring for quality. These may seem less burdensome due to their local and less bureaucratic nature.

155. Some commentators have suggested that rationing of health services is not merely inevitable, but desirable. *See, e.g.*, H. AARON & W. SCHWARTZ, *supra* note 137, at 60. *See also* Schwartz, *We Need to Ration Medicine*, Newsweek, Feb. 8, 1982, at 13.

156. *See* Schwartz, *We Need to Ration Medicine*, *supra* note 155, at 13.

This is not to say that society will or ought to rely solely on physician decisionmaking. Informed consent from patients, malpractice law, and various forms of professional review are several means to oversee physician decisionmaking.

1. Informed Consent

Patients must be well informed about treatment options if they are to serve as an effective check on inappropriate physician decisions. Interestingly, a payment program (such as capitation or MD-DRGs) that places decisions on the physician regarding the range of interventions to offer a patient is more likely to lead to a full disclosure requirement than is a program that relies on fee schedules which limit the services that will be reimbursed. This is so because there is some question whether the physician has a duty to disclose options that are not available to the patient.[157]

2. *Malpractice*

Malpractice law provides a broadly applicable means of regulating physician behavior to prevent harm arising from their response to payment methods that seek to contain medical costs. Malpractice law has not, however, proven to be a uniformly effective mechanism for preventing either undertreatment of patients in programs that constrain costs[158] or excessive interventions with patients under private fee-for-service plans. Most physicians subscribe to the view that malpractice rules force them to use tests and treatments that are not required by their best clinical judgment. This is not only unsupported by the evidence,[159] but is so closely aligned

157. *See supra* note 146.

158. Not only is it difficult to bring refusals of care within malpractice jurisdiction, but the premature discharge of poor patients from hospitals and the substandard conditions in many hospitals where they are treated have also been remarkably unaffected by malpractice litigation. It may be that these patients, less aware of how to pursue their legal rights, do not expect better treatment. Even if they do seek redress they are less likely to bring a successful lawsuit because the usual measure of damages, lost wages and added medical expenses, are largely irrelevant for people with little or no regular earnings whose medical care is paid for by public programs. *See* Rosenblatt, *Rationing "Normal" Health Care: The Hidden Legal Issues*, 59 TEX. L. REV. 1401, 1411-16 (1981). This is confirmed by 1970 data presented by the HEW Secretary's commission on malpractice, which reveals that only 1.2% of malpractice claimants are Medicaid beneficiaries, despite their much higher percentage in the patient population. *See* Rudov, Myers & Mirabella, *Medical Malpractice Insurance Claims Files Closed in 1970*, in SECRETARY OF HEALTH, EDUCATION, AND WELFARE'S MALPRACTICE COMMISSION, REPORT ON MEDICAL MALPRACTICE app. at 1, 11 (1973) [hereinafter cited as HEW REPORT ON MEDICAL MALPRACTICE].

159. *See, e.g.*, Bernzweig, *Defensive Medicine*, in HEW REPORT ON MEDICAL MALPRAC-

with physicians' self-interest under fee-for-service payment that it is suspect.

The question remains whether malpractice law will be an effective policing mechanism if the incentives in medical care are reversed. It seems unlikely that malpractice law by itself would generate much, if any, pressure toward cost-saving behavior.[160] On the contrary, a physician who orders fewer tests, has less equipment available, and relies on less highly credentialed personnel "run[s] the risk of increased exposure to malpractice liability."[161] This occurs simply because a large part of any physician's exposure to liability depends on patients' inclination to sue, and cost-containing steps may well strike patients as blameworthy should any unexpected results occur. But malpractice law does not itself create liability, provided that the steps taken by the physician were medically sound. The premise of cost containment, after all, is that much of what is now done could be foregone without harming patients. A physician whose judgment is consistent with this premise is not guilty of malpractice. Ironically, the very flexibility of professional judgment across a wide spectrum of accepted practice creates doubts about the efficacy of malpractice law as a check on ethical abuses under new payment mechanisms.[162] Were the medical professional to agree upon standards of appropriate care for more conditions, the malpractice system—in which standards are set by the medical profession, not the law[163]—would be more effective to punish inadequate care and ensure that adequate care is not forced to become excessive to avoid liability.[164]

3. *Peer Review*

Since the malpractice system is expensive, slow, and neglects

TICE, *supra* note 158, app. at 38, 40; Project, *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939, 941-43, 953-67.

160. *See* Schuck, *Malpractice Liability and the Rationing of Care*, 59 TEX. L.J. 1421, 1422 (1981).

161. Blumstein, *supra* note 146, at 1395.

162. *See generally* Rosenblatt, *supra* note 158, at 1416-19.

163. Toth v. Community Hosp., 22 N.Y.2d 255, 262, 292 N.Y.S.2d 440, 447, 239 N.E.2d 368, 372 (1968) ("The law generally permits the medical profession to establish its own standards of care.").

164. The data for such standard setting is woefully inadequate, especially for procedures outside the hospital. Wennberg, *Which Rate is Right?*, 314 NEW ENG. J. MED. 310, 311 (1986) ("Decision analyis and consensus approaches may work well to distinguish the clearly inappropriate from the clearly appropriate, but when key facts are unavailable, such techniques can be expected only to point out (not to resolve) the many differences that exist among physicians.").

many cases, other review mechanisms are necessary. Some review programs exist regardless of the payment mechanism: professional and governmental bodies screen, license, and discipline physicians. Except for the most eggregious incompetence their effectiveness is uncertain. Moreover, these processes are usually grounded on a norm of appropriate conduct articulated by the profession. Thus, they would not restrain conduct that departs from earlier views of a patient's best interests (e.g., how intensively to treat a dying cancer patient who develops renal failure) if that conduct accords with *new* norms of appropriate medical behavior. Such changes in medical norms occur for many reasons: new scientific findings, evolving cultural views about life, suffering and death, and changed social attitudes toward the extent that care should be provided under certain circumstances.

The rising costs of health care over the past twenty years have led to the development of many forms of review. Some, such as utilization review committees, are institution-based.[165] Others, such as the Professional Standard Review Organizations (PSROs), operate as part of the reimbursement system. Although good hospitals have traditionally attempted to discover (and prevent repetition of) bad results caused by inadequate care, the thrust of utilization review bodies, like that of PSROs, is avoiding the unnecessary use of resources, rather than protecting patient interests in fidelity or access.[166]

Review mechanisms which focus on patient welfare obviously will be necessary for any payment scheme, particularly one that tries to combine fairness to all physicians with society's goal of reducing the amount of (unnecessary) care provided to patients. As

165. Brown, *The Rationing of Hospital Care*, in 3 SECURING ACCESS TO HEALTH CARE, *supra* note 108, at 253, 280:

> Hospital utilization review committees have had an impact beyond the specific cases to which their negative or corrective judgments have been made. They have also created an environment in many hospitals in which physicians, having received negative peer judgments in the past, try to anticipate such judgments by altering their clinical practice. Utilization review has probably exerted a modest influence on physicians' hospital practices through peer pressure, but it has avoided any fundamental changes in the structure of hospital or medical decisonmaking.

166. In Wickline v. California, 183 Cal. App. 3d 1175, 228 Cal. Rptr. 661 (1986), the Court of Appeals reversed a judgment against the state Medicaid program for harm that occurred to a patient as a result of premature discharge from the hospital following denial by the Medicaid program of the full extension of hospitilization requested by the attending physician. The court held that third-party payors may be held liable when inappropriate discharge decisions result from defects in their cost-containment mechanisms but found that the physician for Ms. Wickline had complied with the ruling without protesting its medical inappropriateness.

was true of malpractice, review procedures will ultimately require more comprehensive scientific data for a better understanding of what constitutes good quality medical care. This is especially true regarding the connection between particular interventions and beneficial outcomes:

> Unless the medical profession accepts responsibility for the question of "which rate is right" and addresses these issues with the current cost-containment context, others will see to it that the "least is always best" theory dominates by default. After all, if physicians can't agree on what is best, why do more?[167]

One method to evaluate the likely success of such efforts is to evaluate experience with attempts to add these considerations to the review process in the wake of the adoption of prospective payment for hospitals in 1983.[168] As HCFA in effect admitted at the time that the prospective payment regulations were first published,[169] its then-existing orientation and experience did not include methods for systematically monitoring the ill-effects of incentives to undertreat Medicare patients. Similarly, HCFA has only recently moved to establish the necessary criteria for peer review of the quality of HMO care, now that HMOs have been permitted since the beginning of 1985 to enroll Medicare beneficiaries under risk contracts with the federal government.[170]

V. CONCLUSION

The greatest significance of the various proposals for containing physician payments lies not in the specifics of the alternatives but in certain factors that are common to them all. First, the plans recognize that medical expenditures must be contained, even at the cost of forgoing some beneficial care. If the choices made in implementing these changes are going to be broadly accepted, they must be based on a legitimate process that utilizes recognized ethical standards.

Second, to the extent that the plans all rely on economically driven behaviors, they reinforce a general trend away from viewing medicine as a special calling to viewing it as part of the marketplace itself. Again, this fact serves to underscore the continuing impor-

167. Wennberg, *supra* note 164, at 311.

168. *See* K. LOHR, R. BROOK, G. GOLDBERG, M. CHASSIN & T. GLENNAN, IMPACT OF MEDICARE PROSPECTIVE PAYMENT ON THE QUALITY OF MEDICAL CARE: A RESEARCH AGENDA (1985).

169. 48 Fed. Reg. 39,160 (1983).

170. Wallace, *June 28 Set as Deadline for Submitting Criteria for Peer Review of HMO Quality*, 15 MOD. HEALTH CARE, June 21, 1985, at 68.

tance of ethical precepts in protecting as much of the old norms of medicine as possible. Finally, the objectives of cost-containment programs must themselves be evaluated from an ethical perspective. If such efforts rest on an intention to reduce waste so that precious resources can be made available to persons who now lack adequate care, then the efforts themselves have ethical justification. If they rest on the decision to exclude certain groups from the access to an adequate level of care, provided by physicians and other professionals who maintain fidelity to the patients' interests, then the efforts themselves are ethically unacceptable regardless of the mechanisms instituted to oversee their operation.