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PSRO program fares well under administration's 1977 'no-frills' health budget

WASHINGTON, D.C.--PSROs fared quite well under President Ford's no-frills budget for health in fiscal 1977. "Quite well" means that they not only won't lose money, but they will also have an increase. Many federally funded health programs can't make that claim.

The Administration has asked for $62 million for next fiscal year, a jump of $25 million from the current level of funding for PSRO. The current level, however, will soon rise to the $47.5 million allotted for the current fiscal year because of last month's congressional override of Ford's veto of the DHEW and Department of Labor budgets (see separate story).

Because of the new Medicare amendment allowing hospital review costs to be paid through the Medicare trust fund, the PSRO program next fiscal year (beginning Oct. 1) can expect up to $27 million through this funding route.

So, what will the proposed budget buy? DHEW Sec. F. David Mathews said the increase would:

--provide in 1977 for the development of PSROs in all of the 203 PSRO areas nationwide. Of these areas, approximately 120 will actually be performing review of hospital admissions in fiscal 1977.

--provide for review by PSROs during

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Texas medical organizations win case; designation of PSRO areas ruled unlawful

The designated PSRO areas in Texas have been ruled unlawful and invalid by U.S. District Court Judge Jack Roberts. The decision on Jan. 9 brought to a close a long-standing suit by the Texas Medical Association and the Texas Institute for Medical Assessment, which had charged DHEW with promulgating PSRO regulations that are "arbitrary, capricious, (or) an abuse of discretion" in not allowing single-state PSRO area designation for Texas.

'PRESSURES' ON OPSR CITED

Judge Roberts' ruling is based on evidence that "pressures emanating from congressional sources," namely, former Sen. Wallace Bennett and Senate Finance Committee Health Adviser Jay Constantine, were brought to bear on the Office of Professional Standards Review, forcing the director to reverse previously agreed-upon tentative guidelines for PSRO area designation, which would have allowed Texas to have its own single-state PSRO.

The court came down heavily on Bennett and Constantine for having "gotten involved in an unprecedented way in HEW' administration of PSRO and HEW's interpretation of 'legislative intent' regarding PSRO."

An important part of the court's ruling refers to a meeting between the OPSR director and Bennett and Constantine "lasting into the early morning hours...wherein the PSRO area designation matter was thrashed out."

'NO SUCH MEETING'

Constantine, in rebutting the court's findings, told PSRO Update "there was no

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PSRO program fares well under administration's 1977 'no-frills' health budget

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fiscal 1977 of an estimated three million admissions of Medicare and Medicaid patients, or 27 percent of total admissions.

--save an estimated $150 million through reductions in unnecessary hospital utilization as a result of these PSRO reviews.

'CONFIDENCE' CITED

Mathews, in several forums, singled out the PSRO effort for special attention, telling reporters at a budget briefing that PSRO is an example of the continued commitment of the administration to improve national health care.

"We are also expanding Professional Standards Review Organizations to help physicians ensure appropriate, but not excessive, care," he said. "This is still a program in which we have a great deal of confidence."

He described PSROs as "a device for the scrutiny of health care" and said the administration "looks forward to fill implementation" of the effort.

The budget documents themselves pledge "a high priority---to evaluation of PSROs so that the further development of the PSRO system can be guided by experience." ■

Congressional vote gives PSRO Program second 'gift' of money in two months

In overturning the presidential veto of the 1976 health budget (among others), Congress last month gave the PSRO program its second gift of money in as many months: budget authority of $47.5 million. The first was an amendment to the Social Security law, allowing hospital review costs to be borne by the Medicare trust fund.

On Tuesday, Jan. 27, the House voted 310 to 113, and the next day, the Senate followed with a vote of 70 to 24 to override President Ford's veto of the 1976 budgets of DHEW and the Department of Labor.

The unexpected override was attributed to the election looming for many members of Congress this year and the pressure of lobbyists who had time during the Christmas break to argue for the many community social programs that can be funded in this budget. Ford has contended that the $45 billion now approved would add a nearly $1-billion deficit to the budget this fiscal year.

The PSRO program will now be able to move to the 1976 budget of $47.5 million, a rise from the previous year's $37 million. Since the budget for the current year (FY 1976) had not been approved until this veto override, DHEW programs had been supported under continuing resolutions -- short-term extensions of the previous year's budget.

The 1976 budget extends, in effect, the fiscal "year" to 15 months, ending Sept. 30 this year, to allow for the switch from a July-June fiscal year to an October-September fiscal year. The $47.5 million PSRO budget is the figure for 12 months.

While PSRO program administrators have not completed details of how the new budget will be spent, one expectation is that the "old" planning PSROs might be converted to conditionals before too much more delay; some have been ready for conditional designation for months, but the Bureau of Quality Assurance had said it couldn't commit funds for more conditionals after last July.

Other speculation centers on the idea that the prevailing "go slow" attitude on starting PSRO review may ease up, to be replaced by encouragement of more hospitals to get into the full review of Title 18 and 19 patients sooner than planned. Within a couple of weeks, the priorities on funding should be announced by BQA.

The earlier financial boost from Congress to the PSRO program was the passage of Medicare amendments Dec. 19, signed into law Jan. 2, which will allow payment of hospital review costs from the Medicare trust fund (PSRO Update, Jan. 1976). That means that, starting with FY 77 (Oct. 1976), an additional $27 million can be obligated from the Medicare trust fund and from Medicaid to pay for the actual costs of review under the PSRO program. ■

Texas medical organizations win case; designation of PSRO areas ruled unlawful

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such meeting." Furthermore, he said, discussions that took place between himself, Bennett and OPSR covered a broad range of issues, in which "our stress was on legislative intent as(was) expressed by Sen. Bennett, who introduced the PSRO bill, the committee report on the bill, the manager of the bill and the conference report." He said the court seemed to ignore clear legis-

lative intent, which was to have multiple PSRO areas except in small and sparsely settled states.

In addition, Constantine said, "It was not a question of designating an organization (the Texas Institute for Medical Assessment, a creation of the Texas Medical Association), but of designation of areas."

Judge Roberts also pointed out that even "when the post-enactment views of Sen. Bennett and Mr. Constantine are excised from HEW consideration, as they must be, neither the PSRO statute itself nor its legitimate legislative history can be soundly said to mandate division of Texas into multiple PSROs" and that "what remains does not reflect a legislative intent either for or against setting any maximum number of doctors for a PSRO area."

The court action enjoins the Secretary of DHEW "from proceeding in any manner or to any extent with implementation of PSRO-area designation in the State of Texas," and it calls on the Secretary to "perform anew his statutory functions of appropriate PSRO-area designations for the state."

NEW LAW COMES INTO PLAY

Whatever action DHEW will now take may be tempered by the recently enacted Medicare amendments signed into law (P.L. 94-182) on Dec. 31, 1975. Section 105 allows physicians in states with two or more PSRO areas where no conditional PSRO has been designated to decide whether they want a local or a statewide PSRO. Under the law, the Secretary of DHEW must undertake a confidential poll of physicians to determine their preference.

The polling is to be done area-by-area, and any one of the areas has the power to reject the single, statewide PSRO.

According to Daniel Nickelson, deputy director, division of program operations, Bureau of Quality Assurance, six states are to be polled -- Texas, Louisiana, Arizona, Indiana, Virginia and North Carolina -- one at a time, starting with those states that have planning PSROs nearest to being converted to conditional status. Thus, he said, the first two are Virginia and Indiana.

MAY BE LAST POLLED

Under this schedule for polling, Texas may be the last state to be polled, since it does not have any PSRO plans under way. The size of Texas also precludes an early polling, since it will take longer to prepare a roster of physicians for the state.

Nickelson pointed out that the Texas court decision doesn't say that the state should go statewide. Conceivably, a pocket of physicians could vote against a statewide arrangement, throwing the whole matter back to DHEW, which could redesignate the same nine areas now in dispute. ■

Mental-health, alcoholism, drug-abuse organizations learn how PSRO affects them

While PSRO and utilization-review programs currently involve primarily short-stay general-hospital care, consumers and providers of mental-health services are gearing up to take an active role in a system that will eventually involve them as well.

The National Association of State Mental Health Program Directors (NASMHPD) is conducting a series of five regional workshops for representatives of more than 20 organizations concerned with mental-health, alcoholism and drug-abuse services.

The workshops are designed to teach how a PSRO works; how to evaluate methods for participation in PSROs by physicians and nonphysicians treating mental illness, alcoholism and drug abuse; how PSRO programs will affect the care given and how mental-health providers and consumers can make PSROs sensitive to their special needs.

CONCERN CONVEYED

Anne Drissel-Duncan, project director for the NASMHPD workshops, said the idea orginated a year ago when officials of DHEW involved in the quality-assurance program met with a liaison group of mental-health officials and found many of them "deeply concerned that DHEW was not fully aware of the unique problems of evaluating the delivery of mental-health services.

"PSRO is structured on the physical-medicine model and is oriented to the physicians as the primary providers of health care. But in the areas we represent, physicians do not dominate care. Lay people are involved as well."

Feelers put out by NASMHPD showed there was also "extensive misinformation" among mental-health, alcoholism and drug-abuse workers about PSROs, along with a desire to have "some say about our destiny."

The workshops, with 30 percent of the estimated $250,000 price tag borne by DHEW, the National Institute of Alcohol and Alcoholism, the National Institute for Drug Abuse and the National Institute of Mental Health, began this fall in Chicago (Oct. 28-29) and Denver (Dec. 8-9). Others were held in Atlanta (Jan. 13-14), San Francisco (Feb. 3-4). The final workshop will be in Boston, March 2-3.

Cosponsoring organizations with the

NASMHPD are the Council of State and Territorial Alcoholism Authorities and the National Association of State Drug Abuse Coordinators, along with 21 other national groups involved in mental-health and drug programs.

NASMHPD is providing staff, facilities and administrative support services to conduct the seminars and bring in expert consultants to develop the agenda and conduct the actual programs.

Seventy percent of the costs of the project, including travel and subsistence for the seminar participants, are borne by the participants or their employers.

While NASMHPD has primary responsibility for the workshops, the staff is in constant consultation with the other sponsoring groups, according to Drissel-Duncan.

$1 BILLION SPENT

The Washington-based organization estimates that the federal government pays more than $1 billion a year for the care of mentally ill, alcoholic and drug-dependent persons, with a sizable chunk of this money spent by Medicare, Medicaid and Maternal and Child Health programs.

Despite this huge outlay, however, very few efforts have been focused on the systems used to deliver care to emotionally disturbed people, NASMHPD believes.

"If the federal government truly seeks to assure that health care paid for (by government dollars) is medically necessary and consistent with professionally recognized standards of care, then the health care of alcoholics, drug abusers and the mentally ill cannot be ignored," according to the NASMHPD workshop proposal.

The goals of the workshops, Drissel-Duncan said, is to examine both positive and negative aspects of eventual PSRO involvement. Participation can mean improved care. It can also mean, she said, application of inappropriate criteria for evaluation. And federal agencies responsible for PSRO management must be aware of the mental-health community's problems, she explained.

At the conclusion of the five workshops, NASMHPD plans to issue a report outlining results of the dialogue and problems that need further work.

Information about PSRO, and technical assistance for other PSRO-program projects, is available to the public through the group's headquarters at 1001 Third St. S.W., Suite 114, Washington, D.C. 20024. Letters should be addressed to Ms. Drissel-Duncan, PSRO workshop director. Or, call 202-638-4141 or 2383. ■

Northeast conference examines cost control vs. quality issue, federal flexibility on PSRO's

Should PSROs focus on cost control, quality assurance, or both? Can the federal government be more flexible in its dealings with PSRO physicians and staff?

These questions, which often generate endless discussion but little consensus, held center stage at the Northeast Conference of PSROs in Boston Jan. 14. The conference provided another forum for about a dozen experts, but produced no consensus during its daylong symposium entitled, "Pluralism: Medicine and Government."

COST OR QUALITY?

Paul J. Sanazaro, M.D. of San Francisco, director of the Private Initiative in PSRO project, warned that no one is going to control medical costs. PSROs, he said, should stay away from cost control and utilization control, and focus on quality assurance by decreasing hospital stays and improving patient care and recovery.

If PSROs don't get away from the notion that they can control costs and utilization, he argued, they'll be saddled with the responsibility for failure when Congress comes to look at the program and to demand an accounting.

Sanazaro said also that hospital review ought to include nonfederal patients, or the PSRO might become too much a part of the federal regulatory-fiscal intermediary system.

Another speaker who stressed quality control was former Sen. Wallace F. Bennett of Utah, (the "father" of the PSRO law), who noted that quality and cost are interdependent. "Quality control and cost control can not only survive together, but they also supplement each other; but quality control is more important," he told the group in his luncheon address.

"...While quality control may be the more important of the two, runaway costs are the most obvious," Bennett said, "and it was these that triggered the search for what became PSRO in 1972."

The president of the Commonwealth Institute of Medicine (Massachusetts), H. Thomas Ballantine, Jr., M.D., said the focus should be on cost effectiveness, not cost control. PSROs can prevent government regulation of medical practice by increasing the effectiveness of the present system through cutting back excessive stays and unnecessary hospitalizations and

by peer review, he said.

Harry C. Kuykendall, M.D., president of the Northeastern Virginia Foundation for Medical Care, saw PSROs as the vehicle to get physicians back in control of hospitals and medical practice. Congress, he said, wanted to control cost by controlling practices. Doctors must resist that control by insisting on the freedom to be their "own determiners," he said.

Physicians will have the final say about delivering care, asserted Robert B. Hunter, M.D., of Washington state, a member of the National PSR Council.

IMPLEMENTING THE PROGRAM

As to the implementation of the PSRO program, Dr. Sanazaro offered two comments as an oral postscript to his article in the New England Journal of Medicine (Nov. 13, 1975), in which he criticizes the government's handling of the program. "Your troubles," he told the PSRO staff and doctors, "are not to be blamed on any one person in a government agency." But, he noted, "Much of what's been happening on the government's side of the fence is directly related to the vacuum on your side of the fence."

He suggested that the current problems with launching the PSRO program may be protracted birth pains, but that nonetheless, this "backing and filling" is a waste of time and effort that may have, as its most serious consequence, the placing of PSROs into a dependency role. "You are put into a position where you have to respond rather than create," he said. He said he believes that "the key to PSRO success is local vitality," and hence, the dependency role may be draining PSROs of their vigor.

He suggested that privately supported PSROs might be the "salvation" of the PSRO concept, and that the federal government could probably accept such a development, provided that: one, the private PSRO get thoroughly into review, and two, that the staff carefully avoid any conflict of interest.

He predicted that the current system of using physician advisers and review coordinators will become outmoded. "There is evidence that you can get the same results with less overhead, expense, time and effort," he said. He didn't elaborate on the evidence, but explained that the indications for admission will become so routine as to be easily monitored by less expensive personnel than physician advisers and review coordinators.

The only representative of the Bureau of Quality Assurance at the symposium was Daniel Nickelson, acting deputy director, division of program operations. He agreed with some of the criticisms of the program, but said the government is trying to be as flexible as it can, given its responsibility to be accountable for the public's money.

Referring to some of the early problems in the PSRO program, Bennett said, "There was some uncertainty at the outset as to whether the Social Security Administration or the health arm of the DHEW should administer the program. Unfortunately, this struggle within the Department adversely affected the program, because it slowed implementation greatly and, at its worst, has resulted in mixed signals being transmitted to physicians and others working in developing PSROs. At this point, he said, "for better or worse, the struggle seems settled. The health side of the Department has taken the lead in implementing the program and Social Security is supporting them in this effort."

On another note, PSRO members were urged to become active in the new health-service agencies being set up under the National Health Planning and Resource Development Act (P.L. 93-641). These HSAs, said Raymond J. Saloom, D.O., of Pennsylvania, a member of the National PSR Council, should depend on PSROs to do quality reviews and to develop quality-of-care guidelines. ■

Liability insurance extending $1-million coverage to be available to all conditionals

PSRO liability insurance for aggregate coverage up to $1 million has been obtained by the American Association of PSROs, with a certificate of coverage from the Lexington Insurance Co. of Boston, starting Jan. 1.

Steven Epstein, counsel for the AAPSRO, said he hoped that by mid-February, the policy would be completed to give coverage up to $1 million for each conditional PSRO that chooses to take the policy. Very few PSROs individually have been able to get liability insurance.

For each PSRO the policy will have a deductible of $2,500. The annual premium will be $1,500.

Public announcement of the successful search for an insurance carrier was made at the Jan. 12-13 meeting of the National PSR Council.

Epstein said he would still welcome legislation extending legal protection to PSROs and individuals carrying out their work beyond the "due care" protection written into the law. ■

Threatened July cutoff spurs support centers' search for wide backing

Bolstered somewhat by the prospects of more federal budget money for PSROs, the 13 state support centers, which are due to lose their federal funding in July, are taking their case to every quarter that might have clout with Administration program planners, most notably the American Medical Association and the American Association of PSROs.

APPEAL TO COUNCIL

The most direct appeal, however, went to the National PSR Council in a letter and supporting material from Joseph W. Marin, director of the Connecticut support center, who acted as spokesman for the group. At the January meeting of the Council, the issue was mentioned by Michael J. Goran, M.D., director of the Bureau of Quality Assurance, who said, "We're examining the impact of our current policy and will report to the next meeting (in March)."

Most support centers were created by state medical societies, which set up foundations or separate corporate institutes to assist new PSROs in multiple-PSRO states.

Marin, in his letter to the chairman of the National PSR Council said, "The policy of discontinuation came as no surprise to the support centers. It has been evident from the beginning that they had been seen by BQA as a concession to organized medicine--to be tolerated but certainly not encouraged. Further, the two most natural evolutionary paths a support center could take in development of the PSRO program have been or will be blocked. These two paths are to act as the nucleus of a statewide data system and to be vigorous in developing and coordinating the statewide PSR Councils."

The position of BQA has been that the support centers, in most cases, have provided a useful service in helping launch PSROs, but that now that the program has developed this far, the support centers ought to depend for their continued existence on subcontracts from the conditional PSROs.■

Candidates being sought for membership on National PSR Council

Suggestions are being sought from national medical and health groups for appointees to the 11-member National PSR Council for three-year terms beginning July 1.

Since members' terms are not staggered, continuity from the present Council is not assured unless some current members are reappointed. William Coughlin, staff assistant to the Council, said that it has not been decided how many members will be reappointed.

Appointment authority is held by the Secretary of DHEW, F. David Mathews, who may either delegate his authority or retain it. In the most recent PSRO example of his interest in appointments, he has chosen to retain his power of appointment to the statewide PSR councils rather than have Assistant Secretary for Health Theodore Cooper, M.D., or the regional health administrators do the choosing.

REVIEW EXPERIENCE NEEDED

The law specifically excludes people who are not M.D.s or D.O.s from being members of the National Council. Coughlin said that one of the prime criteria is for the members to be experienced in the appraisal and review of medical practice. He expected to have a list of possible appointees for Cooper to forward to Mathews by the end of February.

The Council is generally thought to command more respect in Washington than some other advisory committees, largely because of the professional caliber of its members. "There's a lot more desire within this program to use the Council as an asset," Coughlin said.

He credited the Council with providing valuable direction for the program. Pointing out that most Council members are practitioners and have a wide variety of backgrounds, Coughlin said, they have "a dimension of practical experience out there that really doesn't exist in bureaucracies."

FEEDBACK HELPS

Because of this "real-life feedback" provided by Council members, Coughlin said, much of PSRO policy is more realistic than it would otherwise be, and better received in the field.

Under the law, the National PSR Council is charged, among other duties, with reviewing the operations of statewide PSR Councils and PSROs with a view to determining their effectiveness and comparative performance, and conducting studies and investigations for use in developing ways to improve the program and recommending these to the Secretary and to Congress.

Current Council members are: Clement

R. Brown, M.D.; Ruth M. Covell, M.D.; Merlin K. Duval, M.D.; Robert J. Haggerty, M.D.; Donald C. Harrington, M.D.; Cornelius L. Hopper, M.D.; Alan R. Nelson, M.D.; Raymond J. Saloom, D.O.; Ernest W. Saward, M.D. (chairman); and Willard C. Scrivner, M.D. ■

Dentists push amendment to be included in PSROs; prospect for change is dim

If dentists have their way, they'll get an amendment to the PSRO law to put members of their profession into PSROs at all levels--local PSRO organizations, statewide councils and the National PSR Council. However, sources in Washington indicate that prospects for such a change in the law are poor.

LEGISLATION FILED

Dentists, according to American Dental Association spokesman Leonard Wheat, hope to see some action in the next few months on an amendment to include dentists in PSRO. One such proposal has been introduced by Sen. Clifford P. Hansen (R-Wyo.).

"Many people had felt that an amendment would be part of national health insurance," Wheat said; however, "now that national health insurance has been put on the back burner," it's time for an amendment to be seriously considered, he said. The quasi-moratorium on PSRO amendments has guided Congress and the Administration from the beginning, Wheat indicated.

Originally, Sen. Wallace Bennett had wanted to avoid diluting the impact of the bill; it was felt that that might have happened if the legislation had been opened up to amendments. Since the passage of the law, the Congress and DHEW have been reluctant to amend the law to allow more participants, fearing that the program would not have a chance to get thoroughly under way.

As it stands, said Jay Constantine, chief of the health staff of the Senate Finance Committee, "The law is clear in regard to dentists: PSROs are to arrange for review of dental care by dentists. Beyond that," he said, "dental care is nominal in Medicare and of varying amounts in Medicaid. M.D.s and D.O.s handle the overwhelming bulk of hospital care under Medicare and Medicaid," he said.

ADMISSIONS CITED

The ADA insists, however, that with more than one million hospital admissions a year for dental care, and many more than that for dental-related problems, dentists ought to be formally brought into PSROs. Although by law, PSRO review does not have to include nonfederal-paid patients, the trend is toward review of all hospital admissions.

"The best hope," said ADA's Wheat, is to testify before Sen. Herman E. Talmadge's health subcommittee of the Finance Committee at hearings on a bill the senator expects to have in the hopper by mid-month. However, that bill, Constantine said, will not contain amendments to enlarge the coverage of PSROs. "It's an administration- and reimbursement-reform proposal" that will call for a major reorganization in the administration of health-care financing.

CRITERIA STUDIES

Dentists also want to be involved in developing criteria and standards for dental care, said Wheat. To some extent this involvement is already happening, for the American Society of Oral Surgeons has a subcontract from the American Medical Association to develop screening criteria for dental-related diagnoses.

Out of about 100,000 practicing dentists, approximately 3,000 are oral surgeons, and some 85 to 90 percent of that group have hospital-admitting privileges, according to George Moore, assistant director of the Society of Oral Surgeons. It is in this area of dentistry that PSRO review touches most closely, for 4.8 percent of the hospital admissions in a Professional Activity Study survey were for oral surgery, according to Moore. Often oral surgeons serve on hospital review committees. ■

New federal strategy needed to give PSRO program necessary thrust

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ous other factors. Despite the strength of such opposition, however, it may soon be overruled by another perspective that is rapidly gaining momentum: the realization that a much more serious attempt must be made to allocate our limited resources more rationally. Acceptance of this fact is the key to developing more effective mechanisms for containing costs and maintaining quality in our health-delivery system. ■

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OPINION

New federal strategy needed to give PSRO program necessary thrust

In the following article, the author, Cynthia H. Taft, has extracted one of the major points from a paper she prepared with Sol Levine, professor of sociology, Boston University, for a conference on quality assurance in hospitals held last November at Boston University.

The PSRO program offers a good illustration of two problems that seem to underlie almost every federal attempt to intervene in the health-care system. First, the government's basic strategy in PSRO has been to state the overall goals for the program and then to delegate to physicians the job of fulfilling those goals. The problem with this approach is that its effectiveness depends on a consensus about goals, and that consensus simply doesn't exist. Although the program was clearly designed on Capitol Hill as a way of ensuring more effective cost controls in federally financed health programs, "quality assurance" has been the key phrase the government has relied on to rally physician support and get the program moving. Very little attempt has been made to clarify how the cost goals and quality goals are to be reconciled in carrying out the mandated review activities.

Lack of understanding and agreement on the overall goals causes the second weakness in federal strategy: the lack of a specific, operational plan for achieving the program's objectives. Because policymakers believe that sufficient consensus prevails among the major sectors of the system to ensure compliance with stated health goals, they tend to avoid the difficult task of devising operational steps for the program. Instead, they rely on that consensus to promote the, public "good," when in fact this is only one of many goals that may be pursued by individuals and institutions in the health system. Career advancement and institutional survival are also key operative goals, and in some cases conflict with the larger needs of the system.

NO EVALUATION INCENTIVE

Physicians probably will not be responsive to the fundamental policy objective of cost-containment, for many of them see containment as interfering with their freedom to do for their patients whatever they think is needed. This perception makes it very likely that the criteria they use for reviewing services will be based on what is "usual and customary practice." There are simply no incentives in the current law that stimulate the kind of critical evaluation of existing practices that might lead to cost-containment.

What is needed in the PSRO program and in federal health policies generally, is a new model for policymaking. Instead of relying on consensus to fulfill program goals, governmental policies should be directed at the operational goals of each unit in the system. The present PSRO program does not provide sufficient inducement for physicians to spend the time necessary for serious cost and quality assessment, particularly since it is time away from more remunerative activities.

The strength of these material motives must be acknowledged by building into federal policies the kind of financial incentives that will ensure the needed critical evaluation of medical practice.

THE FIXED-BUDGET APPROACH

One way these incentives can be built into policies is through the fixed-budget approach. Instead of merely requesting that providers review services under the PSRO program, the government could establish reimbursement ceilings for Medicare and Medicaid services in each area, to hold federal spending to the total amount spent in that area the previous year for physician and hospital services. In this way, both physicians and hospital administrators would have a strong incentive to devise ways of providing services as efficiently as possible. The quality bias inherent in physician-directed peer review would serve as a check on possible underservicing or other abuses that financial incentives might produce.

ACCEPTANCE THE KEY

There are obviously many complex and difficult arrangements that would have to be worked out in order to implement this strategy. And until now every proposal made for building financial incentives into federal health policies has been successfully blocked by this complexity and numer-

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