

COPING WITH QUALITY/COST TRADE-OFFS IN MEDICAL CARE: THE ROLE OF PSROs†

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INTRODUCTION

The health policy debate suffers from the reluctance of the debaters to face up to one central reality—namely, that high-quality medical care, which all endorse in general terms, can cost a great deal more than we ought to pay.¹ For example, those advocates who emphasize that “health

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1. This statement is meant to alert the reader, at the outset, to the danger of simplistically accepting “quality” as the overriding goal in health care when its achievement requires either more services or higher unit costs per service. See text accompanying notes 46 and 47 *infra*. The possibility that certain expenditures on improved health care may not be justified poses not only the general theoretical problem of allocative efficiency (how much is enough?) but also intimates the potential practical difficulty of appropriately limiting such expenditures through available rationing mechanisms.

We have made a conscious decision to be somewhat hard-boiled about quality/cost trade-offs in this article precisely because their existence is so often ignored or left hopelessly implicit. For more palatable presentations of the hard economic fact of scarcity as it bears on health services, see R. ANDREANO & B. WEISBROD, *AMERICAN HEALTH POLICY—PERSPECTIVES AND CHOICES* (1974) [hereinafter cited as ANDREANO & WEISBROD]; Fuchs, *The Contribution of Health Services to the American Economy*, in *ECONOMIC ASPECTS OF HEALTH CARE* 57 (J. McKinlay ed. 1973); Fuchs, *Health Care and The United States Economic System—An Essay in Abnormal Physiology*, in *ECONOMIC ASPECTS OF HEALTH CARE* 95 (J. McKinlay ed. 1973) [hereinafter cited as Fuchs, *Abnormal Physiology*]; V. FUCHS, *WHO SHALL LIVE? HEALTH, ECONOMICS AND SOCIAL CHOICE* (1974) [hereinafter cited as FUCHS, *WHO SHALL LIVE?*]; Levitt, *Problems of Efficiency*, in *THE ECONOMICS OF MEDICAL CARE* 33 (M. Hauser ed. 1972); Williams, *Foreword*, to *THE ECONOMICS OF MEDICAL CARE* 9 (M. Hauser ed. 1972); Lave & Lave, *Medical Care and Its Delivery: An Economic Appraisal*, 35 *LAW & CONTEMP. PROB.* 252 (1970) [hereinafter cited as Lave & Lave]. The only difficulty with these expositions is that it is possible to agree with each point made without fully comprehending the enormity of the practical problem presented or the social and political dynamics of addressing it through nonmarket mechanisms. In this article

care is a right" are slow to concede that, like other "rights," it cannot be made absolute (in the sense of meeting, at no charge, every colorable need with the finest technology and personnel) without distorting society's priorities. Others, who worry about those priorities, hesitate to contend openly that, except for some disadvantaged groups, spending in pursuit of "quality" in medical care may already be too high.² In other words, in health policy debates perhaps more than anywhere else,³ the inevitable trade-off between benefits and costs is practically unmentionable. A policy dialogue in which a taboo surrounds any concession to the reality of limited resources is bound to be rich in posturing and assertion and, more seriously, is likely to produce programs whose marginal benefits are not worth their costs.

Inhibited discussion of quality/cost issues has focused attention away from the central health policy problem—namely, how to prevent the allocation of excessive resources to health care while still (1) permitting persons to obtain protection against unpredictable medical costs and (2) meeting health needs of disadvantaged people. Weak constraints on consumption of health services, such as those which exist where payment is covered by insurance or provided by the government, can lead to misallocation of whole percentage points of GNP as the population is led to consume health services rather than other things which people could have and would in fact prefer.⁴ Such inefficiency in finding uses for our productive capacity, in effect squandering society's wealth in buying too much of a good thing, will persist until we find and adopt mechanisms which help to assure that the marginal benefit of each particular health service is at least equal, in some sense, to its cost.

This article will examine in detail the difficulties which prevent the health care system, as currently organized, from confronting quality/cost trade-offs in a socially appropriate manner. The conclusions drawn will then be employed in considering whether Professional Standards Review Organizations (PSROs), the regional "peer review" agencies now being

we accept the risk of alienating the reader through our emphasis on cost considerations, but we believe this emphasis is necessary to overcome the medical world's easy equation of quality in health care with human welfare itself. See generally Fuchs, *Abnormal Physiology*, *supra*. A recent demonstration of this bias was the Conference on Quality Assurance in Medical Care at the prestigious Institute of Medicine, National Academy of Sciences, Washington, D.C., on November 6-7, 1974. Among other signs of distorted priorities, Congressman Paul Rogers on that occasion endorsed the "highest possible" level of quality in health care for all. Even allowing for political hyperbole, that statement strikes us as irresponsible, for, though it is hard to know what level of quality we should seek, we should certainly not sacrifice all else to that goal.

2. See Hall, *Impact of Cost-Sharing on Consumer Use of Health Services*, in CONSUMER INCENTIVES FOR HEALTH CARE 333, 334-38 (S. Mushkin ed. 1974) [hereinafter cited as Hall].

3. *But cf.* Blank, *The Delaney Clause: Technical Naivete and Scientific Advocacy in the Formulation of Public Health Policies*, 62 CALIF. L. REV. 1084 (1974).

4. See note 207 and accompanying text *infra*.

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organized pursuant to provisions of the Social Security Amendments of 1972,⁵ are likely to be a mechanism useful in addressing such trade-offs.

PSROs are self-regulatory organizations of physicians which are charged with monitoring individual physicians' decisions affecting the use of health care resources under federal health programs. After a painful experience with cost escalation in these programs, Congress concluded that the control of health care costs requires that physicians, as the critical decision makers in a system where cost constraints are weak, must be governed in some effective way in their diagnostic and therapeutic choices. Apparently responding to Senator Wallace F. Bennett's argument that "actual control of medical practice [should be left] in the hands of those best-qualified—America's physicians,"⁶ Congress borrowed from the traditional model of professional peer review in designing PSROs. But, in providing a detailed statutory mandate, an elaborate administrative framework, and sanctions to back up PSROs' activities, it added mechanisms which might, by somewhat increasing accountability to the public and independence from institutions, make PSROs more effective than earlier efforts at "utilization review."⁷

When fully operational, PSROs will have exclusive authority to supervise resource utilization decisions under the Medicare,⁸ Medicaid,⁹ and maternal and child health programs,¹⁰ and they are likely to be given even broader authority if and when a scheme of national health insurance is adopted.¹¹ PSROs are thus certain to exercise a great deal of responsibility

5. Act of Oct. 30, 1972, Pub. L. No. 92-603, tit. II, § 249F(b), 86 Stat. 1429, amending 42 U.S.C. § 1320 (1971) (codified at 42 U.S.C. § 1320c (Supp. II, 1972)).

6. 118 CONG. REC. 32,478 (1972) (remarks of Senator Bennett).

7. For a description of the operation of such utilization reviews, see R. STEVENS, AMERICAN MEDICINE AND THE PUBLIC INTEREST 460-63 (1971). See also text accompanying notes 111-12 *infra*.

8. Social Security Act, tit. XVIII, 42 U.S.C. §§ 1395, *et seq.* (1971).

9. Social Security Act, tit. XIX, 42 U.S.C. §§ 1396, *et seq.* (1971).

10. Social Security Act, tit. V, 42 U.S.C. §§ 701 *et seq.* (1971).

11. The statute seems to contemplate full and exclusive review responsibility for PSROs under these programs. 42 U.S.C. § 1320c-2 (Supp. II, 1972). The P.S.R.O. PROGRAM MANUAL assigns to PSROs "full responsibility for all decisions having to do with quality, necessity and appropriateness of services" they review, while leaving to Medicare and Medicaid fiscal agents the responsibility for the "determination of eligibility, definition of coverage, and determination of the appropriateness of charges." OFFICE OF PROFESSIONAL STANDARDS REVIEW, DEP'T OF HEALTH, EDUCATION & WELFARE, P.S.R.O. PROGRAM MANUAL, § 701 (Mar. 15, 1974) [hereinafter cited as PSRO MANUAL]. Some time will elapse, however, before PSROs are fully operational since they are to be designated initially on a conditional basis. 42 U.S.C. § 1320-3(a) (Supp. II, 1972). Moreover, a PSRO is initially permitted to review only care "provided by or in institutions" until it requests and receives HEW approval to extend review functions to other health care services. 42 U.S.C. § 1320c-4(g) (Supp. II, 1972). This limitation was added by the conference committee which approved the final legislation, H.R. REP. No. 92-1605, 92d Cong., 2d Sess. 21 (1972), and is inconsistent with the provisions contemplating exclusive PSRO oversight of the quality and appropriateness of services.

for the level of the nation's investment in health services.¹² The thesis of this article is that, although originally conceived by Congress primarily as a cost-control device, physician-dominated PSROs as now structured will systematically exaggerate the value of expensive, high-quality care. As a result, they are likely to perpetuate, if not exacerbate, the allocative biases which already characterize the health care system. The article also notes some positive features of PSROs, however, and suggests some ways of strengthening their cost consciousness.

To see how and why PSROs are likely to prove an inadequate mechanism in balancing benefits and costs requires, first, some understanding of a number of factors contributing to the allocation-of-resources problem in health care.

ALLOCATING RESOURCES TO HEALTH CARE

The Allocative Problem: How Much is Enough?

There are many desirable goods and services which people do not buy simply because they prefer to spend such money as they have on things which they regard as more necessary or desirable. Societies, like individuals, must also allocate limited resources to a variety of uses. To a large extent in the United States this job is left to relatively free markets in which consumers use their dollars to "vote" for those products and services which they want provided. Over time, of course, government has undertaken to make more and more of these allocative decisions, by regulating economic behavior and compelling compliance with legislated norms, as well as by appropriating income from the private sector for public purposes, mostly such things as national defense which people want but cannot buy individually. Government has also assumed a redistributive rôle, altering the allocation of resources by taking money from some members of society and spending it for the benefit of others. Although such redistributions run in all directions, one important goal has been to furnish the poorest citizens with the basic necessities. Government's increasing involvement in the financing of health care has reflected primarily such distributive concerns.¹³

Correctly allocating society's resources is important simply because overinvestment in one activity necessarily means underinvestment in others. The loss in welfare from a misallocation is measured by the

12. See, e.g., Greenberg, *PSRO—On the Way, but to Where?* 290 *NEW ENGL. J. MED.* 1493 (1974):

[I]t is certain that the PSRO system that is currently gestating is destined to be responsible for scrutinizing not merely a slice of the nation's medical services, but virtually the whole of the \$100-billion-a-year health-care enterprise.

Id. Some PSROs will undoubtedly become involved in reviewing claims for Blue Cross and private insurers, as foundations for medical care have done. See note 106 *infra*.

13. See, e.g., Fein, *On Achieving Access and Equity in Health Care*, in *ECONOMIC ASPECTS OF HEALTH CARE* 23-37 (J. McKinlay ed. 1973) [hereinafter cited as Fein, *Access and Equity*].

shortfall from what consumer satisfactions would have been under a better (more efficient) exploitation of society's productive capacity. More narrowly, similar issues are presented by the allocation of resources among various uses within the health sector itself.¹⁴ Although the health system in the United States does not operate with a predetermined budget—as does the British National Health Service—there may nevertheless be identifiable health “opportunity costs” which add a certain poignancy to the identification of waste.¹⁵ But, for the most part, since lower outlays for health care would be reflected primarily in lower insurance premiums and avoidance of increases in payroll or other taxes, the alternative to any particular health expenditure is not a more productive health expenditure but more private spending on whatever else individuals elect to consume. Thus, the allocative problem is not one of deciding how to spend dollars that have somehow been earmarked for health-promoting purposes; nor is it a problem of spending funds already designated for government purposes, in which case one might fear that, if not spent on health care, the money might go to a less popular use, such as supporting the military establishment. Instead, it is primarily a problem of deciding between health care spending and spending on private consumption elsewhere.¹⁶

The present system's capacity for satisfactorily allocating resources to health care is very much in doubt. Even though some citizens get very little medical attention, health care currently claims 7.7 percent of GNP, an average of \$441 per year for every American.¹⁷ In 1950, when GNP (in real terms) was just 39.5 percent of what it is today, Americans spent only 4.6 percent of that much smaller pie on health care, only \$78 per capita (\$144 on a price index adjusted to 1973).¹⁸ The explanation for this

14. Cf. ANDREANO & WEISBROD, *supra* note 1, at 8: “In short, even in the health area—when life itself is sometimes at stake—we must make choices.”

15. “Opportunity costs” are alternative uses for the same resources, the neglect of which is the true measure of the cost of employing them otherwise. Thus, the case against certain kinds of health care spending can frequently be made most effectively by dwelling on particular missed opportunities for improving health in other ways. For example, to use Dr. John Knowles' (then director of Massachusetts General Hospital) illustration, greater health benefits might be gained by diverting resources from caring for a few comatose alcoholics with end-stage liver disease and massive gastro-intestinal bleeding to providing antibiotics for TB victims, immunizations, and prenatal care. Statement by Dr. John Knowles, quoted in M. CRICHTON, *FIVE PATIENTS: THE HOSPITAL EXPLAINED* 200 (1970). It is noteworthy in the present context, however, that Dr. Knowles says of the liver disease victims, “Certainly I think they should be treated . . .” *Id.* See Lave & Lave, *supra* note 1, at 265.

16. This is not to deny, however, the possible desirability of a reallocation of health dollars from low-priority uses to providing valuable care to those elements of the population who are not now receiving it. Although it is analytically correct to keep allocative and distributive issues separate, the net effect of simultaneous policy changes to address both problems would not necessarily be to decrease the total national health budget. See text accompanying notes 211-12 *infra*.

17. Cooper, Worthington, & Piro, *National Health Expenditures, 1929-73, U.S. Dep't of Health, Education, and Welfare*, 37 SOC. SEC. BULL. 3 (No. 2, Feb., 1974) [hereinafter cited as Cooper, Worthington, & Piro]. The figures are for 1973.

18. *Id.* Adjustments are by the Consumer Price Index for all goods and services.

dramatic increase in expenditures cannot be found in dramatically improved health, at least as it can be detected in such indicators as life expectancy.¹⁹ It is thus not obvious that the marginal return from the vast increment in health care expenditures since 1950 has been worth the cost.²⁰ Moreover, greater selectivity in expenditures, perhaps achieved by concentrating on such curable diseases as tuberculosis, might have produced similar benefits at a much smaller sacrifice of other things which might have been enjoyed.

If the increase in health expenditures simply reflected consumers' preferences as to how their money should be spent, we should perhaps be unconcerned. In such a case, though consumer education might seem needed to correct unrealistic expectations or misguided tastes and to help people get value for money in the medical marketplace, the allocation of resources could generally be deemed democratically validated through free consumer choice. But consumer choices in the health care sector have been "free" in the wrong sense, due to the variety of mechanisms which have developed for financing health care. More than any other factor, payment for health care by third parties—government, private health insurers, and Blue Cross and Blue Shield service plans—explains the acceleration of health care spending in this country.²¹ The impact of "third-party payment" in health care differs from that of insurance mechanisms covering other types of hazards because the events insured against—not disease itself, but the provision of particular health services—do not occur fortuitously but are to a large degree discretionary.²² It is thus the nature of medical care itself, specifically the ubiquity of difficult quality/cost issues, which creates the allocative problem.

19. Life expectancy at birth increased only from 68.2 to 71.1 years between 1950 and 1971 after increasing from 54.1 years since 1920. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 1973, at 57 (Table No. 78) (94th ed.). It is difficult to measure the effectiveness of health services, and rough indices like longevity and infant mortality are unreliable. See, e.g., INSTITUTE OF MEDICINE, ADVANCING THE QUALITY OF HEALTH CARE (Policy Statement, August, 1974) [hereinafter cited as ADVANCING THE QUALITY]. Medical care has many other benefits besides increased life span. See text accompanying notes 23-26 *infra*.

20. Of course, increased health care after 1950 may have been needed to offset environmental deterioration. However, if pollution is such a hazard, environmental cleanup would seem a better remedy than increased medical spending. Cf. Lave & Seskin, *Air Pollution and Human Health*, 169 SCIENCE 723 (1970).

21. See M. FELDSTEIN, THE RISING COST OF HOSPITAL CARE 27 (1971) [hereinafter cited as FELDSTEIN, RISING COST]. These points are elaborated in the text accompanying notes 27-40 *infra*.

22. Insurance or pooling of losses is best suited for protecting against those losses over which little control is exercised—thefts, "acts of God," etc. Insurance has costs of its own, however, including those attributable to "moral hazard" or the temptation to insureds to exploit the common fund by, say, arson, taking fewer precautions to avert or minimize the loss, or obtaining gold-plated repair work. These problems, flowing from externalization of private costs, discourage the purchase of insurance and usually induce insurer efforts to prevent or minimize losses and to police the legitimacy of claims. See note 35 *infra*.

The Trade-off Problem: The Benefits of Medical Care

It is a common mistake to think of medical care simply as the difference between life and death and therefore as a necessity which would be consumed at the same level whatever price is charged, except for the falling away of those whose demand is curtailed by impoverishment. While some medical care is clearly of this essential life-and-death character,²³ most of it is not, consisting instead of a variety of interventions of widely varying benefits to patients.²⁴ These benefits range all the way from complete restoration of health through miraculous, life-saving therapies down to simple symptomatic relief, reassurance, and supportive "hand-holding" in the management of self-correcting, chronic, or inevitably fatal conditions about which medical care can do little or nothing in a positive way.²⁵ While most care of the latter types is of undeniable value, it is not beyond price, nor is it invariable in its intensity or in its resource requirements. Because medical care offers many such minor benefits to patients along with its major benefits, medical decision making is apt to be socially inappropriate unless it in some way takes account of the limits of society's resources, at least implicitly acknowledging that improved quality of care—through incremental expenditures for additional benefits—is a relative and not an absolute goal.

Even in the diagnosis and treatment of major disease, there are many opportunities to gain minor benefits in the form of slightly increased probabilities of a favorable outcome, but the decision to incur the necessary expenditures can be made appropriately only in the light of alternative spending options. Thus, for example, a 95 percent certain diagnosis might be made 97 percent certain by additional laboratory tests or X-rays costing, say, \$200 and 99 percent certain by spending an additional \$800 on inpatient diagnostic measures. While a person of means might well tell his doctor to spend the \$1000, an uninsured person of average income and

23. For example, demand for emergency care is highly price inelastic so that an increase in price will have only a minimal impact on consumption. See R. CAMPBELL, *ECONOMICS OF HEALTH AND PUBLIC POLICY* 53-54 (1971). See generally Blumstein & Zubkoff, *Perspectives on Government Policy in the Health Sector*, 51 *MILBANK MEM. FUND Q.* 395, 421-26 (1973) [hereinafter cited as Blumstein & Zubkoff].

24. "Most people think medical care is good for you," says Dr. Lester Breslow, dean of the UCLA School of Public Health. "The fact is that some medical care is good for you, a great deal is irrelevant and, unfortunately, some of it is harmful."

Statement of Dr. Lester Breslow, in *NEWSWEEK*, Dec. 23, 1974, at 48.

25. One indication of the nature and extent of the noncurative aspects of medicine is the large expenditures made in caring for dying patients. In 1967, for example, the Medicare program paid an average of over \$1,150 per decedent, or twice the average for patients who survived. In 1967 and 1968, only 5 percent of all Medicare enrollees died, but payments on behalf of these decedents totaled 22 percent of all Medicare outlays. OFFICE OF RESEARCH & STATISTICS, SOCIAL SECURITY ADMINISTRATION, DEP'T OF HEALTH, EDUCATION, & WELFARE, *RS HEALTH INSURANCE STATISTICS* 1, 8-9 (HEW Pub. No. (SSA) 74-11702, Oct. 17, 1973). Most such care is valuable, but extraordinary life-prolonging measures have human as well as economic costs. Cf. Fox, *Ethical and Existential Developments in Contemporaneous American Medicine: Their Implications for Culture and Society*, 52 *MILBANK MEM. FUND Q.* 445 (1974) (including extensive bibliography).

adequate savings might rationally choose to forgo one or both increments of certainty, depending on the magnitude of the consequences of not knowing for sure. Similarly, the benefit/cost ratio of extra hospital days, follow-up visits to the physician, annual physical exams, preventive screening, and even some widely accepted therapies can be extremely troublesome.²⁶

The ubiquity of trade-offs between benefits and costs greatly complicates the doctor's exercise of discretion in making the decisions which the uninformed consumer-patient delegates to him. Since the costs involved are mainly dollars, and the benefits, while often probabilistic, nevertheless involve an individual's health and sometimes life itself, these trade-offs are fundamentally troubling, not only for the physician but for anyone faced with deciding what another's life, health, comfort, or psychological well-being is "worth." The implications of involving government, PSROs, or any other third party in facing trade-offs of this kind are obvious. For the moment it is only necessary to establish that the need for particular health services is frequently not an all-or-nothing proposition but is, instead, heavily dependent upon the financial resources available.

The Financing Problem: Diverging Social and Private Costs

With this understanding of the nature of medical care and the demand for it, one can better understand how the cost of care has been pushed upward by the spread of third-party payment. Ever since World War II, labor bargaining and the favorable tax treatment of group health insurance premiums²⁷ have helped to induce a steady increase in insurance coverage. While the Medicare and Medicaid programs enacted in 1965 were the most dramatic infusion of new demand and have been widely blamed for

26. Cf. Fuchs, *The Basic Forces Influencing Costs of Medical Care*, in *ESSAYS IN THE ECONOMICS OF HEALTH AND MEDICAL CARE* 41 (V. Fuchs ed. 1972):

[I]t is possible that many of the expensive procedures that are now part of "best practice" techniques are really not worth the money in the sense that their marginal contribution is small and the same amount of resources used in other ways would yield more utility to the consumer.

Id. at 47. See generally A. COCHRANE, *EFFECTIVENESS AND EFFICIENCY—RANDOM REFLECTIONS ON HEALTH SERVICES* (Nuffield Prov. Hosp. Trust, 1972) [hereinafter cited as COCHRANE].

27. Premiums paid by employers on behalf of employees are deductible by the former but not taxable to the latter, and 50 percent of health insurance premiums paid by individuals are deductible up to a maximum deduction of \$150. *Treas. Reg.* § 1.162-10 (1975); *INT. REV. CODE OF 1954* §§ 106, 213(a)(3). Health care expenses are also subsidized through the deductibility of out-of-pocket expenses exceeding 3 percent of adjusted gross income. *Id.* § 213(a)(1). See B. MITCHELL & R. VOGEL, *HEALTH AND TAXES: AN ASSESSMENT OF THE MEDICAL DEDUCTION* (Rand Corp. 1973). The important insight is that employers and employees have had a powerful incentive to buy health insurance with low deductibles ("shallow" coverage) in order that medical bills could be paid with untaxed, rather than after-tax, dollars. See note 35 *infra*. Martin Feldstein estimates that a typical wage earner could purchase nearly 50 percent more health care for the same money in this manner, suggesting why the nation may have become so heavily insured. Feldstein, *The Medical Economy*, *SCIENTIFIC AMERICAN*, Sept., 1973, at 151 [hereinafter cited as Feldstein, *The Medical Economy*].

the cost escalation, they were only part of a larger trend toward third-party payment which was also attended by a steady cost rise.²⁸ As insurance and government financing reduced or eliminated the patient's concern about the cost of care, the physician came to see himself less as a fiduciary with a responsibility for the patient's pocketbook as well as his health and more as a technician freed by insurance to pursue medical results without regard to cost.²⁹ One can understand, of course, how much harder it is to practice medicine if benefit/cost comparisons are essential at every turn, but the luxury of "spare-no-expense" medicine—as taught by American medical schools—may not be affordable if all are to enjoy it at society's expense.

Institutions, too, have come to see insurance as an invitation to improve their services without regard to cost. Because the third-party payer's deep pocket has increasingly guaranteed recoupment of the cost of new and improved services, hospitals by and large have been freed from the necessity to keep the price of care within reach of the average citizen. The consequence has been a great leap forward in the technological sophistication of medical care (as well as in wages in the hospital industry), so that not only are more services available but the cost of each unit of service has also increased.³⁰ An average day in today's hospital (costing \$101 in 1973) is not comparable in quality to an average hospital day in 1950 (costing \$16),³¹ but the improvement has not resulted solely from patient judgments that more expensive equipment and procedures are worth their cost. Instead, the quality differences mainly reflect purchasing decisions made by doctors and are increasingly subsidized through various third-party financing plans and programs.³²

As gradual growth of insurance allowed the cost of care to rise, the pressure on citizens to obtain more insurance protection against potentially catastrophic costs increased commensurately. A vicious upward spiral was thus set in motion, with cost increases stimulated by insurance stimulating more insurance, more cost increases, and so forth.³³ Predictably, this spiral eventually reached the plane of political action. Medicare and Medicaid, designed to help particularly vulnerable groups cope with higher costs, were the first response to the emerging crisis. Now, less than ten years later, still higher costs have produced pressure for a "national health insurance" program which will "solve" the cost problem for everyone. With this diagnosis of the impetus for national health insurance, it does not require much imagination to see the attendant hazard. By "externalizing"

28. See generally note 27 *supra*.

29. On nonprice competition which impels physicians not to skimp in prescribing, see note 69 and accompanying text *infra*. See also note 234 *infra*.

30. FELDSTEIN, *RISING COST*, *supra* note 21, at 6-22; Fuchs, *Abnormal Physiology*, *supra* note 1, at 116-18.

31. Feldstein, *The Medical Economy*, *supra* note 27, at 154.

32. Feldstein finds that the *net* cost of hospital care to patients has hardly changed since 1950. *Id.*

33. *Id.* at 155.

(that is, shifting to the general public) even more of the cost of care, national health insurance would reinforce once again the upward pressures on health care costs, much as Medicare and Medicaid did in the 1960s.³⁴ PSROs are likely to be one of the major mechanisms relied upon to contain this pressure.

Identifying Allocative Inefficiency

To say that third-party payment has resulted in more care being given than people would buy for themselves is not to say that a misallocation of resources has necessarily occurred. A major purpose of private health insurance is to protect against impoverishment and, by the same token, to provide the means of buying services which could not have been afforded without it; indeed, avoidance of the anguish involved in having to economize on health expenditures is an entirely rational motive for purchasing insurance. But even granting the rationality of some increased spending occasioned by third-party payment, there remains good reason to believe that the volume of health services has surpassed what provident individuals would choose to spend if they knew the value of each service and could design their own insurance coverage, carefully balancing the benefits and costs against other uses for their money.³⁵

The foregoing suggestion that an "optimal" level of health care spending can be deduced by hypothesizing what knowledgeable and prudent individuals would buy with their own money omits any concern about disparities of income and the impact of poverty on such purchasing decisions. There appears to exist, however, a substantial, if ill-defined, societal commitment not to force disadvantaged individuals to forgo needed medical care out of economic hardship, and indeed the Medicare and Medicaid programs were designed to relieve the aged and the poor of just such an economic constraint. Because any conception of allocative efficiency must incorporate society's preference for improving distributive justice in this important area, the following test might be used to evaluate the health care financing system's performance, or, for that matter, that of any public subsidy program: Does it give reasonable individuals what they want *and only what they want*, in the sense that, understanding the alternatives,

34. See generally Newhouse, Phelps, & Schwartz, *Policy Options and the Impact of National Health Insurance*, 290 N. ENGL. J. MED. 1345 (1974) [hereinafter cited as Newhouse, Phelps, & Schwartz].

35. Individuals have not had the knowledge, the opportunity, or the incentive to determine their own insurance coverage. Because it is marketed to groups under a special tax dispensation (*see note 27 supra*), health insurance has been designed largely to allow employees to use untaxed dollars to pay basic medical expenses. The tax advantage, together with the providers' interest (reflected in Blue Cross and Blue Shield policies) in assuring payment for services rendered, seems to have led to underuse of deductibles and coinsurance devices which help to curtail unnecessary services and control costs. Moreover, professional opposition has discouraged insurer efforts to supervise physician decision making with a view to cost control. Cf. *United States v. Oregon State Med. Soc'y*, 343 U.S. 326 (1952).

they would purchase it for themselves assuming their income was not below a certain level, perhaps the median in the population?³⁶ Although one cannot pretend that this conception of "optimality"—given the imponderables with which it bristles—can be readily applied in practice, it nonetheless contributes to an understanding in "macro" terms of the allocative-distributive issues with which health policy must deal.

Another way of understanding the allocative issue in health care is through the graphic conceptualization in Figure 1.³⁷ The "benefits" curve in Figure 1a illustrates heuristically a possible set of relationships between the benefits of health care and the inputs necessary to obtain them. At low input levels, the curve rises steeply, showing large returns (measured in dollars on the vertical axis) from each unit of input. The leveling off of the curve reveals that smaller and smaller health returns are obtained from further increases in inputs. The curve is completely level after point *x*, illustrating the concept of "unnecessary care"—namely, that which returns no net health benefit at all to the patient.³⁸ The curve declines after point *y*, to show that some medical care is positively harmful.

A policy maker seeking to allocate societal resources optimally must attempt to equate marginal benefits and marginal costs so that "the last dollar's worth of resources devoted to health care increase[s] human satisfaction by exactly the same amount as the same dollar's worth devoted to other goals."³⁹ In Figure 1a, a straight line portrays the dollar cost of the inputs on the horizontal axis. The *slope* (rate of increase) of this line is the

36. This conception of "shadow demand" for health care permits the policy planner to correct for distributive inequities and to make paternalistic adjustments in observed demand. Thus, if people with average income were thought to undervalue preventive care, the planner could subsidize such care to encourage its utilization. Equalization of access between average-income and low-income persons could (depending on a value judgment concerning the demands of distributive justice) be sought on the basis of either physician contacts per capita or the proportion of symptoms attended to (since low-income people are apt to have more health problems). Compare Feldstein, *The Medical Economy*, *supra* note 27, at 156, 158 (using physician visits), with McDonald et al., *Effects of Quebec Medicare on Physician Consultation for Selected Symptoms*, 291 N. ENGL. J. MED. 649 (1974). This problem of defining "equalization," whether to focus on inputs or outputs, is a major source of difficulty. While the issue has not been addressed much in the health area, it has received widespread attention in the field of educational finance. See Fein, *Access and Equity*, *supra* note 13, at 29-32. Cf. J. COONS, W. CLUNE, & S. SUGARMAN, PRIVATE WEALTH AND PUBLIC EDUCATION 2 (1970). See also Karst, *Serrano v. Priest, Inputs and Outputs*, 38 LAW & CONTEMP. PROB. 333, 340-43 (1974); McDermott & Klein, *The Cost-Quality Debate in School Finance Litigation: Do Dollars Make a Difference?* 38 LAW & CONTEMP. PROB. 415, 419-23 (1974); Michelson, *What is a "Just" System for Financing Schools? An Evaluation of Alternative Reforms*, 38 LAW & CONTEMP. PROB. 436, 436-45 (1974).

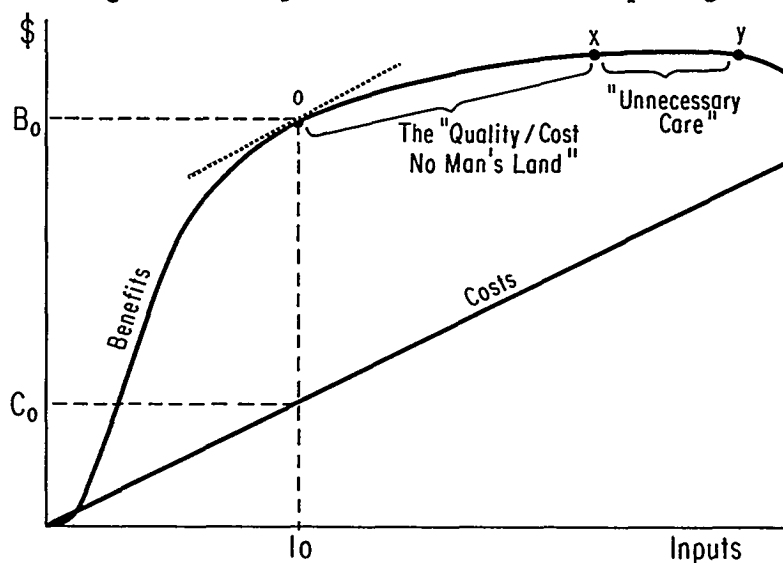
37. The diagram is adapted from Fuchs, *Abnormal Physiology*, *supra* note 1, at 98. See also Neuhauser, *The Future of Proprietaries in American Health Services*, in REGULATING HEALTH FACILITIES CONSTRUCTION 233, 233-34 (C. Havighurst ed. 1974) [hereinafter cited as Neuhauser].

38. For a discussion of how the concept of "unnecessary care" might be expanded to encompass some of the care to the left of point *x*, see text accompanying notes 83-86 *infra*.

39. Fuchs, *Abnormal Physiology*, *supra* note 1, at 97-98.

critical feature and is reflected in the dotted parallel line, which allows the decision maker to find the point of tangency (o), where the benefits curve is rising at exactly the same rate as the cost line. After this point, the increase in benefits obtainable by adding more inputs is no longer as great as the cost of those inputs, that is, marginal benefits do not at least equal marginal cost. I_0 then represents the optimal quantity of inputs and C_0 the optimal level of expenditures. Beyond these points, added inputs and expenditures, though productive of greater health, are inappropriate because greater benefits can be gained by employing resources in nonhealth uses.

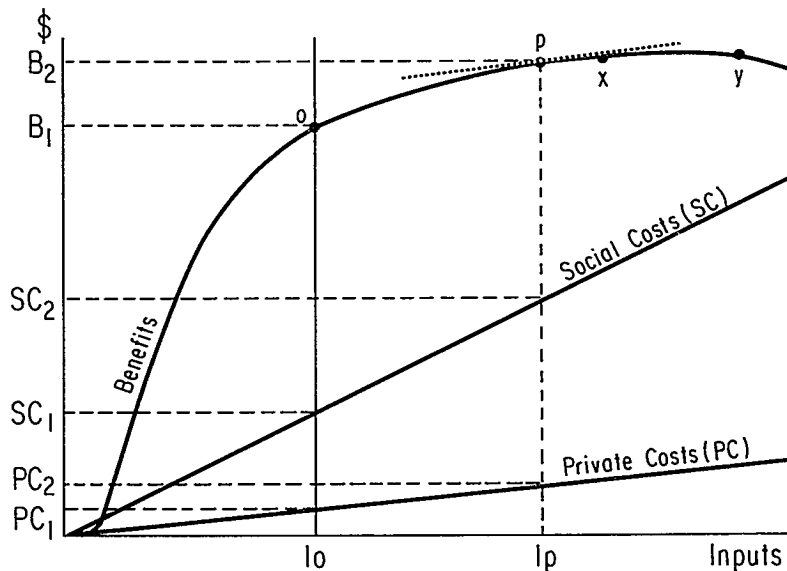
Figure 1a. The Optimal Level of Health Care Spending



The portion of the benefits curve between o and x is identified as the "quality/cost no man's land," signifying care which may seem warranted as long as the decision maker—public or private, as the case may be—does not consider the true cost of providing it. Such care, when provided, is an artifact not of benefit/cost calculations (which would contraindicate it) but of the distortions introduced by physician control of demand and the health care financing system and of the inability or unwillingness of public decision makers or providers to impose limits on the provision of care falling in this range. The curve is of course drawn in such a way as to make the "quality/cost no man's land" look very large in relative terms.

There is no way of knowing how much of the care possible above point o in Figure 1a is in fact being rendered, but Figure 1b illustrates the potential for distortion introduced by third-party payment, which causes social and private costs to diverge. The "private costs" curve portrays the costs visible to private decision makers under a 20 percent coinsurance

Figure 1b. The Distortion Introduced by the Divergence of Private and Social Costs



requirement ($SC=5 \times PC$), and the slope of this line is used to find point p , the amount of benefits sought by rational, subsidized consumers. I_0I_p indicates the additional inputs consumed as a result of the implicit subsidies, and the points on the vertical axis reveal the benefit/cost relationships: $PC_1PC_2 < B_1B_2$, showing that the additional care makes sense from the standpoint of private decision makers; $B_1B_2 < SC_1SC_2$, showing that the extra care is a poor social investment. The vertical axis also provides a striking illustration of the importance of viewing the benefits of health care in marginal rather than aggregate terms since the benefits of spending at the level SC_1 are very large (B_1), while the benefits of increasing spending to the level of SC_2 are small (B_1B_2).

A major theoretical complication presented by the benefit curve in Figure 1a is of course the valuation of health benefits in dollar terms.⁴⁰ While there is no serious theoretical problem with having individuals value their own preferences regarding life, health, and risk aversion in deciding how much to spend to satisfy them,⁴¹ explicit use of such calculations to

40. The curve's general configuration is primarily a function of the nature of medical care (see text accompanying notes 23-26 *supra*), and not of specific values, so that the diagram remains useful for present purposes even though values are debatable. To avoid objections as much as possible, one might employ as hypothetical values those implicit in the consumption decisions of reasonable individuals with median income, optimal insurance coverage, and good information and understanding of probabilities. See text accompanying note 36 *supra*.

41. See notes 65-67 and accompanying text *infra*. But cf. Calabresi, *Commentary*, in *ETHICS OF HEALTH CARE* 48, 52 (Inst. of Med., Nat'l Acad. of Sciences 1974):

I'd like to know, for instance, if any individual does value his own life in a way that can meaningfully be used in choosing between life and death risks. If each of us were

prescribe public or third-party health care spending would be bound to generate great misunderstanding. Figure 1a is therefore meant only to illustrate the problem and not to prescribe a solution, just as the earlier attempt to state the principle of optimality in terms of the preferences of "reasonable individuals" with at least median income was likewise offered only as a conceptual construct, not as a rule of decision. As will appear, circumscribing government's decision-making role is a more promising strategy for controlling costs than forcing it to engage in explicit valuations of life and health. The former strategy implies returning many of the hard decisions to the ken of private individuals who, knowing their own preferences and frequently having the benefit of professional advice, are on balance better able to face trade-offs of this very difficult kind.⁴² Fortunately, such a strategy can be carried out without sacrificing the societal commitment to improved distributive justice or other essential values; some collective valuations would be necessary, however, to assure that all care which appears to lie below point *o* in Figure 1a is in fact being rendered, even to individuals who cannot afford it. As to care above point *o*, major efforts to reintroduce resource constraints on private decision making are desirable, and subsequent discussion suggests how this can be done.

While there is probably no way of knowing whether 7.7 percent of GNP would be too much to devote to health care in an equitable system providing reasonable access to care for everyone, there are a number of reasons to believe that a great deal of health care is currently being given without significant regard to quality/cost trade-offs. The variable payoff from medical care, the absence of substantial cost constraints, the wide discretion accorded physicians, and the weakness of regulatory or privately (insurer) initiated cost-control mechanisms all suggest that point *o* in Figure 1a is not a significant restraint on the health care system's consumption of society's resources. There is for all practical purposes no one in the system of insured-fee-for-service health care who has and can consistently act on an incentive to conserve resources; neither patient, nor physician, nor institution, nor insurer, nor regulator, nor government faces in any true sense the cost of each procedure at a point where it can be effectively weighed against its benefit. On the other hand, the ability of prepaid "health maintenance organizations," working within a fixed budget, to provide good-quality care at a substantial cost saving⁴³ is confirming

paid to take a one in a million chance to lose our life, realistically, how much would we ask? How much more would we ask if the chance of death were one in one thousand? or one in two? I would suggest that the value that most of us would give to our lives would not be the same value in the three cases, after discounting by mathematical risk. In other words, the value we as individuals put on our life is not independent of the gamble we are taking. This fact makes it very, very difficult as a practical matter to define any value as the appropriate one in creating incentives for safety.

Id.

42. See notes 65-67, 218-30 and accompanying text *infra*.

43. See, e.g., M. ROEMER *et al.*, HEALTH INSURANCE EFFECTS—SERVICES, EXPENDITURES, AND ATTITUDES UNDER THREE TYPES OF PLANS 43-49 (1972); Roemer &

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evidence that much health care spending yields such limited benefits as to be dispensable. Finally, a great deal of specific scientific evidence on particular procedures and treatments also indicates the existence of important opportunities for reducing health care spending without unduly adverse health effects.⁴⁴

Thus, although a major misallocation of resources seems to have occurred, its precise extent is incalculable.⁴⁵ The challenge presented by the runaway costs of health care is therefore not to quantify the existing misallocation but to examine ways in which quality/cost trade-offs are being, or might be more effectively, faced.

THE QUALITY IMPERATIVE

The importance attached to the aggregate *quantity* of society's resources invested in health care quickly focuses attention on the *quality* of care, since quality claims provide much of the justification for more and better health services. The quantitative, or cost, issue is thus largely inseparable from the qualitative one. While it is true that outcomes of care may frequently be improved without significant added expenditures—for example, by better education of physicians, greater productive efficiency, or strategic input substitutions,⁴⁶—this aspect of quality is relatively noncontroversial, as is the elimination of those expenditures which contribute nothing to the quality of outcomes. Although a PSRO would surely be concerned with cost and quality problems of these less controversial kinds, there are many cases, of perhaps much greater allocative importance in the aggregate, in which a positive contribution to quality carries a possibly unjustified price, and it is these cases which will be exceedingly difficult for the PSRO to handle appropriately.⁴⁷

Shonick, *HMO Performance: The Recent Evidence*, 51 MILBANK MEM. FUND Q. 271, 294-95 (1973). See also note 207 and text accompanying notes 98-106 *infra*.

44. See, e.g., COCHRANE, *supra* note 26; Neuhauser, *supra* note 37, at 236-37.

45. *But cf.* notes 206-10 and accompanying text *infra*. To know the extent, if any, to which current spending is unjustified under the conception of optimality advanced earlier would require information which is not easily obtained. Even rough estimation of the misallocation is difficult since consumer ignorance and income inequalities can always be offered to dispute findings based on observed consumer behavior. Conceivably, some departure from system optimality, such as that which might accompany adoption of national health insurance, might be regarded as tolerable in view of otherwise unachievable gains in access to care or in higher-quality care for persons who would otherwise be deprived.

46. See, e.g., P. ELLWOOD, P. O'DONOGHUE, W. MCCLURE, R. HOLLEY, R. CARLSON & E. HOAGBERG, *ASSURING THE QUALITY OF HEALTH CARE* 63 (1973).

47. The following table provides a typology of changes in quality/cost relationships which should concern PSROs:

<u>Effect on Quality/Costs</u>	<u>Examples</u>	<u>Probable Initiator</u>
(1) increased/reduced	elimination of either useless x-ray with attendant irradiation or surgery with attendant risk	PSRO
(2) increased/constant	improved communication with patient, better records	PSRO

The difficulty attaching to quality/cost problems in medical care is undeniable. Quite simply, the threshold at which it becomes possible for actors in the medical care system to say "no" to increased quality on cost grounds is very high. While this is frequently true of the individual buying care for himself or members of his family, it is even more true of government, physicians and most other onlookers who might be called upon to make decisions rationing the amount of care which individuals may receive. To the extent that collective or professional decision making differs from that of knowledgeable and rational individuals constrained by no less than median income and freely purchased insurance coverage, there exists what might be called a "quality imperative," systematically biasing decisions in the direction of inappropriately high costs.

The Societal Bias Toward More and Better Care

Decisions Affecting Identifiable Individuals' Life or Health

Obviously, when human life is at stake, one hesitates to begrudge the expenditures necessary to save it. Some point probably exists, however, beyond which individuals would not impoverish themselves or their heirs for the sake of preserving life a little longer or beyond which the quality of life to be obtained would seem not to warrant large expenditures. Nevertheless, it is true and deserving of some credit that our society purports to value human life highly and, where a specific life is discovered in the balance, will not often allow it to be extinguished where lack of money is the only obstacle to saving it.

This general attitude notwithstanding, Americans tolerate death in many forms as one price of maintaining a technological society. Thus, it has been pointed out that our very large expenditures to save an identifiable life in jeopardy, such as an intercontinental balloonist or boatman lost at sea, stand in sharp contrast to our lesser regard for "statistical lives,"⁴⁸ those lives which predictably will be lost as a result of

(3) constant/reduced	elimination of useless lab test or hospitalization	PSRO
(4) reduced/reduced	shortened hospital stay, fewer tests	PSRO or provider (HMO)
(5) increased/increased	lengthened hospital stay, extra tests	PSRO or provider

The other possible combinations of impacts, *e.g.*, reduced quality/increased costs, are nonproductive or worse and for the most part irrelevant. Clearly there can be no controversy once a particular quality/cost issue is assigned to category (1), (2), or (3), though debate regarding categorization is likely to be extensive. *See* text accompanying notes 75-76 *infra*. Categories (4) and (5) alone present the problem of the trade-offs between quality and cost, requiring an explicit or implicit valuation of a particular health benefit. It is the PSRO's capacity for examining these potentially large categories, corresponding to the "quality/cost no man's land" in the diagram in Figure 1a, which is examined in this article.

48. *See generally* Fried, *The Value of Life*, 82 HARV. L. REV. 1415 (1969); Schelling, *The Life You Save May Be Your Own*, in PROBLEMS IN PUBLIC EXPENDITURE ANALYSIS 127 (S. Chase ed. 1968).

some societal undertaking such as maintenance of an automobile-based economy or the construction of a bridge or tunnel. This seeming hypocrisy simply reflects society's need periodically to reaffirm its humanitarianism by saving identifiable lives, yet at the same time to avoid the high costs of regularly saving statistical lives, an enormous number of which are routinely threatened. The latter life-saving projects would simply be too expensive in the aggregate, though cheaper on a per-life basis. Democratic government is quite uncomfortable when placed in the position of being directly responsible for a human life, and counting costs becomes exceedingly difficult when the question is presented in such explicit terms. The problem is hardly less with major afflictions not having death as a prognosis.

Increasing governmental involvement in health care, while justifiable on many grounds, carries with it a major risk that very large amounts of spending will be necessitated simply to maintain government's humanitarian image.⁴⁹ The flood of anecdotes of individual hardship collected in congressional hearings about the health care system and the natural response of the legislators⁵⁰ reflects the growing sense of governmental responsibility for the preservation and enhancement of individual lives, a trend which inexorably puts government more and more in the position of the giver of health and even of life itself.

Perhaps the clearest example of government's difficulty in grappling with these issues was the extension in 1972 of Medicare coverage to all victims of chronic renal failure.⁵¹ This measure was enacted following active lobbying by the Kidney Disease Foundation and legislative hearings in which an officer of the Foundation underwent treatment on an artificial kidney machine in the presence of the House Ways and Means Committee.⁵² The cost of the kidney disease program is expected ultimately to exceed \$1 billion per year,⁵³ and many observers have noted that this

49. See ARTIFICIAL HEART ASSESSMENT PANEL, NAT'L HEART & LUNG INST., THE TOTALLY IMPLANTABLE ARTIFICIAL HEART 9-13, 72-74, 133-41, 243-47 (HEW Pub. No. (NIH) 74-191, 1973) [hereinafter cited as ARTIFICIAL HEART PANEL]; Calabresi, *Toward a Theory of Tragic Choices*, April, 1973 (lectures delivered at the U. of Pa. Law School) [hereinafter cited as Calabresi, *Tragic Choices*]; Zeckhauser, *Coverage for Catastrophic Illness*, 21 PUB. POLICY 149 (1973) [hereinafter cited as Zeckhauser].

50. See, e.g., E. KENNEDY, in CRITICAL CONDITION: THE CRISIS IN AMERICA'S HEALTH CARE (1972).

51. 42 U.S.C. §§ 426(e)-(g) (Supp. II, 1972).

52. Statements of Shep Glazer and other witnesses representing the National Association of Patients on Hemodialysis, in *Hearings on National Health Insurance Proposals before the House Comm. on Ways and Means*, 92d Cong., 1st Sess., pt. 7 at 1524-46 (1971); N.Y. Times, Oct. 22, 1972, § 4, at 7, col. 1.

53. In the End-Stage Renal Disease Program's first year (fiscal 1974), HEW spent \$250 million to provide some 13,000 patients with regular dialysis or a kidney transplant. The number treated is expected to grow for ten years, thereafter remaining stable at 60,000 patients a year, at an estimated cost of at least \$1 billion annually. See INSTITUTE OF MEDICINE, *DISEASE BY DISEASE TOWARD NATIONAL HEALTH INSURANCE* (Panel Report, June 1973) [hereinafter cited as DISEASE BY DISEASE]; *ESRD: A Billion a Year for Dialysis and Kidney Grafts*, MED. WORLD NEWS, May 3, 1974, at 16.

legislative precedent would appear to justify similar programs for victims of other particular diseases.⁵⁴ Few commentators have been willing to argue openly that the cost to the public of this particular life-saving program is not justified, or to raise in their argument the questionable quality of life enjoyed by many victims of kidney disease "saved" by the treatments.⁵⁵ Instead, the argument is usually put on the narrower opportunity-cost ground that the same money could achieve greater health benefits if put to other particular uses.⁵⁶ Others have observed the huge potential of unlimited government financing for stimulating new and expensive technology in the areas of cancer treatments, artificial hearts, maintenance of hemophiliacs and care of defective infants.⁵⁷ It seems certain that, sooner or later, government will have to face the dilemma of how to place limits on the commitment of funds to the treatment of catastrophic disease.⁵⁸ Its unwillingness to address this dilemma in the case of renal disease seems directly traceable to the advocates' ability to frame the issue in terms of identifiable rather than statistical lives.

Although the important decisions on catastrophic illness will be made by government rather than by PSROs, such decisions will affect the climate in which PSROs will function.

Decisions Affecting "Statistical Lives" and Other Probabilities

Fortunately (given the sensitivity of explicit life-or-death questions), a great deal of money questionably spent on medical care goes not toward saving lives in specific jeopardy but toward reducing already small

54. One critic's reaction to the vote to cover treatment of end-stage renal disease under Medicare was:

If this goes into effect next year, every lobby will troop up to Congress to demand equal treatment for sufferers of cancer, leukemia, hemophilia, multiple sclerosis, and any number of other diseases.

N.Y. Times, Oct. 22, 1972, § 4, at 7, cols. 5 & 6. A HEW source called the provision the proverbial "camel's nose under the tent." *Id.* at col. 1. Congress has recognized the issue; three Senators inconclusively debated the equity and wisdom of covering some, but not all, catastrophic disease. 118 CONG. REC. 33,008 (1972) (remarks of Senators Hartke, Bennett & Long).

55. See Abram, Moore, & Westervelt, *Suicidal Behavior in Chronic Dialysis Patients*, 127 AM. J. OF PSYCHIATRY 1199 (1971); Holcomb, *Social Functioning of Artificial Kidney Patients*, 7 SOC. SCI. & MED. 109 (1973); McKegney & Lange, *The Decision to No Longer Live on Chronic Hemodialysis*, 128 AM. J. OF PSYCHIATRY 267 (1971).

56. Alternative uses which might produce greater health benefits include expenditures for environmental improvement, for health education, for research into the causes of diseases and methods of prevention or early intervention, and for restructuring the health care delivery system to improve coordination and efficiency and to increase access to care and the availability of primary care and ambulatory services. See DISEASE BY DISEASE, *supra* note 53, at 5, 7, 8; Somers, *Catastrophic Health Insurance? A Catastrophe!*, 48 MED. ECON. 213 (May 10, 1971); Zeckhauser, *supra* note 49, at 19. See also note 15 *supra*.

57. DISEASE BY DISEASE, *supra* note 53, at 5, 7-9; Somers & Somers, *Major Issues in National Health Insurance*, 50 MILBANK MEM. FUND Q. 177, 209 (1972); Altman, *Costs of Kidney Therapy: Two Fundamental Questions Raised*, N.Y. Times, Jan. 23, 1973, at 13, cols. 1, 4-6.

58. See ARTIFICIAL HEART PANEL, *supra* note 49, at 9-13.

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probabilities of adverse but not necessarily fatal consequences. Even here, however, collective decision making is likely to feature a general bias toward an excessively high level of quality and a reluctance to curb expenditures which have small but nonnegligible benefits, frequently of a probabilistic character.

Whether a particular expenditure of this kind will be made depends, essentially, on the decision maker's willingness to gamble, as well as on the availability of resources with which to avert the small but unwanted risk. While individuals can rationally elect to run a small risk to save a significant sum, democratic society finds it hard to take even appropriate gambles with the lives or health of its citizens. Indeed, such gambles are apt to be feasible only in those cases in which both the risks and the benefits are distributed generally over the population so that no one can be said a priori to gain at the expense of someone else's life or health. Thus, the automobile, though costly in terms of lives, does not greatly offend the social conscience because of the roughly equal exposure of all to the risk of death in an automobile accident, the absence of disproportionate benefits to any single group from automobile use, and the sense that individuals to a significant degree control their own exposure. But as soon as the gainers and the losers—the gamblers and the gambled-with—can be identified as distinct groups, collective decision making becomes biased in the direction of preventing losses to the seemingly disadvantaged group by imposing relatively large aggregate costs on others. In the provision of federally financed health care, the gainers and the losers from cost-control measures are rather easily identified, with the predicted result.

The difficulty of limiting the consumption of health care which is not clearly justified in benefit/cost terms lies ultimately in the special importance attached to the health care of the poor. The burden of collective decisions to accept some loss of statistical lives and health as a means of preserving resources (so that government may pursue other projects or so that taxpayers may enjoy the other good things of life) is seen as falling most heavily on persons who lack the resources to buy fuller insurance coverage or the extra margins of protection which are available to the nonpoor. Economic inequality, acceptable within limits in many areas, is for complex reasons less acceptable when improved chances of a longer life and freedom from disease appear too obviously among the privileges of wealth.

The majority's special concern over this particular form of inequality is reflected in the decision to provide the poor with health care rather than with cash benefits of equal value. This decision is particularly striking since the poor themselves would almost certainly prefer to have other things instead or, more precisely, to have somewhat poorer quality health care

and the difference in cash.⁵⁹ One explanation for the majority's attitude is simple paternalism, the view that "we" know better than "they" do what is good for them. In addition, the health care of the poor has symbolic significance as an expedient way to expiate the guilt fostered by inequality in general.⁶⁰ A cynic might go so far as to suggest that the majority is merely indulging a preference that the poor endure a less visible and less morally troubling form of hardship.

With these symbolic influences in the background, collective decisions seeking to limit the quantity of publicly provided health care will not necessarily be tailored with the objective of providing only "average" care to disadvantaged persons. Because the quality imperative dictates that no one should very obviously enjoy better health care than anyone else on the basis of income, the ideal to be striven for is likely to be higher. Roughly speaking, there will be a strong inclination to allow everyone to have care at a level of quality roughly equivalent, in appearance at least, to that enjoyed by upper-middle-class policy makers themselves.⁶¹ Any obvious concession by such policy makers to limited resources can be made to seem antihumanitarian. Especially if issues are presented one by one, as in the case of the proposal to cover renal disease under Medicare, the small societal cost of each humanitarian action can, through "the tyranny of small decisions,"⁶² add up to a large potential bill.

The Professional Bias Toward Quality

"Need" Versus "Demand"

Physicians are the leading exponents of quality in medical care. Their orientation is summed up rather well in the concept of "need," as opposed to "demand," for medical services. The concept of medical "need" is essentially noneconomic. It is embodied in a professional consensus defining those services which represent appropriate professional interven-

59. The greater political feasibility of redistributing income in this form, which in part accounts for its selection by advocates for the poor in preference to lobbying for cash payments, reflects directly the symbolic significance of health care. See Fein, *Access and Equity*, *supra* note 13, at 24-29. There is also, however, the practical problem that poor people who spent a cash payment on something other than health insurance could not be turned away when a serious health problem developed, again because of society's and providers' overriding commitment to avoiding this form of suffering. Knowing this, poor people may feel well enough protected to spend their money otherwise. Thus, publicly supported care is clearly justified, but the case for total equality in this area among income classes is not as obvious as is sometimes asserted. See Blumstein & Zubkoff, *supra* note 23, at 407-12.

60. Society may also see expenditures for health care as an investment and as providing a necessary pre-condition for equality of opportunity. The popularity of such early childhood programs as Head Start reflects a similar willingness to invest in services that remedy disabilities which come about through no fault of the victims.

61. Zeckhauser, *supra* note 49, at 160-61.

62. Policy analysts often use the term "incrementalism" to describe the process of change by many minor, seemingly inconsequential adjustments. See, e.g., Lindblom, *The Science of "Muddling Through,"* 19 PUB. AD. REV. 79 (1959). The cumulative effect may be quite substantial, however, and not necessarily the result which would have been chosen if a single decision had been compelled.

tion to deal adequately with the patient's particular medical condition.⁶³ Resource limitations which impede need fulfillment are regarded by physicians only with frustration as unjustified constraints. Because need is defined in terms of what is technically feasible, without specific regard to dollar cost, a resource-allocation problem is sharply presented.⁶⁴ In fact, need appears to be the standard by which "quality of care" is evaluated: any failure to meet professionally defined needs is ipso facto inadequate quality.

Need for health care differs from "demand" for it in two respects. First, need is solely a product of professional judgment, whereas demand is in part a function of consumer preferences.⁶⁵ It thus seems clear that, in Boulding's words, an "uneasy Aristotelian mean" must be sought between these poles so as to preserve the patient's right to control his own destiny.⁶⁶ The second difference is that demand necessarily depends in part upon the patient's ability to pay for the care, either out-of-pocket or through a third-party payer. Because of the widespread conviction that income should not visibly affect patient access to health care, shortfalls between perceived need and what is demanded are seen not as revealing patients' differing "utility functions" but as reflecting an impermissible inequality.⁶⁷ The result is a high level of societal acquiescence in the use of physicians'

63. See Boulding, *The Concept of Need for Health Services*, in *ECONOMIC ASPECTS OF HEALTH CARE 3* (J. McKinlay ed. 1973) [hereinafter cited as Boulding]; Jeffers, Bognanno & Bartlett, *On the Demand Versus Need for Medical Services and the Concept of "Shortage,"* 61 *AM. J. PUB. HEALTH* 46 (1971).

64. Victor Fuchs has noted that a physician's decisions are guided by a "'technological imperative'—namely, the desire . . . to do everything that he has been trained to do regardless of the benefit-cost ratio." FUCHS, *WHO SHALL LIVE?*, *supra* note 1, at 60. See also Cooper & Culyer, *Equality in the National Health Service: Intentions, Performance and Problems in Evaluation*, in *THE ECONOMICS OF MEDICAL CARE 47* (M. Hauser ed. 1972):

The gap between what at any moment in time is technically feasible and what, in the context of competing claims upon resources, can be delivered to the patient apparently in need, is becoming increasingly obvious.

Id. at 49.

65. People vary widely in their feelings about medical care and the strength of their desire to consume it. See, e.g., E. Koos, *Illness in Regionville*, in *THE HEALTH OF REGIONVILLE 30, 38* (1954); McKinlay & Dalton, *Social-Psychological Factors Affecting Health Services Utilization*, in *CONSUMER INCENTIVES FOR HEALTH CARE 251* (S. Mushkin ed. 1974).

66. Boulding, *supra* note 63, at 17. For a review of literature on the doctor-patient relationship stressing the physician's dominance, see Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 *YALE L.J.* 1533, 1533-55 (1970). The emerging law of informed consent reveals a concern for attaching greater importance to individual choice. See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972). See also Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 *RUTGERS L. REV.* 228 (1973). For the suggestion that "we cannot entirely cede decisions to experts" because the provision of medical care is a "social and moral activity with a technical substratum," less "like the supply of water [than like] the provision of education," see Starr, *A National Health Program: Organizing Diversity*, 5 *HASTINGS CENTER REP.* 11 (1975) [hereinafter cited as Starr].

67. This article suggests ways of satisfying distributive concerns without incurring the high costs which would come from perpetuating and exacerbating resource misallocations. The key to the problem is in distinguishing those areas where preferences are less of a factor—i.e., where demand variations are more likely to reflect differences in ability to pay than in

concepts of need to define the requisite "quality of care" or, what is very nearly the same thing, the appropriate level of spending on health care.

The Determination of Need

The medical profession's preference for defining need in its own way has an important economic dimension, since the definition tends to determine overall demand for medical services. Indeed, the frequent observation that physicians can "create their own demand" refers to the ability of physicians, the dominant decision makers in the system, to justify large expenditures on those services which they themselves render by pointing to the existence of a benefit to the patient and to a professionally developed norm which legitimizes the outlay.⁶⁸ Under these circumstances, who is to say that the benefit is not worth the cost? "Need" thus becomes a wild card giving the medical profession a powerful hand in any quality/cost dispute. The defender of efficiency in resource allocation who calls attention to costs can, once again, be denigrated as mercenary, willing to trade the life and health of others for mere dollars.

Although it is consistent with his self-interest, the individual physician's preference for high-quality care may not be attributable in any important degree to social irresponsibility or a crass desire to maintain demand for his services. Indeed, a sincere concern for his patients' welfare is probably dominant in his numerous decisions for more and better services. Cost issues, while sometimes admitted, are seen as irrelevant when life, health, and comfort and convenience—in short, the needs—of the patient are at stake. Indeed, with cost constraints lifted by the availability of third-party payment, the physician may regard it as his ethical responsibility to help the patient get all the benefits he can from the common fund.⁶⁹

willingness to pay—from those areas where qualitative differences are marginal and preferences are therefore more likely to be decisive. Market demand, reflecting the strength of individuals' preferences for various qualities of life and health, for security versus risk-taking (see note 41 and accompanying text *supra*), for hope versus fatalism, for home versus institutional environments, and for dignity versus the insults of technology, would seem to have a role in efficiently and fairly rationing health services. See note 220 *infra*. See also Arrow, *Government Decision Making and the Preciousness of Life*, in *ETHICS OF HEALTH CARE* 37-39 (Inst. of Med., Nat'l Acad. of Sciences, 1974); Boulding, *supra* note 63:

If the question is asked, how does one use a combination of the grants economy and the price structure in producing a system of medical care that compromises between needs and demands, a much richer and more satisfactory answer will likely result than if one simply asks, what is the need for medical care? Almost everyone who has raised children has heard the anguished cry, "But I need—" and soon learns to interpret this as meaning, "I want something badly but I am not prepared to pay the price for it."

Id. at 21.

68. See V. FUCHS & M. KRAMER, *DETERMINANTS OF EXPENDITURES FOR PHYSICIANS' SERVICES IN THE UNITED STATES 1948-68* (HEW Pub. No. (HSM) 73-3013, 1972) [hereinafter cited as FUCHS & KRAMER].

69. An alternative ethical hypothesis is that physicians should recognize their social responsibility by curbing their instinct to spend, perhaps asking at the "micro" level this question suggested by the "macro" proposition in the text accompanying note 36 *supra*: "Would I, in good conscience as an expert professional, advise this patient, assuming he has at least moderate income, to buy this particular service with his own money?" Whether or not

Exactly how physicians' conceptions of need are arrived at is a matter for some conjecture. A reasonable hypothesis would be that the average doctor is morally reluctant to deny his patients any services which he would willingly purchase for himself or the members of his family in similar circumstances. No one could ask for a better ethical principle, but the moral correctness of this impulse does not mitigate its distorting economic effect. Precisely because the high income of the average physician allows him to buy many things, including health care, which the society cannot afford to make available to everyone, reliance on the physician's personal "utility function" to determine the allocation of resources is bound to produce more health care and less of other things than the public in fact wants. But to the extent that the physician's impulse toward excessive spending originates in his felt obligations to his patients, most people would consider it above legitimate reproach.

The typical physician's view of the entire health policy debate is thus colored by his traditional dedication to his own patients. Indeed, his "micro" view makes it hard for him to recognize "macro" problems of limited access to care and ever-rising costs outpacing benefits, or at least to accept the proposed remedies which threaten his ability to do for his patients whatever he may think they need. Medical tradition and the values inculcated from the very beginning of medical education make the physician unreceptive to "macro" conceptions of the health care system and resistant to benefit/cost calculations.⁷⁰ The success of PSROs will turn in large measure on their willingness and ability to adopt a "macro" view in spite of their constituents' predominantly "micro" orientation.

Process Versus Outcome

Professional quality assessment has traditionally been directed to examination of the process of treatment, through such techniques as the "medical audit," to determine that no prescribed or desirable steps were omitted. It has become fashionable of late to observe that such process review is a poor substitute for outcomes assessment, which would look mainly to the results of therapy.⁷¹ For example, a recent study of how

one would be bothered by the implicit conversion of the doctor-patient relation into a tripartite affair with the physician mediating between his patient's interest and society's, the physician is in a poor position to adopt this policy because his patients would rapidly learn to prefer physicians who were less "socially responsible" and provided more care. See text accompanying note 87 *infra*.

70. The interesting exception to this generalization, which proves the force of it, is the M.D. who specializes in epidemiology and public health, the only branch of medicine which emphasizes "macro" concepts, statistical incidence of disease, and effectiveness of cures. E.g., COCHRANE, *supra* note 26. Medical students are taught principles of triage, however, and in times of emergency or war, triage officers play critical roles in allocating resources to achieve social objectives. See note 69 *supra*.

71. See, e.g., ADVANCING THE QUALITY, *supra* note 19; Statement of Dr. Patrick O'Donoghue, in *Hearings on Health Maintenance Organizations Before the Subcomm. on Public Health and Environment of the House Comm. on Interstate and Foreign Commerce*, 92d Cong., 2d Sess., 489-536 (1972); Williamson, *Outcomes of Health Care: Key to Health Improvement*, in *METHODOLOGY OF IDENTIFYING, MEASURING AND EVALUATING OUTCOMES OF HEALTH SERVICE PROGRAMS, SYSTEMS, AND SUBSYSTEMS* 75 (C. Hopkins ed. 1970).

different types of peer review varied in their assessment of the quality of care rendered in a set of selected cases found that, while 63 percent of the outcomes achieved were deemed satisfactory, less than 2 percent of the cases could be said to have been adequately handled using process norms developed in advance for the conditions treated.⁷² While not conclusive, this study suggests that traditional process norms of quality, implemented on a large scale by promulgation of therapeutic protocols or by medical audit, could increase the cost of care dramatically without producing significant improvements in patients' health.⁷³ The problem is of course that ideal professional standards, while slightly narrowing the margin for error, have very great costs as perfection is approached. PSROs will have authority to promulgate process norms and, even though charged with examining outcomes in establishing such norms, may find it easier to raise costs than to lower them. Moreover, in reviewing services on a case-by-case basis, they may fail to appreciate the importance of many structural and nontechnical facets of health care which can influence outcomes.⁷⁴

An equally troublesome source of difficulty in the prescription of quality in medical care is the absence of good evidence as to which therapeutic measures in fact lead to good outcomes. A leading publicist of this uncertainty is Dr. A. L. Cochrane, who has noted that many widely accepted therapies have never been subjected to randomized controlled clinical trials to establish their efficacy in improving patients' health.⁷⁵ Viewing the problem from the standpoint of the British National Health Service, Cochrane expresses concern for the economic waste involved in the persistent use of unproved therapies and goes so far as to embrace explicit benefit/cost analysis, involving the troublesome problem of valuing human life and relief of various types of suffering.⁷⁶ It should be noted, however, that this explicit weighing of competing needs occurs more naturally in allocating a fixed health care budget (as in the NHS) than in

72. Brook & Appel, *Quality-of-Care Assessment: Choosing a Method for Peer Review*, 288 N. ENGL. J. MED. 1323 (1973).

73. It is of course possible that 100 percent compliance with prescribed processes would have yielded good outcomes in the remaining 37 percent of cases, and that these results would have justified the additional costs involved.

74. The beneficial influence of such nontechnical factors as comprehensiveness and continuity of care, coordination of services, accessibility of care, physician-patient rapport, and patient compliance, has been widely recognized. See, e.g., LEE & JONES, *THE FUNDAMENTALS OF GOOD MEDICAL CARE* (Comm. on the Costs of Medical Care Pub. No. 22, 1933); Donabedian, *Promoting Quality Through Evaluating the Process of Patient Care*, 6 MED. CARE 181, 182, 196-98 (1968).

75. COCHRANE, *supra* note 26. Examples of widely used therapies whose superiority to cheaper alternatives is doubtful include tonsillectomies, "Pap" smears, coronary care units, and hospitalization for routine childbirths (versus home midwife care). *Id.* at ch. 6. Cochrane pleads for clinical trials of accepted therapies and greater reluctance to plunge forward with expensive new treatment modes without clear evidence of their worth.

76. Primarily addressing treatments whose added costs are incurred without any demonstrable benefit to the patient, Cochrane seldom directly acknowledges the presence of the more difficult issue which arises when *some* benefit is present but there is doubt that it justifies the cost. Nevertheless, he does recognize the trend of his own argument at one point, reluctantly endorsing the "quantification of all the various types of output." *Id.* at 77.

an open-ended health care system such as Medicare or Medicaid, where there is an ostensible commitment to meeting all health "needs." PSROs, representing a doctor constituency and functioning in a system with no explicit resource constraint, will find it extremely difficult to adopt Cochrane's view of things.

Living with the Quality Imperative

Despite the force of the quality imperative, some limits do exist to our society's willingness to buy health services whenever a colorable need exists or some small benefit can be derived. Examination of some of the mechanisms used to contain health care spending illustrates the society's occasional resourcefulness in defusing potentially explosive conflicts, such as those which are seemingly resolvable only by a choice between the two unsatisfactory extremes of very large economic outlays and an open betrayal of humanitarian ideals. The essential strategy in structuring institutions to reflect allocative concerns is to avoid direct and open confrontation with issues of this kind, giving effect to cost concerns in less obvious ways. The defenses thus established may have reduced society's financial commitment from what it would be if quality/cost issues had always to be faced explicitly with respect to identifiable lives by medical technicians or politically visible decision makers. Even so, the probability still remains that, by the standard of optimality suggested earlier, excessive health spending has been and will continue to be tolerated in many sectors.

Cost Sharing and Coverage Limits

One defense against confrontation with explicit quality/cost choices is the limitation of coverage of public financing programs. To a still unsettled degree, it is considered acceptable to use deductibles and coinsurance to encourage efficient utilization of health services.⁷⁷ A reduction of "shallow," first-dollar coverage by use of a sizable deductible would cause persons without really serious health problems to weigh benefits and costs and to insist that their physician do so as well.⁷⁸ Similarly, coinsurance gives the patient some financial stake in the decisions being made. The perception that important needs will be met prevents the cost-sharing technique from violating the quality imperative. Even so, many observers feel that payment barriers must be lowered or eliminated for the poor.⁷⁹

77. Newhouse, Phelps, & Schwartz, *supra* note 34; Davis, *National Health Insurance*, in *SETTING NATIONAL PRIORITIES: THE 1975 BUDGET* 207, 230-34 (Brookings Inst. 1974) [hereinafter cited as Davis].

78. Feldstein, *A New Approach to National Health Insurance*, *PUB. INT.*, Spring 1971, at 93. See also M. PAULY, *NATIONAL HEALTH INSURANCE: AN ANALYSIS* 33-48 (Am. Enterprise Inst. for Pub. Policy Research, 1971).

79. *E.g.*, Davis, *supra* note 77, at 230-34, 239-41. Cf. Brian & Gibbens, *California's Medi-Cal Copayment Experiment*, *MED. CARE*, Dec., 1974 (Supp.). See also Hall, *supra* note 2.

Exclusion of certain services from coverage, particularly elective procedures such as cosmetic surgery, is another way of reducing aggregate consumption. The Medicare program, for example, excludes from coverage those services which are not "reasonable or necessary," a provision which leads to retrospective inquiry as to whether a provider should be reimbursed for a service rendered to a particular patient. But because this inquiry appears to concern only a technical legal issue of coverage and the provider's right to recover money,⁸⁰ it is not so highly charged as the question whether a particular patient should or should not be given a particular service. The result is a somewhat more dispassionate inquiry than would otherwise be possible given the quality imperative, because the issue involves only future (and therefore "statistical") patients in similar circumstances. The advent of PSROs, however, will change the nature of decision making on these issues to some extent.⁸¹

Finally, a public program's potential exposure to extremely large costs for the treatment of catastrophic illness could be limited, as it usually is under private insurance, by placing a top dollar limit on coverage. Such a limitation eventually throws the individual back on his own resources or on provider-dispensed charity, but only after a very large public outlay has failed to cure him. Limiting coverage may seem more palatable as a mechanism of cost control than other, more explicit mechanisms for making what Guido Calabresi calls the "tragic choices."⁸² Whether Congress will adopt a dollar limitation on benefits if it enacts a national health insurance program depends in part on the manner in which the issue is presented and in part on Congress' assessment of the potential costs of an unlimited commitment, which is likely to call forth expensive new technology.

"Unnecessary Care" and "Overutilization"

Another defense against confrontation with the quality imperative involves a subtle incorporation of economic factors into the concept of

80. Formerly, Medicare beneficiaries whose care was not covered by Medicare could be billed by the provider. The 1972 Social Security Amendments provided that where a patient acts in good faith, he is not responsible for payment. Act of Oct. 30, 1972, Pub. L. No. 92-603, tit. II, § 213, 86 Stat. 1384, amending 42 U.S.C. § 1395 (1971) (codified at 42 U.S.C. § 1395 pp (Supp. II, 1972)). See S. REP. NO. 1230, 92d Cong., 2d Sess. 254, 294-95 (1972) [hereinafter cited as S. REP. NO. 1230]. See generally S. LAW, BLUE CROSS: WHAT WENT WRONG? 130-35 (1974) [hereinafter cited as LAW]. Providers are similarly protected, and regulations establish presumptions to aid in determining when they (and patients) had or should have had knowledge of coverage limitations. 20 C.F.R. §§ 405.195-196, 405.330-332, 40 Fed. Reg. 1022-24 (1975). This approach has been criticized for unduly restricting Congress's limitation on liability for noncovered services. *E.g.*, LAW, *supra*, at 131-32.

The PSRO statute likewise provides that a PSRO's disapproval of services as "medically unnecessary" is not to block payment for them where "the Secretary [of HEW], pursuant to regulation determines that the claimant is without fault . . ." 42 U.S.C. § 1320c-7(a) (Supp. II, 1972).

81. See text accompanying notes 199-205 *infra*.

82. Calabresi, *Tragic Choices*, *supra* note 49.

medical need by expanding the notion of "unnecessary care."⁸³ This notion has usually implied the absence of any benefit to the patient, and to buttress the argument in specific instances, particularly where unnecessary surgery is involved, concern has been expressed about the potential for affirmative harm.⁸⁴ Nevertheless, it seems likely that some of the care objected to as "unnecessary" may in fact have benefits to the patient outweighing any risk to his health. Thus, benefit/cost concerns may also be present in classifying some care as unneeded.

The concept of "unnecessary care" merges subtly with "overutilization," the term most frequently used to describe the use of an excessive amount of resources in the care of a patient. Particular emphasis is placed on the overuse of the hospital when care could be rendered effectively and appropriately in a shorter time, in a less sophisticated facility, or on an outpatient basis. Overutilization usually seems to employ the physician's conception of need as a reference point, but in practice the concept could easily incorporate a more rigorous economic dimension.

Semantically, the policing of unnecessary care and overutilization is on safe ground, but much of the care falling within these categories is probably neither wholly useless nor affirmatively harmful. Thus, these concepts can be and probably are in fact used in some utilization review programs to give effect to a degree of economic awareness.⁸⁵ Even though the quality imperative impedes explicit benefit/cost analysis, many physicians would probably tolerate some cost consciousness in utilization review out of a recognition that numerous tests, x-rays, and hospital days are of only slight value and unlikely to justify their cost. The present reluctance of physicians to give effect to such economies in their practices may reflect fears of malpractice claims based on departures from custom⁸⁶ and concern about denying patients benefits which they want and which other doctors' patients

83. See note 47 and accompanying text and text accompanying note 38 *supra*. Why doctors would prescribe and patients would accept care which was truly "unnecessary" is a matter for conjecture, but there is widespread agreement that it occurs. For example, an oversupply of surgeons is cited as the chief reason for much surgery. Bunker, *Surgical Manpower: A Comparison of Operations and Surgeons in the United States and In England and Wales*, 282 N. ENGL. J. MED. 135 (1970); Lewis, *Variations in the Incidence of Surgery*, 281 N. ENGL. J. MED. 881 (1969). The ability of doctors to create their own demand is deduced from this circumstance, among others. See FUCHS & KRAMER, *supra* note 68; Feldstein, *The Rising Price of Physicians' Services*, 52 REV. OF ECON. & STAT. 121 (1970).

84. See, e.g., S. REP. NO. 1230, *supra* note 80, at 254.

85. See generally Stuart & Stockton, *Control over the Utilization of Medical Services*, 51 MILBANK MEM. FUND Q. 341, 342-43, 359-76 (1973) [hereinafter cited as Stuart & Stockton].

86. Physicians are said to practice "defensive medicine," ordering unnecessary tests and x-rays primarily as a protection to themselves against malpractice claims and not because the patient is benefited. See generally DEP'T OF HEALTH, EDUCATION & WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 14-15 (HEW Pub. No. (OS) 73-88, 1973); *id.* (APPENDIX) at 38-40 (HEW Pub. No. (OS) 73-89, 1973); *Project—Medical Malpractice: A Study of Defensive Medicine*, 1971 DUKB L.J. 939 [hereinafter cited as *Malpractice Project*].

are enjoying at third-party expense. Indeed, many physicians might welcome collective efforts to eliminate the costly nonprice competition which compels them to prescribe at least as many very high-quality services as other doctors.⁸⁷ Given this amount of professional willingness to accept cost-conscious review, professional utilization reviewers, if motivated to act aggressively, might well be able to use the notions of unnecessary care and overutilization to confront some quality/cost trade-offs.⁸⁸ The question remains whether PSROs will be so motivated.

Regulation of Capital Investments

The recent emphasis on controlling capital investments in health care facilities and equipment⁸⁹ may be understood as an attempt to reduce the cost of health care without the necessity for explicitly valuing the benefit of incremental units of care to individual patients. Investment limitations are designed to create artificial shortages of facilities and equipment, thereby forcing providers to ration the available care. In effect, providers are made to decide which patient, either *A* or *B*, is to receive the only available treatment. Decisions of this "either/or" kind can sometimes be quite difficult,⁹⁰ but most often a resource constraint will not require explicit choices but will instead induce greater physician awareness of medical priorities and alterations in patterns of practice. Nevertheless, "either/or" decisions are still involved, and implicit "no" decisions are frequently made. By contrast, because of ethics and the quality imperative, providers are virtually unable to say "no" when issues are presented in explicit "yes/no" terms regarding the needs of a single patient. Facilities regulation is thus the first step in a two-step process which limits resource availability as a prelude to provider decisions allocating resources according to relative needs. The result, in causing provider decisions to be cast in "either/or"

87. Repression of such competition, by PSROs or otherwise, could be socially beneficial as a corrective for the distorting effects of the divergence of private and social costs under third-party payment. Noncartel solutions to this problem may be preferable, however. See note 236 *infra*.

88. Note that incorporation of economic factors in utilization review necessitates imposing some form of collective choice on health purchasing decisions. At present, collective financing programs decentralize consumption determinations to individuals and their physicians. Since this arrangement provides the least incentive for cost consciousness, interest developed in utilization review as a means of achieving accountability. While reliance on consensual valuations and preferences is one way of imposing a degree of cost constraint, there are advantages to the alternative path of restoring individuals' responsiveness to market incentives wherever relevant and possible and retaining decentralized decision making.

89. The most recent manifestation of this trend is the National Health Planning and Resources Development Act of 1974, Act of Jan. 4, 1975, Pub. L. No. 93-641, 88 Stat. 2225, amending 42 U.S.C. § 201, *et seq.* (1971). See also Social Security Act § 1122, 42 U.S.C. § 1320a-1 (Supp. II, 1973). See generally REGULATING HEALTH FACILITIES CONSTRUCTION (C. Havighurst ed. 1974).

90. Fortunately, they are only seldom presented in as stark a form as those explicit life-and-death choices necessitated by the limited quantity of hemodialysis machines prior to the extension of Medicare to cover kidney disease. See, e.g., Calabresi, *Tragic Choices*, *supra* note 49; Dukeminier & Sanders, *Legal Problems in Allocation of Scarce Medical Resources: The Artificial Kidney*, 127 ARCH. OF INT. MED. 1133 (1971).

rather than "yes/no" terms, would seem substantially to improve the chances for appropriate recognition of quality/cost trade-offs.

Two important assumptions underlie capital investment controls and are necessary to assure that regulatory curtailment of supply will not result in denial of obviously beneficial care, thereby compromising this cost-control device under the quality imperative. The first such assumption is that the mere availability of facilities induces their utilization in very many cases where the benefit to the patient is not great enough to justify the expense entailed. There is evidence which supports the existence of just such a tendency for supply to create its own demand,⁹¹ and, indeed, this should not be surprising in light of the wide availability of third-party payment to cover inpatient and other care which would otherwise not be prescribed.⁹²

Another assumption is also necessary to allay concern that the burden of facility regulation will fall unevenly on patients, namely, that providers, facing a shortage of facilities, will ration the available care to patients strictly in accordance with potential medical benefits. The possibility exists, however, that perceptions of relative social worth, the admitting physician's status in the hospital, or even side payments will also weigh in such decisions even if adequate financial coverage of the entire population were assured.⁹³ Government could escape some of the responsibility for reducing access to care by establishing standards of nondiscrimination. Thus, there is no reason traceable to sensitivity on distributive issues why collective decisions on facility investments could not be economically rigorous. This approach successfully frames the issue to involve only statistical lives and health benefits.

Even granting the relative advantages of capital investment regulation, decision making by politically responsive agencies on the question of public need for new hospital beds or new diagnostic or therapeutic equipment remains difficult. The claims of quality remain substantial, and the normative, professionally defined conception of need can be advanced with great force in regulatory proceedings. Moreover, present utilization rates are, *prima facie*, the most powerful indicator of medical need, and these in turn are determined by physician decisions inadequately constrained by cost considerations. Further, the regulators themselves are unlikely to have

91. The responsiveness of demand to bed supply was first noted in M. ROEMER & M. SHAIN, *HOSPITAL UTILIZATION UNDER INSURANCE* 12 (AHA Hosp. Monograph Series No. 6, 1959). See also Klarman, *Approaches to Moderating the Increases in Medical Care Costs*, 7 *MED. CARE* 175, 177-79 (1969) [hereinafter cited as Klarman].

92. Curbing facility expansion induced by subsidized demand seems generally safe since no evidence suggests that, in the relevant ranges, availability of hospital beds or other facilities has a material impact on health status. Klarman, *supra* note 91, at 178.

93. On the need to examine the possibility of an adverse effect on accessibility of care, see Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need,"* 59 *V.A. L. REV.* 1143, 1201-02 & n.199, 1220 & n.243 (1973) [hereinafter cited as Havighurst, *Certificate of Need*].

a strong incentive to control costs which are, for the most part, hidden from public view and paid by others. They may also be heavily influenced by the provider establishment and reluctant to face the criticism that they are unresponsive to the need for high-quality care.⁹⁴ A recent examination of the likely behavior of such regulatory agencies concluded that such regulation is capable at best of only small improvements and at worst of furthering provider interests rather than the public's.⁹⁵ It is possible, while adhering to this expectation, to admire the attempt, through such regulation, to make intractable quality/cost problems somewhat more manageable.

More Stringent Resource Constraints: The Contributions of HMOs

Regulation of capital investments imposes only a partial resource constraint and, as such, may simply divert expenditures into unregulated channels, such as an expanded work force or higher wages.⁹⁶ No truly comprehensive resource constraint, such as that imposed by the fixed annual budget of the British National Health Service, has yet been imposed in the United States, though the proposed Health Security Act, originally sponsored by Senator Edward Kennedy, would make use of this approach to cost control.⁹⁷ In view of the desire to expand access to health care and the probable ineffectiveness of the measures being relied upon to bring costs under control, the fixed-budget approach is a strong candidate for adoption here in the long run. Even so, the level of expenditures budgeted for at the outset of such a program might well incorporate any excesses fostered by the previous controls, perpetuating any resource misallocations which had become embedded in the system. There is also a longer-run hazard that, as may have occurred in Great Britain, excessive stringency could someday result if annual appropriations proved inadequate to keep pace with inflation, to allow for keeping up facilities, or to meet legitimately higher costs involved in new, more effective modes of treatment.

Acceptance of the desirability of a comprehensive resource constraint does not require one to embrace the notion of a governmental takeover of

94. Regulating the construction of health facilities, for example, requires more than just a "feel" for the "right" number of hospital beds. No regulator can easily withstand the political pressure if his chief weapon is his intuition. The recognition that he lacks technical knowledge that might buttress his case against political pressures tends, therefore, to cause the administrator to shy away from regulation. Instead of saying "no," he says "yes."

Fein, *Access and Equity*, *supra* note 13, at 41.

95. Havighurst, *Certificate of Need*, *supra* note 93.

96. "[I]nflationary pressures may, like a balloon, bulge out at another place even if growth in one direction is effectively prevented." *Id.* at 1148. *See also id.* at 1217-19. Total health care costs would be unaffected or even increased if the artificially induced shortages raised prices, if unregulated noncapital costs were equally prone to rise in response to subsidized demand, or if regulation slowed down the introduction of desirable changes in the delivery system; a more appealing possibility, though it remains uninvestigated, is that resources might be reallocated to uses having greater marginal benefits. *See id.* at 1204-24.

97. S. 3, 93d Cong., 1st Sess. (1973).

the health care system under either the National Health Service or the Health Security Act model. A relatively free market can generate this solution as well as government and, by preserving alternatives and opportunities for choice by individual consumers, can help to assure that neither excessive spending nor excessive stringency will ultimately result. The best example of the effective use of resource constraints on providers in the American health care system is the so-called "health maintenance organization" (HMO), a private entity which accepts contractual responsibility for providing comprehensive care to a defined population for a fixed payment received in advance.⁹⁸ Although HMOs' development has been hampered by professional opposition, by limitations on their marketing opportunities, and by restrictive state and federal legislation,⁹⁹ they have demonstrated a capacity to provide good-quality health care at a price below the cost of equivalent third-party coverage.¹⁰⁰ In particular, they have shown an ability to conserve in the use of hospital and other resources, a cost consciousness attributable to the resource constraint imposed by their prepayment feature and made effective by confronting the HMO physicians with decisions cast more in "either/or" than in "yes/no" terms. Without a third party's blank check, HMO doctors have a strong incentive to use patient education and preventive measures wherever they are cost-effective and to diagnose and treat disease before it becomes acute. An HMO's budget constraint also encourages elimination of redundant tests and x-rays, substitution of nonphysician for physician manpower and outpatient for inpatient care wherever possible, and attention to distinguishing between effective and ineffective measures.

HMOs' incentives to economize could sometimes lead to inappropriate sacrifices of quality, especially where the HMO was excessively attuned to earning short-run profits.¹⁰¹ Indeed, most of the recent hesitancy of policy makers to improve HMOs' market opportunities is traceable to concerns about such overeconomizing, concerns prompted in part by some disturbing experiences,¹⁰² but also reflecting the quality imperative and the

98. The term "HMO" was coined and popularized by Dr. Paul M. Ellwood, Jr. See P. ELLWOOD, W. MCCLURE, R. HOLLEY, R. CARLSON & E. HOAGBERG, *THE HEALTH MAINTENANCE STRATEGY* (Institute for Interdisciplinary Studies 1970), reprinted in 9 *MED. CARE* 291 (1971), and in 118 *CONG. REC.* 32458 (1972) [hereinafter cited as *HEALTH MAINTENANCE STRATEGY*]. First the Nixon Administration and later others adopted it for use in legislative proposals.

99. See generally INSTITUTE OF MEDICINE, NAT'L ACADEMY OF SCIENCES, *HMOs: TOWARD A FAIR MARKET TEST* 19-49 (May 1974) [hereinafter cited as *HMOs: TOWARD A FAIR MARKET TEST*]; Holley & Carlson, *The Legal Context for the Development of Health Maintenance Organizations*, 24 *STAN. L. REV.* 644 (1972); Rhein, *HMOs: Threat or Opportunity?*, *MED. WORLD NEWS*, Jan. 27, 1975, at 53; Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 *HARV. L. REV.* 887 (1971).

100. See note 43 and accompanying text *supra*.

101. See Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 *LAW & CONTEMP. PROB.* 716, 754-56 (1970) [hereinafter cited as Havighurst, *Health Maintenance Organizations*].

102. See, e.g., H. SCHWARTZ, *THE CASE FOR AMERICAN MEDICINE* 177 (1972) (noting an HMO's "strong economic interest in having its seriously ill patients die quickly and

medical profession's interest in restraining HMO competition. Although the best-known prototype HMOs have never been shown to offer poorer-quality care than the traditional system and in fact have many qualitative advantages over fragmented fee-for-service care, regulation may still be appropriate to assure that HMOs address quality/cost trade-offs with adequate attention to the quality dimension. Government should concentrate its efforts on assuring that an appropriate level of quality is maintained in those situations where consumers have little capacity or opportunity to choose or to judge quality for themselves¹⁰³ and where potential tort liability is also an uncertain inducement to good performance.¹⁰⁴

Quality standards established for HMOs, on the other hand, could easily be set too high to give consumers a sufficient range of quality/cost options. It should be regarded as an important policy objective to provide opportunities for consumers to select not only a different style of care with certain qualitative advantages of its own but also a lower-cost plan which omits some of the marginally productive steps which are dictated by traditional quality standards.¹⁰⁵ Such economizing choices are rational if they are made in a market where information and advice are available, where providers have a long-term stake in their reputations, where marginal consumers' ability and willingness to shift loyalties induce high standards, and where the law of torts keeps providers attuned to the outcomes they achieve. Even an imperfect market allows quality/cost trade-offs to be faced not only by HMO physicians in their internal decision making but also by consumers in their choices among providers and prepayment plans.

inexpensively. Death is the ultimate economy."'). *But see* Havighurst, *Health Maintenance Organizations*, *supra* note 101, at 748-59. Medi-Cal, California's Medicaid program, which has experimented with HMO care, has been severely criticized for allowing profiteering and inadequate care. *See generally* COMPTROLLER GENERAL, *BETTER CONTROLS NEEDED FOR HEALTH MAINTENANCE ORGANIZATIONS IN CALIFORNIA* (Report to Senate Finance Comm., 1974); Hester & Sussman, *Medicaid Prepayment: Concept and Implementation*, 52 MILBANK MEM. FUND Q. 415 (1974); Schneider & Stern, *Health Maintenance Organizations and the Poor: Prospects and Pitfalls*, 70 Nw. U.L. Rev. 90 (1975) (this issue).

103. *See* HMOs: TOWARD A FAIR MARKET TEST, *supra* note 99, at 51-61.

104. *See* Curran & Moseley, *The Malpractice Experience of Health Maintenance Organizations*, 70 Nw. U.L. Rev. 69 (1975) (this issue). *Cf.* Havighurst & Tancredi, "Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance, 51 MILBANK MEM. FUND Q. 125 (1973).

105. Members of insured employment groups and federal program beneficiaries have only limited opportunities to enroll in HMOs. For largely unsuccessful recent efforts to change this situation, see Act of Oct. 30, 1972, Pub. L. No. 92-603, § 226, 86 Stat. 1329; Act of Dec. 29, 1973, Pub. L. No. 93-222, § 2, 87 Stat. 914.; Proposed Regs. 40 Fed. Reg. 6602-05 (Feb. 12, 1975). The poor and people in rural environments are least likely ever to have sufficient market opportunities to protect themselves, even under unrestrictive regulatory conditions. Federal financing programs improving these citizens' ability to pay may not expand their options sufficiently to dispense with strong regulatory controls. Individuals will have an incentive to economize by choosing lower-quality medical care at a lower price only if they can keep the resources saved. Public financing schemes may not achieve this, though consumers may at least be induced to enroll in a plan which provides more benefits for the same federal payment. *See* note 222 *infra*.

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Moreover, there is evidence that the presence of meaningful quality/cost options in the marketplace induces cost consciousness on the part of traditional providers and some corrective actions.¹⁰⁶

PSROs AND THE QUALITY IMPERATIVE

With some understanding of the constraints on both political and professional decision making concerning quality/cost trade-offs in the health sector, an examination of the PSRO itself can now proceed. Although the history and substance of the PSRO statute make clear that cost considerations are to be given due consideration, the structure of the PSRO and its political and professional milieu cast doubt upon PSROs' ability to face quality/cost issues in a socially appropriate manner.

The PSRO Law and Its Interpretation

The Legislative History

The PSRO legislation originated in the Senate Finance Committee as an amendment to H.R. 1, the omnibus Social Security Act amendments already passed by the House. Because it bears major responsibility for imposing the taxes needed to support the Medicare and Medicaid programs, the Finance Committee is highly cost-conscious. It is also far-removed from direct concern with patients' lives, health, and welfare and is probably more inclined than most other agencies of government to see quality/cost issues as involving statistical lives and health, to compare expenditures on health care with other priorities, and to be skeptical about an unremitting emphasis on the quality of care.¹⁰⁷

The PSRO legislation was developed in the Finance Committee against a background of intense concern on the part of the Committee and its staff about cost overruns in the Medicare and Medicaid programs.¹⁰⁸ The Committee noted that 1967 cost estimates were being exceeded at a

106. The so-called foundations for medical care which follow the "California model" of claims review, typified by the San Joaquin Foundation for Medical Care, were directly inspired by HMO competition, which is much more active in California than elsewhere. See Sasuly & Hopkins, *A Medical Society-sponsored Comprehensive Medical Care Plan*, 5 MED. CARE 234 (1967). See also C. STEINWALD, AN INTRODUCTION TO FOUNDATIONS FOR MEDICAL CARE 6-25 (1971). Havighurst, *Health Maintenance Organizations*, *supra* note 101, at 769-77. Other mechanisms which the fee-for-service sector might employ in fighting HMO competition through cost control include PSROs, health planning agencies, and third-party-payer claims review and utilization controls.

107. This is not to say that the Finance Committee is excessively—or sufficiently, for that matter—concerned with the cost issue, but only to suggest that a decision maker's direct responsibility for payment and revenue-raising often mitigates the impact of the quality imperative.

108. See generally STAFF OF THE SENATE COMM. ON FINANCE, 91st CONG., 1ST SESS., MEDICARE AND MEDICAID: PROBLEMS, ISSUES, AND ALTERNATIVES 3-27 (Comm. Print 1970) [hereinafter cited as STAFF PAPER]. For the Justice Department's argument on the central importance of cost control in the PSRO program, see Memorandum in Support of Defendant's Motion for Summary Judgment, Ass'n of Am. Physicians & Surgeons v. Weinberger, No. 73-C-1653 (N.D. Ill. decided May 8, 1975).

rate which would produce a \$240 billion deficit over a 25 year period for part A of the Medicare program alone.¹⁰⁹ Senator Bennett, noting that the unit cost of services was "only part of the problem," argued that "without effective professional controls on utilization the costs of the program will continue to soar."¹¹⁰

The PSRO amendments reflected the Finance Committee's finding that the utilization review process which hospitals had been required to implement under the Medicare program had been "ineffective as a curb to unnecessary use of institutionalized care and services."¹¹¹ Largely because such utilization review was based in the institutions themselves, it was, in the Committee's view, "more form than substance."¹¹² Thus, the Finance Committee's stance can best be described as one of frustration at the difficulty of getting providers to take seriously their cost-control responsibilities. Even so, the matter was ultimately left in provider hands.

The Finance Committee's decision about how to deal with the inadequacy of utilization review was heavily influenced by Senator Bennett, who firmly believed that the problem of curbing utilization could not be handled directly by the federal government. Thus, the PSRO amendments were an attempt to institutionalize the concept of peer review, eliminating as many of its faults as possible but preserving the principle that only physicians actively engaged in practice should review the work of other physicians. The federal government, in effect, undertook not to regulate medical care directly but instead to mandate and regulate peer review practices as an indirect means of imposing controls over individual physicians. It is not altogether clear, however, whether the motivation for such complete reliance on practitioners was simply practicality in administration, a perceived need for general physician acceptance, or an overriding concern that there be no sacrifice of the quality of care, of which doctors are clearly the staunchest defenders. This is obviously an important issue in assessing whether Congress intended PSROs to act aggressively on those cost issues which involve a possible sacrifice in quality.¹¹³

109. S. REP. No. 1230, *supra* note 80, at 254.

110. 118 CONG. REC. 32,477 (1972).

111. S. REP. No. 1230, *supra* note 80, at 255.

112. *Id.* See also *id.* at 255-56; STAFF PAPER, *supra* note 108. These documents present reasons for ineffective utilization review, including deficient regulations, laxity both by intermediaries and by SSA, conflicts of interest in institutions, insufficient professional participation, and the absence of norms. Critical factors which emerged were the institutions' desire to avoid deficits which would accompany low occupancy rates (accounting for the observation that the effectiveness of utilization review is inversely related to the available supply of hospital beds) and circumstances in which physicians who had a financial interest in the facility were on the institutional review committee.

113. Cf. 117 CONG. REC. 21,267 (1971) (remarks delivered by Senator Bennett before the American Ass'n of Medical Society Executives in Hershey, Pa., on June 18, 1972): "It seemed to me that the key to making a review system workable and acceptable was the practicing physician." *Id.*

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The Statute Itself

The "declaration of purpose" in the law emphasizes a desire "to promote the effective, efficient, and economical delivery of health care services of proper quality."¹¹⁴ The use of the modifier "proper" does not signify a desire to raise the quality of care, and, although the statute recognizes the interest of the public in "improved health services," it expresses no more than a desire that services "conform to appropriate professional standards," leaving the matter of what is "appropriate" open for examination. The main emphasis in the statement of purpose is on eliminating unnecessary care and inappropriate utilization of facilities.

The section of the law dealing with duties and functions of PSROs notes generally the responsibility of the PSRO to determine whether¹¹⁵

- (A) such services and items are or were medically necessary;
- (B) the quality of such services meets professionally recognized standards of health care; and
- (C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type.

Although quality is given nearly equal billing with cost considerations here, the further implementing provisions never address quality alone but instead treat it as only one of several criteria to be employed. The initial limitation of PSRO jurisdiction to "services provided by or in institutions,"¹¹⁶ which was added only in the House-Senate conference where the House's views on PSROs were first asserted,¹¹⁷ strongly suggests that Congress saw the statute as primarily cost-oriented. Excessive utilization of resources occurs primarily in inpatient care, whereas quality concerns would probably be greatest with respect to outpatient care, where existing peer-review mechanisms are least effective.

Thus, quality concerns are not prominent in the statute, a fact which clearly reveals Congress's primary interest in reducing utilization in hospitals and other facilities. Of course, it would have been unseemly for Congress to insist upon cost control without some regard for the quality of care provided, and therefore the inclusion of quality as a regulatory objective—though not an independent goal—might fairly be regarded less as a mandate to regulate quality aggressively than as a constraint, an assurance that undue sacrifices of quality would not be made in the name

114. 42 U.S.C. § 1320c (Supp. II, 1972).

115. *Id.* § 1320c-4(a) (1).

116. *Id.* § 1320c-4(g). *See* note 187 *infra*.

117. JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE ON H.R. 1, CONF. REP. No. 1605, 92d Cong., 2d Sess. 21 (1972), reprinted in U.S. CODE CONG. & AD. NEWS, 92d Cong., 2d Sess. 5370, 5391-92 (1972).

of economy. Congress may also have been seeking to protect against the possibility that regulatory controls over fees and charges, imposed under H.R. 1 by means other than PSROs, would induce providers to dilute the content and quality of each billable service as a means of maintaining their income.¹¹⁸

Postenactment Interpretation

The cost concerns of the legislation were, however, diluted from the very beginning. One of the earliest administrative issues was where governmental responsibility for implementation and oversight of the PSRO program would be lodged.¹¹⁹ The principal alternatives within the Department of Health, Education and Welfare (HEW) were the Social Security Administration (SSA) and the Office of the Assistant Secretary for Health. SSA, as a paying agent under the Medicare program, is in much the same position as the Senate Finance Committee, having its eye very much on costs,¹²⁰ and it could probably have been depended upon to maintain a strong orientation toward the control of overutilization. By contrast, the Assistant Secretary for Health (an office traditionally filled by a physician acceptable to organized medicine), in whom responsibility was in fact lodged, might have been expected to yield substantially to the profession's views and to deemphasize cost control. As will be seen, this latter expectation was realized.

A great deal of the discussion surrounding the PSRO concept in the period since its enactment has been rendered almost unintelligible by operation of the quality imperative in a highly charged political and professional environment. In fact, the political campaign over the PSRO program began in earnest only after the law's enactment, when it became clear that the support of organized medicine would not be easily gained. The Office of Professional Standards Review (OPSR), which was set up in the Assistant Secretary's office to oversee implementation of the program, viewed the success of the program, probably correctly, as dependent on physicians' willingness to cooperate, and it embarked on a campaign to persuade doctors that the program was a desirable professional endeavor to which they could safely lend their support. In the rhetoric of this highly politicized debate, "quality of care" became something of a "code word" for professional prerogatives, and "cost control" was soft-pedaled, having become a "buzz word" for government interference.

In the selling effort by HEW officials, cost and quality were both discussed, but quality gradually emerged as the dominant theme, to which HEW spokesmen returned whenever the unpleasant subject of cost was

118. Cf. Posner, *Regulatory Aspects of National Health Insurance Plans*, 39 U. CHI. L. REV. 1, 10 (1971).

119. See Lander, *PSROs: A Little Toe in the Door*, HEALTH/P.A.C. BULL. 1, 5-6 (July/Aug. 1974) [hereinafter cited as Lander].

120. See LAW, *supra* note 80, at 130-35.

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touched upon. A question-and-answer brochure prepared for doctors by OPSR took this position on the question:¹²¹

Is the purpose of PSRO to assure quality or control cost?

The primary emphasis of the PSRO program is on assuring the quality of medical care. Providing quality care may increase health services for some patients in certain areas and could increase costs in those circumstances.

PSRO will be concerned also with whether medical care is necessary and delivered in the proper setting. If overuse or uneconomical use of services are identified and eliminated, cost savings will result.

Dr. Henry Simmons, Deputy Assistant Secretary for Health and Director of OPSR, adopted an I'm-glad-you-asked-that attitude whenever this question came up and hastened to clear up any "misconception" which the questioner might have gained from the legislation or from the Senate Finance Committee report. He also minimized PSROs' cost-control function by saying "utilization review is probably the smallest part of what PSROs will be doing."¹²² In general, OPSR's view seems congruent with that of the AMA: "Quality control is the prime objective of Peer Review and cannot be allowed to become secondary to cost control."¹²³

OPSR has also reassured doctors about the impact of the PSRO program on the demand for medical services. Any cost reductions achieved by PSROs in policing overutilization, Dr. Simmons has indicated, might be more than offset by improvements in quality "where we are currently underutilizing services, as in the treatment of hypertension."¹²⁴ Dr. Simmons has also held out the possibility that¹²⁵

the total cost of medical care in this nation may well rise, and if it does, it will not mean that PSRO has failed. Total cost is not the key issue.

121. OFFICE OF PROFESSIONAL STANDARDS REVIEW, DEP'T OF HEALTH, EDUCATION, AND WELFARE, PSRO: QUESTIONS & ANSWERS (HEW Pub. No. (OS) 74-50001, 1973), reprinted in 2 CCH MEDICARE & MEDICAID GUIDE ¶ 12,855.75 (1974) [hereinafter cited as PSRO: QUESTIONS & ANSWERS].

122. Address by Dr. Henry Simmons, entitled "PSRO and the Quality of Medical Care," before the Indiana Medical Association, May 16, 1974 [hereinafter cited as Simmons Speech]. In this speech, delivered at the height of the struggle to obtain AMA acceptance of the program, Dr. Simmons mentioned quality assurance as the exclusive function of PSROs ten different times. At three additional points he referred to the purpose of the program in a manner implying a conflict with cost-control objectives but never attempted to resolve the conflict.

123. AMERICAN MEDICAL ASSOCIATION, PEER REVIEW MANUAL 16 (1972). See also this declaration by the director of the AMA's Center for Health Services Research and Development:

It seems apparent after examining the legislation that the primary, if not total intent of the program is to contain the *cost* of medical care.

Despite the legislative intent of the program, however, the concern of health care providers and insurers should be to reassign priorities of the PSRO program to assure that maintenance of high quality care is the *primary* focus of PSRO's.

Theodore, *Towards a Strategy for Evaluating PSRO's*, WESTCHESTER MED. BULL., Nov., 1974 (reprints available from AMA).

124. Simmons Speech, *supra* note 122.

125. *Id.*

The most important message in the rhetoric is that HEW perceives no incompatibility between the cost-control mission of PSROs and high quality standards. "PSRO is not a cost-control program—it is a waste control program," said Dr. Simmons, calling doctors' attention to their own control over the standards to be employed in policing overutilization and noting that the law "does not ask [doctors] to develop an inexpensive standard."¹²⁶ The examples of cost control cited to indicate how utilization review would work appear noncontroversial, involving potential cost reductions which would leave quality unaffected. For example, Assistant Secretary for Health Dr. Charles C. Edwards cited the case of patients suffering myocardial infarction, who could "do just as well" with two rather than three weeks in the hospital, and the case of cataract patients, who, it was alleged, could be "properly and effectively treated without hospitalization."¹²⁷ In the first case, the medical evidence is strong that the added costs contribute nothing to the effectiveness of treatment.¹²⁸ The cataract case, though more debatable and not yet scientifically confirmed, is based on some evidence and a strong testimonial that patients are no worse off when treated on an outpatient basis.¹²⁹ While such opportunities for cost savings without adverse effects on quality are probably fairly common and provide a useful agenda for PSRO action, they are not the only cases in which economizing would be appropriate.

Public statements by HEW officials have emphasized other positive aspects of the PSRO as a way of minimizing its cost-control mission. Among these is the policing of poor quality care provided by aberrant members of the profession, the traditional function of professional peer review. The PSRO program is said to provide a mechanism to overcome the inability of good physicians "to act effectively to correct unethical practices and poor quality care which they see going on about them."¹³⁰ The PSROs' systematic collection and analysis of data concerning medical care is said to provide a basis not only for identifying "those who are consistently delivering mediocre or substandard care" but also to strengthen the profession's own understanding, enabling doctors "to identify

126. *Id.*

127. Address by Dr. Charles Edwards, entitled "Improving the Nation's Health Care System," before the 1973 Annual Program Conference of the National Association of Blue Shield Plans, Chicago, Illinois, October 25, 1973 [hereinafter cited as Edwards Speech].

128. See Hutter, Sidel, Shine & DeSanctis, *Early Hospital Discharge After Myocardial Infarction*, 288 N. ENGL. J. MED. 1141, 1141-44 (1973) (describing a prospective randomized controlled study of 138 patients with uncomplicated myocardial infarction). The study supports the contention that no additional benefit accrues to the patient (as measured by a variety of outcome indices) from a three-week as compared to a two-week hospital stay. The findings apply only to the best-risk subgroup (approximately 15 percent of myocardial infarction patients). See also COCHRANE, *supra* note 26, at 50-54 (citing evidence that hospital coronary care unit treatment does not generally yield better results than home treatment for ischaemic heart disease).

129. See Jervey, *Postoperative Care of the Cataract Patient*, 69 TRANSACTIONS AM. OPHTH. SOC'Y 263 (1971); *Phaco-emulsification Heads for Respectability*, MED. WORLD NEWS, Oct. 12, 1973, at 17.

130. Simmons Speech, *supra* note 122.

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trends, unusual variations in patterns of care, or outcomes of care among providers."¹³¹ PSROs are also expected to assist the profession in continuing education of practitioners, an aspect, incidentally, which is particularly emphasized to allay doctors' fears of more coercive sanctions.¹³² Particularly important is the expectation that PSROs¹³³

could be the missing link between a new finding on what would be a superior type of care and the intelligent, expeditious and widespread adoption of that kind of care throughout the population.

The public discussion of the PSRO program reveals the extraordinary difficulty of dealing openly with quality/cost trade-offs in a political environment. Nevertheless, aside from the unmentionability of such trade-offs, the debate has been useful in highlighting some strengths of the PSRO idea as well as some of the hazards, particularly the risk that "norms, standards, and criteria" will produce rigidly uniform, "cookbook medicine," with inadequate allowance for patients' differences,¹³⁴ and also higher costs, associated not only with adherence to unrealistically ambitious norms¹³⁵ but also with the extensive review program itself.¹³⁶ The success of OPSR in obtaining the profession's general, though far from unanimous, assent to the program is also an important step forward.¹³⁷ It

131. *Id.*

132. *See, e.g.*, PSRO: QUESTIONS & ANSWERS, *supra* note 121.

133. Simmons Speech, *supra* note 122. Conspicuously missing in Dr. Simmons' discussion is any mention of the possibility of slowing down the adoption of unproved, but popular and expensive, new techniques. *See generally* COCHRANE, *supra* note 26. One such innovative procedure is coronary bypass surgery, which replaces a portion of a defective artery leading directly from the heart with a vein from the leg. Despite the procedure's high cost (\$6,000 average, more with complications) and unproven effectiveness (no systematic study has proved benefits, some 25 percent of patients soon have heart attacks, and 10 percent die quickly), the operation is popular (some 35,000 had been performed by late 1972). *See* N.Y. Times, Oct. 22, 1972, § 1, at 61, cols. 1-3.

134. On the dangers of "cookbook medicine," *see* AM. MED. NEWS, Apr. 1, 1974, at 20-23; *Id.*, May 20, 1974, at 19-21.

135. S. Fleming, HEW Deputy Ass't Sec'y for Policy Development, voiced concern that PSROs might "induce a ratcheting up process, in which the most expensive levels of care would become the norms." AM. MED. NEWS, Feb. 26, 1973, at 3. *See also* Welch, *Professional Standards Review Organizations—Problems and Prospects*, 289 N. ENGL. J. MED. 291 (1973).

136. One PSRO review of an individual case may cost \$10-20. Flashner, *Professional Standards Review Organizations*, 223 J. AM. MED. ASS'N 1473, 1483 (1973); Frederick, *PSROs: How the First Ones Are Working*, MED. WORLD NEWS, Oct. 25, 1974, at 53, 56, 59 [hereinafter cited as Frederick]. Not all cases will be reviewed, as PSROs have broad power to exempt particular providers or diagnoses. PSRO MANUAL, *supra* note 11, at §§ 705.14(a)(1) & (2), 705.14(b)(3), 705.15(b), 705.23. The Institute of Medicine estimates PSRO costs at 2-5 percent of the overall cost of care. ADVANCING THE QUALITY, *supra* note 19, at 30. All PSRO costs will be borne by the federal government. 42 U.S.C. § 1320c-17 (Supp. II, 1972).

137. The AMA House of Delegates voted in June of 1974 not to seek repeal of the PSRO legislation and instead to "exert its influence on behalf of 'constructive' amendments and 'sound' regulations." AM. MED. NEWS, July 8, 1974, at 1. Nonetheless, grass roots support for PSROs seems weak. One sample survey showed that only 41.5 percent of MDs and DOs providing patient care favor PSROs, with 53.1 percent opposed. Also 19.5 percent of GPs

remains to be seen whether the obeisance paid to the quality imperative in the political struggle for acceptance betokens a total or only a partial inability of PSROs in practice to address quality/cost issues with some cognizance of the consumer's interest in lower cost.

Organizational Aspects

The force of the quality imperative in physician decision making strongly suggests that professionally dominated PSROs will be unable to address effectively any but the very easiest questions in which quality and cost come into conflict. It is possible, however, that a PSRO-like mechanism could allow doctors to back off far enough from specific clinical situations to examine matters with some regard for the limits of society's resources. Conceivably, by insulating the physician decision makers from political pressures, by introducing some nonphysician viewpoints, by imposing a strong overseeing authority, or by some combination of these approaches, a physician-run self-regulatory mechanism might be capable of sufficient tough-mindedness to serve the public interest well. Indeed, such regulation, if it could be achieved, might be about as close as one could hope to come, outside a fixed-budget system, to regulation of provider decision making which appropriately balances attention to cost and a scientific and humane concern for the quality of care. Regrettably, the PSRO program seems not to have been structured to achieve this result.

Composition

Prior to January 1, 1976, HEW can enter into PSRO contracts only with nonprofit associations comprising a substantial proportion of the practicing physicians and osteopaths in the designated PSRO area.¹³⁸ Membership in the organization must be voluntary and open to all licensed doctors in the region. If ten percent of the area's doctors object to the organization which HEW proposes to designate a PSRO, HEW must conduct a poll to see if the organization is "representative" of the physicians practicing in the area.¹³⁹ The effect of these provisions is to guarantee that the affected practitioners will have an opportunity to control the initial designation of a PSRO.

After January 1, 1976, by which time local doctors should have been able to organize themselves if they were inclined to do so, HEW may enter agreements with other types of organizations which it finds capable of performing the PSRO function.¹⁴⁰ This may occur, however, only if there is no other available and acceptable candidate which meets the narrower criteria requiring broad physician involvement. Moreover, a PSRO selected

said they would give up Medicare/Medicaid patients rather than be subject to review. A majority of some types of physicians did favor PSROs—among them, those younger than 45 years old (54.9%), those with hospital-based practices (61.8%), and northeasterners (57%). *MED. WORLD NEWS*, Oct. 25, 1974, at 70, 77.

138. 42 U.S.C. §§ 1320c-1 (b) (1) (A) (iii), (c) (1) (Supp. II, 1972).

139. *Id.* § 1320c-1 (f).

140. *Id.* § 1320c-1 (b) (1) (B).

under this second set of criteria is subject to having its authority terminated by nonrenewal of its contract if the local doctors should at some point elect to offer a candidate meeting the stricter standards.¹⁴¹ As a practical matter, then, only organizations sponsored by or totally acceptable to local practitioners can realistically be expected to serve as PSROs.

The medical societies themselves are excluded from serving as PSROs, since membership in a PSRO cannot be conditioned on membership in an organized medical society.¹⁴² Nevertheless, the societies will have de facto control, and society-organized "foundations for medical care"¹⁴³ will be the most common type of recipient of a PSRO contract.¹⁴⁴ The role of the state societies has been a matter of intense interest to the American Medical Association in the implementation of the PSRO mandate. The AMA pressed HEW to designate entire states as PSRO regions in the hope of concentrating development at the state level, where the AMA's own power, through its constituent state medical societies, is greatest. HEW responded by stretching its own published criteria for area designations and designating 28 entire states as PSRO regions.¹⁴⁵ In addition, it announced that in some other states it would fund, as "statewide support centers," organizations of practicing physicians which "have continuing relationships with state medical and other professional societies, agencies, and organizations" and which could show "actual knowledge and expertise in the conduct of PSRO-peer review activities by description of previously provided services."¹⁴⁶ This was a clear invitation to already organized medical groups to seek federal funding to assist, and thereby influence, developing PSROs in their critical phase.¹⁴⁷

Even though it has been popular of late for Congress to prescribe consumer involvement in various regulatory and planning activities in the health sector,¹⁴⁸ consumers were provided practically no role in the PSRO program.¹⁴⁹ Of course, given the technical aspects of utilization review and

141. *Id.* §§ 1320c-1(c) (1), (2) (A) (d).

142. *Id.* § 1320c-1(b) (1) (A) (v).

143. *See* note 106 *supra*.

144. 118 CONG. REC. 32,477 (1972) (Remarks of Senator Bennett). *See also* Lander, *supra* note 119, at 15; Frederick, *supra* note 136.

145. PSRO MANUAL, *supra* note 11, § 204.3. The states of Georgia and Washington, each with over 4,000 practicing physicians, were designated single-state PSRO areas even though the criteria (*id.* at § 202(d)) suggest 2,500 as the maximum physician population in a PSRO area.

146. *Id.* § 308.

147. It has been suggested that the thread on which HEW hangs its authority to fund such support centers is a thin one. *See* Lander, *supra* note 119, at 6-7 (referring to 42 U.S.C. § 1320c-18, which authorizes HEW to "provide all necessary technical and other assistance."). This argument has merit, especially in view of the provision for other statewide mechanisms and the clear expectation that technical assistance would come from OPSR and the NPSRC. The PSRO MANUAL also cites 42 U.S.C. §§ 1320c-5(a), c-12(c) (Supp II, 1972), neither of which suggests any warrant for such centers. *Id.* at ch. 3 (support centers).

148. *E.g.*, National Health Planning & Resources Development Act of 1974, P.L. 93-641 (Jan. 4, 1975).

149. 42 U.S.C. § 1320c-11(b) (3) (Supp. II, 1972) provides that four members of each Statewide Professional Standards Review Council are to be "persons knowledgeable in health

quality assurance, it is not clear that consumers could contribute greatly to achieving the PSRO's scientific objectives. Moreover, with respect to quality/cost trade-offs, consumers, like everyone else involved in the regulatory process, are usually more impressed with the visible benefits of health care than with the hidden costs which those benefits entail.¹⁵⁰ Although involving consumers in the PSRO endeavor might have supplied an important humanizing element, it probably would not have significantly improved PSROs' ability to deal with the hard quality/cost questions.

Oversight

Even though PSROs will be dominated by local physicians, effective central direction and oversight might lead them to give some recognition to the cost element where quality/cost tensions arise, inducing reductions in utilization even where local physicians could persuasively argue that some sacrifice in the quality of care was involved. Since payment under the Medicare and Medicaid programs originates with federal and state governments, cost consciousness is apt to be highest at the governmental level. By the same token, the decision makers' removal from the level where encounters between providers and patients occur weakens the impact of the quality imperative. Such cost-conscious oversight, combined with the PSRO's overriding concern for quality, might have produced a balanced approach to allocative issues, but unfortunately neither the PSRO statute nor its administration suggests that PSROs will often be required to violate their members' preferences.

The only likely source of effective oversight for PSROs is the National Professional Standards Review Council (NPSRC).¹⁵¹ The NPSRC com-
 care." Only 18 states will have such Councils. PSRO MANUAL, *supra* note 11, at § 204.3. See note 151 *infra*.

150. See Havighurst, *Certificate of Need*, *supra* note 93, at 1183, 1190-94.

151. 42 U.S.C. § 1320c-12 (Supp. II, 1972). The PSRO statute did create other quasi-supervisory bodies, the Statewide Professional Standards Review Councils, but these are unlikely to exercise effective oversight. They are to play a purely advisory role, with no direct authority over PSROs, and only 18 states will have the three or more PSRO areas needed for the creation of a Council under section 1320c-11(a). PSRO MANUAL, *supra* note 11, at § 204.3. Another possible source of advice to PSROs—though not of oversight—is the advisory groups representing nonphysician providers, hospitals, and other facilities that are to advise the Statewide Councils or PSROs directly where there is no Council. 42 U.S.C. § 1320c-11(e) (Supp. II, 1972).

If so inclined, HEW itself could exercise strict oversight of PSROs, allowing a PSRO's authorizing contract to lapse at the end of its 12-month term or terminating the contract where a hearing establishes that a PSRO is not "substantially complying with or effectively carrying out" its agreement. *Id.* § 1320c-1(d)(2). One cannot yet be certain whether HEW will use this ultimate sanction against PSROs, especially to enforce attention to quality/cost trade-offs; but one may well doubt it. Given the all-or-nothing nature of this sanction and HEW's strong desire to make PSROs work, the sanction is unlikely to be imposed except for serious incompetence or noncooperation. Furthermore, if one PSRO is disbanded and another formed, the same physicians will probably be involved, though after Jan. 1, 1976, a non-physician organization is eligible to be designated a PSRO if no available qualified physician organization appears. *Id.* § 1320c-1(c)(1). The PSRO MANUAL deals only with physician PSROs. PSRO MANUAL, *supra* note 11, at § 510.16. Dr. Simmons, head of OPSR, has

prises 11 physicians, a majority of whom must be selected by HEW from recommendations by "national organizations recognized by the Secretary as representing practicing physicians."¹⁵² HEW is also required to appoint as members physicians who have been recommended by consumer groups and other health care interests. Although all members are physicians and the majority in fact represent the interests of practitioners, the very existence of the NPSRC suggested that, in spite of the law's emphasis on local autonomy and regional standards, some uniformity of practice might be imposed on the PSROs from above. This possibility, reinforced by statutory language,¹⁵³ was threatening to providers and produced a political tension which influenced OPSR's implementation of the law.

The NPSRC is charged, among other things, with providing technical assistance to PSROs in utilizing and applying norms and, where the "actual norms of care" in a PSRO area are "significantly different from professionally developed regional norms of care," with informing the PSRO and initiating a period of discussion and consultation concerning the reasons for such divergence.¹⁵⁴ If there is a "reasonable basis" for using norms other than those professionally developed by the National Council for the region, the PSRO "may apply such norms in such areas *as are approved*" by the NPSRC.¹⁵⁵ Moreover, the act contemplates that the Council's approval of regional norms "shall be based on its analysis of appropriate and adequate data."¹⁵⁶ Thus, the law seems to support the view that PSROs must apply the nationally approved and professionally developed norms of care unless they can secure specific approval from the National Council to deviate from that standard.¹⁵⁷

Perceiving a threat to local decision making, the AMA raised the question, "Who would have the right to set norms and how would they be determined?"¹⁵⁸ Seeing this as a sensitive and strategic issue, OPSR responded that the "clear intent is to use norms, criteria, and standards developed by physicians in the PSRO area"¹⁵⁹ and that the PSRO would retain the "overall responsibility for the development, modification, and

recognized this essential fact of PSRO life—that HEW needs the acquiescence of local physicians more than vice versa. "There is no way we can force the profession to do anything," he noted recently, "and we don't intend to." *AM. MED. NEWS*, April 1, 1974, at 21.

152. 42 U.S.C. § 1320c-12(b) (Supp. II, 1972).

153. *Id.* § 1320c-5(a) (quoted in text at note 155 *infra*).

154. *Id.*

155. *Id.* (emphasis supplied).

156. *Id.* § 1320c-5(c) (1).

157. *Accord*, 2 CCH MEDICARE & MEDICAID GUIDE ¶¶ 12,855, 12,870 (1974) (local PSRO norms "must be approved by" the NPSRC). Nowhere in the statute are PSROs given authority to "develop" norms; the Act speaks in terms of PSROs "utiliz[ing]" professionally developed norms, which are to be prepared under the NPSRC's direction. 42 U.S.C. § 1320c-5(c) (2) (Supp. II, 1972).

158. American Medical Association, PSRO—Deleterious Effects (information package, 1974).

159. OFFICE OF PROFESSIONAL STANDARDS REVIEW, DEP'T OF HEALTH, EDUCATION & WELFARE, OPSR MEMORANDUM 2 (No. 4, April, 1974).

content of norms, criteria and standards."¹⁶⁰ Even though the statute requires the NPSRC to prepare and distribute "materials indicating the regional norms to be utilized,"¹⁶¹ OPSR stated that the National Council would provide, when available, "sample sets of norms and criteria to each PSRO"¹⁶² and called upon PSROs to review them promptly "in order to adopt them or adapt them for their use."¹⁶³ The OPSR declared further that "*alternatively*" a PSRO could choose "to develop its own criteria and standards and/or select its own norms."¹⁶⁴ The *PSRO Manual* provides no mention of approval by the National Council as contemplated by the act. Although the portion of the *PSRO Manual* dealing specifically with the National Council has not yet been released,¹⁶⁵ it appears that the OPSR has concluded that it must rewrite the statute in order to satisfy the AMA.¹⁶⁶ It is noteworthy that the *PSRO Manual*,¹⁶⁷ OPSR's only authoritative statement of its interpretation of the law, has not been

160. PSRO MANUAL, *supra* note 11, at § 702.2.

161. 42 U.S.C. § 1320c-5(c) (1).

162. PSRO MANUAL, *supra* note 11, at § 709.11.

163. *Id.* at § 709.12.

164. *Id.*

165. The PSRO MANUAL's table of contents lists "National Professional Standards Review Council" as Chapter XVI, "[t]o be issued subsequently."

166. OPSR has definitely altered its position on the National Council's standard-setting role. While the PSRO MANUAL, issued March 15, 1974, clearly contemplates an advisory role for the Council (*see* notes 160-64 and accompanying text *supra*), just three months earlier OPSR had told physicians to expect a more powerful Council: "The National Professional Standards Review Council *must* approve norms used by a PSRO that are significantly different from professionally developed regional norms." PSRO: QUESTIONS AND ANSWERS, *supra* note 121 (emphasis supplied). This change in orientation need not, of course, be characterized as a caving-in to pressure from organized medicine, but may be seen as a tactical soft-pedaling of ultimate national authority as a means of gaining the necessary level of acceptance for the PSRO program. The Medicare program similarly began with significant concessions to provider interests, but tough national standards on cost containment ultimately emerged. *See generally* H. SOMERS & A. SOMERS, MEDICARE AND THE HOSPITALS; ISSUES AND PROSPECTS, ch. 7-8 (The Brookings Institution, 1967); J. FEDER, THE CHARACTER AND IMPLICATIONS OF SSA'S ADMINISTRATION OF MEDICARE (Policy Center, Inc., 1975) (forthcoming).

Two contrasting statements made by OPSR spokesmen since the PSRO MANUAL show the different emphasis which may be placed on the National Council's authority: OPSR Director Simmons flatly promised Indiana doctors,

The local PSRO decides what standards it will practice under. No one else has the authority to set those standards—no State organization and, certainly, not the Federal Government. That authority is reserved to the locality.

Simmons Speech, *supra* note 122. On the other hand, PSRO's Dr. James Roberts, interviewed by AM. MED. NEWS, waffled:

I don't think the council will get involved in the initial phase of a PSRO's criteria development. The council does have authority under the law to make certain judgments about differences in criteria from one PSRO region to another. But the council's main concern right now is to see that this program gets under way.

AM. MED. NEWS, May 20, 1974, at 21.

167. HEW has issued only the first seven of 17 proposed chapters of the PSRO MANUAL, which nevertheless codifies much of the practice of prototype PSROs and represents HEW's approach to PSROs after a year and a half of work. It is the best available guide to PSROs, but it is not definitive; HEW characterizes the PSRO MANUAL in its foreword as "interim guidelines" to "be issued as proposed regulations" only after "experience is gained."

promulgated as regulations, thus avoiding the Administrative Procedure Act's requirements for rule making.¹⁶⁸

The reasons why the PSRO statute—and, even more forcefully, OPSR's interpretation of it—emphasizes local development of norms, criteria, and standards are not altogether clear. The easiest explanation is the political need to satisfy the medical community's fears regarding the extent of change to be wrought by the PSRO program. Major differences in the modes of diagnosis and treatment exist among areas without a readily identifiable explanation,¹⁶⁹ and it is frequently unclear which standard is the most appropriate. In the light of these variations in practice, national control could be seen as producing inflexibility, denying appropriate recognition both to different schools of thought and to the "art" of medical practice, and discouraging experimentation with a variety of approaches to disease conditions. Other reasons for relying on local standards may be that different levels of wealth have produced different standards of practice in various places and that resource availability, such as travel time to hospitals, availability of sophisticated equipment, and opportunities for consultation and referral, vary greatly from place to place.

Against these arguments for localism, there are strong arguments for effective federal oversight. Medically, there is a need to discover and root out backward practices and to improve the spread of knowledge. The NPSRC is in an excellent position to review comparative performance, spotting weaknesses and strengths as revealed by both outcome and utilization data, and to implement the findings from controlled clinical trials of established and other therapies.¹⁷⁰ It is possible, of course, that the advisory function visualized for the NPSRC by OPSR will in fact prove sufficient to allow medically appropriate changes in local practice to be rather swiftly implemented.

Perhaps more important, the NPSRC's national perspective and reliance on impersonal statistics would allow it to develop a cost consciousness which local PSROs cannot be expected to develop on their own. From the PSRO's local perspective, any cost savings which it might effectuate by stricter utilization controls would not accrue to it or even to the residents of its area but would instead be reflected in a relatively small saving in the total federal health budget. PSROs will thus face only a variety of "yes/no" decisions, that is, whether to allow local patients to enjoy particular benefits at federal expense or to save money which, if devoted to meeting health needs at all, would in no identifiable way benefit local doctors or patients. In these circumstances, only the NPSRC, of all the various decision makers, might be capable of achieving large savings in resources at the sacrifice of only small, or merely arguable, gains in quality.

168. 5 U.S.C. § 553 (1971).

169. For example, a recent study, designed to test whether physicians did certain questionable things out of fear of a malpractice suit, discovered by comparing practices in North Carolina and California that practices did indeed differ greatly but that the difference could not be explained by legal fears alone. *Malpractice Project*, *supra* note 86, at 958-59.

170. See text accompanying note 75 *supra*.

Although the NPSRC would have no direct authority to reallocate the dollars thus saved, it would be in a good position within HEW to lobby for reallocations of resources which would further health objectives in other ways. To this small extent, it would face “either/or” choices—that is, opportunity costs—rather than the loaded choice between meeting and not meeting a specific health need.

Delegation

Each PSRO is required to “utilize the services of, and accept the findings of, the review committees” of institutions in the area, if such institutions have demonstrated, to the PSRO’s satisfaction, “their capacity effectively and in timely fashion” to carry out such review.¹⁷¹ This means that most hospitals will carry out their own utilization review, much as they did under the original Medicare legislation. Recalling that the poor experience under that program was noted in the legislative history of the PSRO amendments,¹⁷² one might well inquire as to the basis for expecting any improvement. The individuals carrying out delegated review will necessarily be those associated with the institutions affected, even though one purpose of the PSRO amendments appeared to be the removal of responsibility to a higher level, where physician-reviewers’ personal involvement would weigh less substantially against true objectivity.¹⁷³ Unlike the previous practice, however, the norms to be applied will be developed by the PSRO itself and will reflect the practice in the entire area rather than in the individual institution.¹⁷⁴ Moreover, PSROs are charged with monitoring each institution’s performance of delegated review to make sure that it is meeting its responsibility.¹⁷⁵

On the negative side, however, utilization review by each institution brings the decision somewhat closer to the level of patient care and thereby increases the inhibition against making decisions which, in the view of physicians, sacrifice any element of quality. Moreover, any link between physician reviewers and the institutions by staff privileges is also likely to reduce willingness to restrict utilization. Finally, the quality imperative and deference to fellow professionals may well increase willingness to grant exceptions from standards and to tolerate a certain degree of fudging in medical records to strengthen the case for federal payment.

171. 42 U.S.C. § 1320c-4(e) (1) (Supp. II, 1972).

172. See notes 111 and 112 and accompanying text *supra*.

173. The statute provides that

such [PSRO reviewer] physicians ordinarily should not be responsible for, but may participate in the review of care and services provided in any hospital in which such physicians have active staff privileges.

42 U.S.C. § 1320c-4(a) (5) (Supp. II, 1972). Review by delegatee hospitals or organizations is expressly exempted from this requirement. See also PSRO MANUAL, *supra* note 11, at § 520.08(d).

174. PSRO MANUAL, *supra* note 11, at § 720.01. The PSRO MANUAL provides for an exception to this in the case of hospitals which have already implemented a review system and established standards before the area’s PSRO standards have been issued. *Id.* at § 709.15 (note). Even after the PSRO is operating, hospitals may receive permission to utilize their own standards rather than the PSRO’s. *Id.* at § 709.42.

175. *Id.* at § 720.01.

Decision Points

The PSRO's confrontations with quality/cost trade-offs will occur at a number of points, and it is possible to speculate about how the context of particular decisions will affect the impact of the quality imperative. For example, it is difficult to imagine a professional group like a PSRO applying sanctions¹⁷⁶ against a physician who could plausibly maintain that he had acted in good faith and in the best interests of his patients. On the other hand, a PSRO might be able through its educational endeavors to reduce hospital stays for certain classes of patients even though a significant number of doctors believed added hospitalization was medically necessary.

Establishment and Application of Norms, Standards and Criteria

In its norms, standards and criteria for inpatient care and ancillary services, the PSRO will establish a range of acceptable practice.¹⁷⁷ Providers delivering a level of care below a PSRO range will probably increase the amount of care given¹⁷⁸ so as to avoid criticism and the

176. The act provides PSROs with two basic sanctions against noncomplying providers. A PSRO can disapprove specific services and thereby deny federal payment for them. 42 U.S.C. § 1320c-7 (Supp. II, 1972). A PSRO can also recommend to the Secretary of HEW (*id.* § 1320c-6) that a provider be disciplined for violating a duty under the act. *Id.* § 1320c-9(a)(1). Upon finding (a) that the provider has failed in a substantial number of cases substantially to comply with his statutory obligations, or (b) that he grossly and flagrantly violated any obligation in one or more instances, the Secretary can either (1) exclude or suspend the provider from eligibility to provide health services on a federally reimbursable basis, or (2) require that the provider pay back to the Government the excess charges (not to exceed \$5000). *Id.* at §§ 1320c-9(b)(1), (3). The criminal sanctions in the first version of the PSRO legislation introduced by Senator Bennett in 1970 were eliminated from later versions. Compare Social Security Amendments of 1970, Amendment No. 851 to H.R. 17550, § 1160, in 116 CONG. REC. 29603, 29607 (1970), with Social Security Amendments of 1971, Amendment No. 823 to H.R.1, § 1160, 118 CONG. REC. 1017, 1019 (1972).

Educational activities, not sanctions, are the cornerstone of PSRO efforts to effectuate compliance with regional norms. OPSR, echoing the Senate Finance Committee Report, has repeatedly emphasized that sanctions will be imposed only if "voluntary and educational efforts" fail to yield compliance. See, e.g., PSRO MANUAL, *supra* note 11, at § 110.20; S. REP. NO. 1230, *supra* note 80, at 266. In the section on sanctions, the Act imposes on PSROs the duty "to use such authority or influence it may possess as a professional organization" to assure compliance. 42 U.S.C. § 1320c-9(c) (Supp. II, 1972). Moreover, to promote acceptance of their review functions, PSROs are required to involve practitioners in the operations of the PSRO and to publicize its activities. *Id.* at § 1320c-4(d).

For a discussion of possible HEW sanctions against PSROs themselves, see note 151 *supra*.

177. 42 U.S.C. § 1320c-5(b)(1) (Supp. II, 1972). See also PSRO MANUAL, *supra* note 11, at § 709.

178. Utilization review as now done by prototype PSROs and contemplated by OPSR's PSRO MANUAL deals only with the high end of the range, setting maximum lengths of stay qualifying for federal financing. See Frederick, *supra* note 136; PSRO MANUAL, *supra* note 11, at §§ 705-705.26. However, the very concept of a "range" implies a lower limit as well, and it is clear that PSROs will ultimately turn to enforcing lower limits so as to improve quality by eliminating "under-utilization." See, e.g., 118 CONG. REC. 1018-19 (1972) (remarks of Senator Bennett); text accompanying note 124 *supra*.

increased hazard of a malpractice suit.¹⁷⁹ Although the top of the range will surely curtail some overutilization, the PSRO's procedures will permit extension of stay by physician recertification and continued stay review¹⁸⁰ and will also allow the provider or the patient to seek specific relief from disapproval of care in an individual case.¹⁸¹ These procedures result in posing the quality/cost issue in the starkest "yes/no" terms, that is, with an identified patient seeking care and a specific professional opinion that a need for such care exists. To predict the overall impact of standards applied in such circumstances is impossible, since it depends to such a large degree on the effect of making the doctor face a personal cost, an encounter with the bureaucracy, to obtain further coverage for his patient. But costs could be cut significantly if current overutilization reflects not so much doctors' convictions as to their patients' needs as their inertia in ordering discharges or the practice of "defensive medicine."¹⁸² By the same token, however, inertia would continue to operate within the ranges established.

In establishing norms, standards and criteria, the PSRO will view cost, if at all,¹⁸³ in only the most abstract terms while perceiving quality more immediately. Since the PSRO has no power to accumulate or reallocate any savings it achieves, it has no incentive to weight cost considerations heavily. The standard-setting decision will thus be largely a "yes/no," or "micro," proposition and not an "either/or" decision focusing in "macro" terms on alternative uses of resources. The issue would be whether most of the patients staying the extra day or getting the extra test are benefited—that is, "need" the added care. Although the issue is not presented with respect to identifiable patients, doctors will think of it in terms of their past and future patients and will be reluctant to deny the latter what they deem to have been needed care in other circumstances. The professional quality imperative will thus assure that the standards will be liberal ones, the more so as extensions or exceptions in specific cases are made difficult to obtain. Dr. Edwards' statement that PSROs can be a "vehicle for change whereby

179. The PSRO law does not on its face attempt to enforce PSRO norms by building them into malpractice law. Nonetheless, given the likely prestige of professionally developed and federally mandated norms, they are likely to influence malpractice standards. Further, the statute's attempt to immunize complying physicians from malpractice liability, albeit not clearly, may lead courts to imply negligence from noncompliance. 42 U.S.C. § 1320c-16(c) (Supp. II, 1972), discussed in Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822, 838-42 (1974) [hereinafter cited as *Geo. Wash. Note*]; Comment, *PSRO: Malpractice Liability and the Impact of the Civil Immunity Clause*, 62 GEO. L.J. 1499 (1974).

180. 42 U.S.C. § 1320c-5(d) (Supp. II, 1972); PSRO MANUAL, *supra* note 11, at §§ 705.21-705.27.

181. 42 U.S.C. § 1320c-8 provides for hearings on and appeals of PSRO denial of payment.

182. *See* note 86 *supra*. Because compliance with PSRO standards by providers immunizes them from malpractice lawsuits, there will be a reduced incentive for providers to prescribe care primarily to protect themselves from possible liability. *See* note 179 *supra*.

183. The PSRO MANUAL requires only that PSROs consider "typical patterns of practice" in their areas and expert professional opinion in setting standards. PSRO MANUAL, *supra* note 11, at § 709. There is no mention of the cost of compliance as a factor to be weighed.

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the best and most effective care becomes the standard of care"¹⁸⁴ suggests the direction which PSROs are most likely to take in setting standards.

*Prior Authorization*¹⁸⁵

The PSRO is given the authority to determine, in advance, the necessity and the appropriateness of elective hospital admissions and of "extended or costly courses of treatment"¹⁸⁶ when such treatment is "provided by or in institutions."¹⁸⁷ It is noteworthy that the PSRO is merely authorized, not required, to engage in prior authorization of hospitalization and treatment, and it is not clear whether PSROs will elect to do so even though they are required to declare, in accordance with regulations, "the types and kinds of cases . . . with respect to which" they will exercise such authority.¹⁸⁸ It would seem permissible for HEW's regulations to make prior authorization mandatory in some cases rather than discretionary.¹⁸⁹

Prior authorization of payment for hospitalization or treatment presents difficult "yes/no" decisions. In the case of an application for hospital admission, the reviewer would have only a medical record and the admitting doctor's recommendation. Although under these circumstances disapprovals would probably be rare, the necessity for affirmatively justifying an admission might discourage doctors from proposing admission except where clearly indicated.¹⁹⁰ Physicians might come to anticipate lax enforcement, however, and might find ways of circumventing the screening process by recasting diagnoses—for example, recording "suspected pneumonia" instead of "bronchitis"—or stretching other truths concerning the

184. Edwards Speech, *supra* note 127.

185. "Prior authorization" describes utilization review before hospitalization. It corresponds with the PSRO statute's "advance" determination of necessity, appropriateness, and economy, 42 U.S.C. § 1320c-4(a)(2) (Supp. II, 1972), and with the PSRO MANUAL's "Pre-admission Certification of Elective Admissions," PSRO MANUAL, *supra* note 11, at § 705.14(b). The PSRO MANUAL defines the following additional types of review of individual hospitalizations: (1) "Concurrent Admission Certification" within "the first working day following admission" (*id.* at §§ 705.13, .14(a)); (2) "Emergency Admission Certification" (*id.* at § 705.15); and (3) "Continued Stay Review" of longer than average inpatient stays (*id.* at § 705.2). A final review, "Retrospective Individual Claims Review," is not to be used unless other reviews "have not been performed effectively." *Id.* at § 707.

Other writers use other nomenclatures. See, e.g., Stuart & Stockton, *supra* note 85, at 344-45 (describing "antecedent," "in-process," and "ex post facto" controls).

186. 42 U.S.C. § 1320c-4(a)(2) (Supp. II, 1972).

187. *Id.* § 1320c-4(g). The initial limitation to review of institutional care may be ended with HEW permission.

188. 42 U.S.C. § 1320c-4(a)(3) (Supp. II, 1972).

189. Although mandatory prior authorization for some cases would be consistent with the statute, the PSRO MANUAL, *supra* note 11, §§ 705.13, 705.14(b), now allows each PSRO total discretion as to whether and when to perform preadmission review. Section 705.13 does seem incidentally to require one form of "prior authorization": "For elective surgery, certification should be confirmed before surgery is performed."

190. One PSRO-prototype physician reviewer notes:

Doctors caught on. They learned they were under surveillance and they soon came to know what we would allow. We keep them on their mettle. Sometimes I wonder what my purpose is, I say yes so often, no so infrequently. But I know we're having an impact, that just by our presence doctors upgrade their performance.

Frederick, *supra* note 136, at 56.

patient's complications or therapeutic alternatives. The prospects for effective preadmission review thus seem seriously compromised by the "micro" character of the decision and the reviewing physician's unwillingness to second-guess a colleague on the basis of a bare record.¹⁹¹

Review of hospitalization immediately after admission¹⁹² seems equally unlikely to result in cost savings, however, except in cases where egregious abuses have occurred. A decision requiring immediate discharge of an already admitted patient may be even more difficult to make than a decision not to admit him in the first place. On the other hand, some impact on admissions might occur by virtue of the review process itself, discouraging such things as hospitalization solely for the doctor's or the family's convenience.

Where prior authorization of hospitalization or treatment is denied by the PSRO or where coverage of a continued stay is refused following admission or after some designated interval, the provider and the patient are both to be advised of the decision.¹⁹³ This allows them jointly to decide whether to proceed with the treatment, either in the hope of a reversal of the decision on appeal or on a private-payment basis.¹⁹⁴ In view of the opportunity to proceed at the patient's own expense, the PSRO's decision will not necessarily be determinative of whether the proposed care or treatment is in fact given. In light of this circumstance, perhaps the PSRO could be persuaded to perceive its role as rationing only public financing, not health care itself, with the result that it could be much more aggressive in its forays into the quality/cost no man's land.

Obviously, it would be extremely difficult to convince PSRO doctors to view their decisions on prior authorization as governing only the source of payment, since the low income of most Medicare and all Medicaid beneficiaries makes private payment an unrealistic option. Nevertheless, this view, which must be adopted if the impact of the quality imperative is to be minimized, is the one which Congress expected PSROs to take. From Congress' point of view, the Medicare and Medicaid programs, while guaranteeing "medically necessary" care, do not, or should not, represent a federal financial commitment which is coextensive with doctors' most

191. Professional opposition to prior authorization of hospital admission was demonstrated following HEW's publication of proposed regulations to require it. Proposed HEW Regs. 45 C.F.R. § 250.20(a)(4), 39 Fed. Reg. 1499 (Jan. 9, 1974). HEW retracted its proposal under AMA pressure. *HEW Yields to Heavy Provider Opposition and Drops Mandatory Hospital Pre-Certification*, PSRO LETTER 1 (No. 13, Feb. 15, 1974).

192. The AMA not only opposes preadmission review, see note 191 *supra*, but also at least some forms of postadmission review. It recently sued to invalidate HEW's regulations providing for PSRO-like hospital-based utilization review after admission, 20 C.F.R. §§ 405.1035, 405.1137, 39 Fed. Reg. 41604 (1974), because decisions would have to be made within 24 hours and could be made by nonphysicians and physicians who had not seen the affected patients. *American Med. Ass'n v. Weinberger*, Civ. No. 75-C-560 (N.D. Ill., decided May 27, 1975), *aff'd*, No. 75-1547, 7th Cir., July 22, 1975. See AM. MED. NEWS, Feb. 24, 1975, at 1 (article); *id.* at 4 (editorial).

193. 42 U.S.C. § 1320c-7 (Supp. II, 1972); see also PSRO MANUAL, *supra* note 11, at §§ 705.13, 705.24.

194. See Geo. Wash. Note, *supra* note 179, at 830-32.

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expansive conceptions of need.¹⁹⁵ Thus, a PSRO's adverse ruling on a question of coverage should mean, not necessarily that the doctor's recommendation was medically unsound or unreasonable or was not in the

195. This view would be somewhat easier to accept under a national health insurance program covering large numbers for whom private payment is in fact a realistic option. Because the PSRO program is initially confined to reviewing care under Medicare and Medicaid, however, there is a lesser likelihood that clear distinctions will be drawn between care which is appropriately government-financed and that which should be purchased privately if at all. Nevertheless, under Medicare, physicians are paid only "usual and customary" fees, and 53 percent of all physicians charge their patients more (*i.e.*, do not "accept assignment"). Cooper, Worthington, & Piro, *supra* note 17, at 10. Similarly, recent proposed regulations would limit Medicare and Medicaid payments for certain drugs to the cost of generic equivalents, at least suggesting that providing "average" rather than highest-quality medical care is the object of the federal programs. 39 Fed. Reg. 40,302 (1974).

In *Association of Am. Physicians & Surgeons (AAPS) v. Weinberger*, Civil No. 73-C-1653 (N.D. Ill., decided May 8, 1975), upholding the constitutionality of the PSRO law, the three-judge court recognized the distinction, emphasized here, between (1) a mechanism merely limiting government's financing obligations, and (2) an outright prohibition against care of a particular type, as in the abortion cases, *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973). This distinction is also pertinent to the AMA's current challenge to HEW's utilization review regulations. See note 192 *supra*. These cases deserve further comment.

Although the AAPS and the AMA both assert an invasion of physicians' rights, the physicians' only substantial claims (*i.e.*, those not amounting merely to a claim of economic substantive due process) derive from the rights of patients. They are of two types: First, the physician organizations claim intrusions on the doctor-patient relationship, relying on the Supreme Court's recognition of certain areas where government must recognize the supremacy of private decisions. Thus, in the abortion cases, *supra*, the Court held that government cannot intrude on the decision to terminate an early pregnancy. Nevertheless, the Court has allowed government substantial freedom to economize by narrowing the coverage of an insurance program so long as the lines drawn are rational and nondiscriminatory and do not interfere unduly with protected rights. Compare *Geduldig v. Aiello*, 417 U.S. 484 (1974), with *Memorial Hosp. v. Maricopa County*, 415 U.S. 250 (1974). Cf. *Cleveland Bd. of Educ. v. LaFleur*, 414 U.S. 632 (1974). Although state restrictions on Medicaid payment for nontherapeutic abortions raise substantial constitutional questions, *Roe v. Ferguson*, 515 F.2d 279 (6th Cir. 1975), a finding of their unconstitutionality would not imply a broad right to noninterference in medical care to be provided at public expense. Not only do restrictions on abortions not save money (delivering babies costs more), but they are subject to strict judicial scrutiny because of their intrusion on private choices. Utilization review raises no such sensitive issues.

The AAPS and AMA claims also amount to an assertion of a broad "right to health care," a concept hitherto advanced primarily by consumer groups. Recognition of a constitutional right to receive at government expense any care prescribed by a physician in good faith would require a considerable extension of such "right-to" cases as *Griffin v. Illinois*, 351 U.S. 12 (1956), and *Boddie v. Connecticut*, 401 U.S. 371 (1971), and the Supreme Court has refused to extend such holdings to provide protection against social or economic deprivations. *E.g.*, *Lindsey v. Normet*, 405 U.S. 56 (1972); *Dandridge v. Williams*, 397 U.S. 471 (1970). Also, in *San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1, 20-25 (1973), Justice Powell carefully distinguished total deprivation of services available only from government (*e.g.*, denial to indigents of access to the courts, as involved in *Griffin* and *Boddie*) from comparative inequity (variations among districts in per-pupil public school expenditures). But, even if there were a constitutional guarantee of access to such basic necessities as health care, its fulfillment would require no more than some basic level of protection. See generally Michelman, *On Protecting the Poor Through the Fourteenth Amendment*, 83 HARV. L. REV. 7 (1969). The lines sought to be drawn by utilization review do not threaten to deprive patients of all health care or such basic protection.

Following completion of this article, a preliminary injunction was issued in favor of the AMA. *American Med. Ass'n v. Weinberger*, Civil No. 75-C-560 (N.D. Ill., decided May 27, 1975), *aff'd*, No. 75-1457, 7th Cir., July 22, 1975. Judge Hoffman's ruling inadequately

patient's interest, but only that the need was not of sufficient priority to warrant a public outlay.¹⁹⁶ An adverse determination should be, in effect, a conclusion that a particular expenditure, which some persons with particular preferences or wealth could rationally choose to make, is nevertheless outweighed by other demands on society's resources. Adoption of such an approach by a PSRO would return many questionable purchasing decisions to private hands, the only place where ultimately valid benefit/cost comparisons can be made.¹⁹⁷

Although Congress saw PSROs primarily as a mechanism for defining the federal financial commitment, physicians nevertheless have insisted on viewing the PSRO in more radical terms—as the arbiter of care itself. However, while they are correct that much care which they recommend will not be provided without federal payment, the doctor's professional function is not usurped. What happens instead is that, in the case of certain procedures or treatments, which the PSRO is charged with identifying, a resource constraint is introduced (or reintroduced) into the management of each case—namely the patient's ability and willingness to pay for nonessential care. Although practically all other producers in the society must compete for the consumer's dollar against alternative uses for it, physicians expect the individual physician's production decisions automatically to trigger payment by a complaisant third party. By their radical interpretation and insistence on the quality imperative, physicians have kept the PSRO program on the defensive politically, thus guaranteeing that no more than the most tentative probes into the quality/cost no man's land will occur.

Because PSROs will be run by doctors having an interest in maintain-

recognizes the considerations advanced herein, though much of his heavy emphasis on the possibility of adverse health effects from utilization review appeared in his assessment of the "irreparable harm" necessary to justify a preliminary injunction. Nevertheless, in assessing plaintiffs' likelihood of success on the merits, he again attached decisive weight to the possibility of adverse health effects, declaring that, if the cost-control regulations prevented patients from obtaining needed hospitalization, they would thwart "the larger purpose of the Medicare and Medicaid programs, . . . the delivery of medical services to those otherwise unable to obtain them." *Id.* The opinion thus begs innumerable quality/cost questions and reflects the dominance of the quality imperative. Perhaps the ultimate decision on the merits will be more satisfying.

196. There are two distinct issues which PSROs seem likely to confuse. First, is the care unproductive or even counterproductive? An affirmative judgment by the PSRO reflects adversely on the doctor's professional competence, and it is this implied rebuke which, coupled with the widespread disagreement on the technical issues involved, makes PSROs so threatening to physicians. Second, should the federal government pay? Here, if the distinction is rigidly maintained, there is no possible reflection on the prescribing physician, unless he has failed to prepare his patient for the possibility that self payment will be required. The PSRO program would have had a better chance of successfully addressing quality/cost trade-offs if it had been portrayed as involving the second question primarily.

OPSR's emphasis on quality assurance, and the attempt to subsume cost control under that rubric (*see* text accompanying notes 121-29 *supra*), is the main source of the problem since it introduces the implication of fault on the part of the physician whose prescriptions are not honored by the PSRO. Under a standard giving greater weight to cost factors, a physician who practiced top-class medicine and who sought PSRO approval for additional medical procedures for his patients might often be turned down, but such a negative decision is clearly of a different character than a determination that the care is wasteful or counterproductive.

197. *See* text accompanying notes 41-42, 65-67 *supra* and 218-30 *infra*.

ing demand for medical services, they are unlikely to make much headway in distinguishing between truly essential care—that which is “medically necessary,” in the words of the statute—and merely desirable care which, because society regards it as falling in the quality/cost no man’s land, should be privately evaluated and purchased only by those who want it badly enough (and can afford) to pay. By definition, the medical benefit from this excluded care is not important enough to be covered by a public program in a society which cannot meet its citizens’ every need.¹⁹⁸

Retroactive Denial of Payment

The PSRO statute provides as one sanction for overutilization the denial of payment for the excess services rendered.¹⁹⁹ The emphasis in the program is, however, on antecedent and concurrent review, and HEW’s *PSRO Manual* states that “[r]etrospective review of individual hospital claims . . . will be used only when required forms of review have not been implemented or, where implemented, have not been performed effectively.”²⁰⁰ This minimization of the importance of retrospective review and its attendant threat of retroactive denial of payment to the provider²⁰¹ may be a tactical mistake, however, if there is serious interest in promoting cost-conscious decisions.

Providers’ dislike for retroactive denial is based on their experience with Medicare and Medicaid review, where decisions were highly unpredictable. For this reason, relief from the threat of retroactive denial was an important objective in the Social Security Act Amendments of 1972²⁰² and seems logically to dictate a preference for prior authorization and concurrent review. Nevertheless, fair and effective retrospective review, such as a PSRO could be expected to provide in the interest of providers, would establish a much better climate for facing quality/cost trade-offs.

198. The argument for having PSROs ration Medicare and Medicaid money (with the result that certain procedures would be realistically available only to the more affluent) might be stated as follows:

Some people do get more of certain services, but after all the services don’t—on the average—yield high benefits (relative to their costs). Therefore, though the rich may ‘waste’ their money in purchasing the services, we shall not invest government funds to increase the availability of the services. The poor should not be distressed—they are not being denied things of considerable value.

Fein, *Access and Equity*, *supra* note 13, at 26. However, Professor Fein presents this statement as a hypothetical argument, which he vigorously rejects, for “maintaining the status quo,” (*Id.*), which is of course not what is proposed here. Although recognizing the distinction between “basics” and “extras” (*Id.* at 29), Professor Fein suggests that the society might choose to ignore it and instead to eliminate income as a rationing device altogether. *Id.* at 29-31. The high costs of such a policy must be recognized, and consideration should be given to the alternative of improving distributive equity by allowing federal beneficiaries to choose whether to spend “extra” health dollars on health or something else.

199. 42 U.S.C. § 1320c-7(a) (Supp. II, 1972). *See* note 176 *supra*.

200. PSRO MANUAL, *supra* note 11, at § 707(b).

201. The PSRO MANUAL promises, “When a PSRO is carrying out its review responsibilities there will be no retroactive review potentially leading to the denial of payment.” *Id.* at § 701. The Senate Finance Committee, on the other hand, although clearly sympathizing with doctors potentially denied payment unfairly after the fact, specifically contemplated some forms of retrospective review and denial of payment. S. REP. No. 1230, *supra* note 80, at 263.

202. *See* notes 80 *supra* and 203 *infra*.

Under a system of retrospective claims review, PSRO decisions would be made in a context where only the provider's right to payment, not the patient's right to treatment (already given), was at stake. The focus on dollars rather than care itself would reduce the PSRO's temptation to give the patient and the physician the benefit of the doubt and would mean that the only treatment perceived to be in issue was that of future statistical rather than presently identifiable patients. In this setting, PSRO standards might more easily be seen only as limiting the scope of federal health programs and assuring a minimum quality of service therein and not as defining the proper practice of medicine per se. Decisions reached by the PSRO under this view should normally not be perceived as implying criticism of the prescribing physician, since it might well be appropriate for the treatment or procedure to be provided to the patient on a self-pay basis. Further, providers should normally not, in fairness, be denied payment retroactively in cases where the PSRO decision was one of "first impression" rather than a reiteration of a previously established standard.²⁰³ If provider interests were protected in this manner, a PSRO engaged in retrospective review might be capable of successfully balancing quality and cost considerations.

The possibility of retroactive denial of payment for specific admissions or courses of treatment would lead providers in turn to be more careful in their utilization decisions. Perhaps surprisingly, such decisions, though made privately and not by regulatory authority, would reflect a degree of cost consciousness not otherwise obtainable. The hospital, necessarily anticipating the results of a subsequent review of its right to payment, would limit admissions wherever chances of receiving payment were not reasonably good. On the other hand, desiring to satisfy doctors and facing a need for revenue as well as the possibility of a malpractice suit if admission were denied arbitrarily, the hospital would have strong incentives to admit whenever indicated under the prevailing standards. The hospital would also take pains to make a record which would sustain it in the subsequent review process and would take a much greater interest in the effectiveness of the review procedure than it would if it were simply carrying out a mandate to conduct delegated utilization review under federal law.

The argument that retrospective review is more effective than contemporaneous review seems subtle but is not. The one-step decision faced by the PSRO in determining whether particular patients should be admitted to the hospital at federal expense is made in a context permitting few "no" decisions if any sacrifice of a benefit to the patient is entailed. In the two-step retrospective review process, the PSRO faces only the question of whether a provider should be paid under a federal financing program for care already rendered, and a certain degree of cost consciousness could be given effect. The provider would in turn be driven to anticipate the

203. In light of considerations such as this, the Social Security Act protects providers acting in good faith against retroactive denials of payment by Medicare intermediaries. See note 80 *supra*. It seems probable that physician-dominated PSROs will take a cue from Congress's treatment of this analogous situation.

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possibility that such care as is given may ultimately be at his (or its) own expense.²⁰⁴ Presumably, at that point, the patient would frequently be asked to decide whether to risk having to pay for the treatment himself if the PSRO should subsequently determine that the federal program should not pay for it.²⁰⁵ In this way, retrospective review could place many of the decisions concerning care in the quality/cost no man's land back where they are most likely to be appropriately made, in the hands of the individuals whose prospects and preferences are immediately concerned.

PSROS IN POLICY PERSPECTIVE

Resource Allocation and Health Policy

There is a great deal of evidence of inappropriate spending in the health services industry,²⁰⁶ but it is impossible to measure either its amount or, a fortiori, the net loss in consumer welfare which results from investing resources in marginally productive health services instead of in other things which people would prefer to have. The concern about allocative inefficiency is hardly a quibble, however, since very large amounts may be involved. If, for example, a 20 percent saving²⁰⁷ could be effectuated in personal

204. Obviously, the uncertainty necessarily involved for both provider and patient would produce some pressure, particularly from hospitals, for a system using prior authorization exclusively. These pressures would have to be resisted if the purpose of helping the PSRO to avoid "yes/no" decisions is not to be defeated, but both provider and patient should be protected against financial loss in cases of first impression. Analogies to the legal system and familiar administrative processes may prove instructive in allowing PSRO policies to evolve through a blend of "legislative" rule making and case-by-case adjudication. An "advisory opinion" procedure might serve to protect providers and patients in cases of uncertainty, but decisions reached under such circumstances should be subsequently reviewed before prospective policy is finally established.

205. Precaution would have to be taken to prevent the hospital (or physician) from exacting such a commitment to pay from all Medicare beneficiaries to protect itself from any disallowances that might subsequently occur. See Geo. Wash. Note, *supra* note 179, at 833-37 & n.65. This might be done by regulations which permitted patients to waive their rights to indemnity only when informed by personal letter that the hospital had, in good faith, preliminarily determined that the case did not conform to established PSRO standards. See note 80 *supra*.

206. The misallocation of resources takes the form of too many extra services and too-high unit costs, both supported by only weak claims of added quality. See text accompanying notes 35-45 *supra*. Although it may not be inappropriate to spend as much as 7.7 percent of GNP on health (see text accompanying note 17 *supra*) in view of the many currently unmet needs, some current objects of health spending do seem not to be worth their cost.

207. Surprisingly, there is indirect legislative support for the hypothesis that 20 percent of health care spending, at least for the aged, could be safely dispensed with. The 1972 Medicare amendments allow an HMO prepaid under Medicare to retain as "profit" some of the savings which it may achieve by outperforming the rest of the system, but only up to 20 percent of the actuarially predicted cost of serving the same population through other providers in the area. 42 U.S.C. § 1395I(2) (Supp. II, 1972). The theory of this "profit" limitation was that cost savings up to 20 percent are reasonably safe and do not impair essential quality but that federal beneficiaries must be protected by eliminating HMOs' incentive to skimp beyond that point. See S. REP. No. 1230, *supra* note 80, at 234-35.

A recent study suggests that in selecting among various types of national health insurance plans, ranging from a high-deductible plan to a free, full-coverage plan, "American society . . . will potentially be determining whether 5, 8, or 11 percent of its resources will be devoted to medical care." Newhouse, Phelps, & Schwartz, *supra* note 34, at 1354. Compare text accompanying note 17 *supra*. This may make the hypothesized saving of 20 percent of

health expenditures, it would mean the reallocation of more than \$16 billion, well over one percent of GNP, from health care to other uses,²⁰⁸ a saving of about \$300 per year for each American family of four. The losses from reduced quality in health care would not, by hypothesis, be nearly so large as this benefit, and society could rationally agree with the comic-strip urchin who, when told that though he was not very rich he still had his health, replied, "Well, I'd be willing to swap a little health for my own pony."²⁰⁹ The present state of the economy reminds us that Americans have many unsatisfied, nonequestrian wants.²¹⁰ Many of these are in no sense frivolous, and some of them even have a larger bearing on health than do marginal medical services.

Although the high level of health spending is currently receiving attention from policy makers, allocative inefficiency as such has not been identified as a matter for attention. Indeed, Congress and the executive branch would probably be quite content if they could bring health care cost increases into line with inflation rates generally, even if the spending level attained was highly inefficient from an allocative standpoint.²¹¹ Nevertheless, concern over the limited accessibility of needed health services to substantial segments of the population has produced some awareness that improving allocative efficiency could make available at least some of the capital and manpower resources required to meet currently unmet needs. The allocative issue has thus been brought to light in just about the only way it could be, by a forceful demonstration of some of the high opportunity costs of marginal health care. Policy makers have gradually come to perceive the cost of overutilization of health resources in terms of other, more attractive health-producing investments which might be made. By the same token, the potential cost of providing additional care to the really needy is more and more being counted, not exclusively in dollars which must be raised from hard-pressed taxpayers, but in relatively unproductive services which could readily be forgone.

personal health expenditures, 1.3 percent of GNP, seem conservative enough for present purposes. *But see* note 45 and accompanying text *supra*.

208. Personal health care expenditures were \$80 billion in fiscal 1973. Cooper, Worthington, & Piro, *supra* note 17, at 13.

209. Blake, *Tiger* (King Features Syndicate, Inc. 1974) (cartoon).

210. In a deep recession, federal or private plans which continue to supply the means to consume health services have even more troublesome misallocative effects. Taxes or payroll deductions for health plan premiums are the same in bad times as good, leaving hard-pressed contributors to skimp on other needs. Plan beneficiaries, on the other hand, are limited to "in kind" benefits and thereby prevented from forgoing marginal health care in favor of more food or fuel or other higher priority items. The recent concern over the loss of insurance coverage by the unemployed points up the problem as one of feast or famine.

211. Static conditions such as chronic inefficiency, once embedded in the economy and in government's and individuals' budgets, are no longer political issues, but such inefficiencies continue as a kind of hidden tax earmarked for the preservation of an overexpanded sector of the economy. *See, e.g.,* R. NOLL, REFORMING REGULATION chs. 3, 4 (1971); M. WEIDENBAUM, GOVERNMENT-MANDATED PRICE INCREASES (1975). On application of these observations to the health sector, *see* Noll, *The Consequences of Public Utility Regulation of Hospitals*, in CONTROLS ON HEALTH CARE 25 (Inst. of Med., Nat'l Acad. of Sciences 1975) [hereinafter cited as Noll Paper]; Havighurst, *Certificate of Need*, *supra* note 93, at 1188-94.

As attractive as it may be as a policy objective to reallocate health care resources from marginally productive to highly cost-effective uses, the mechanics of doing so on a large scale have not been worked out.²¹² The main sticking point remains the extraordinary difficulty of responsibly confronting quality/cost trade-offs. The true cost of failing to solve this problem is measured not by just the dollars being wasted but, perhaps more persuasively, by the lost opportunity to meet important health objectives.

Coping with Quality/Cost Trade-Offs

Even if health care is not so sacrosanct as to defy all spending restraints,²¹³ powerful symbolic values must nevertheless be respected in formulating public policy. The most highly charged problems are those of making needed care accessible to the poor and near poor²¹⁴ and of avoiding an absolute commitment to life-saving at all costs in the treatment of catastrophic disease.²¹⁵ Putting these special problems aside, however, there remain a very large number of low-level, marginal decisions which affect the consumption of health services and which, though influenced by the quality imperative, are nevertheless amenable to some control in recognition of quality/cost trade-offs. It is on these less controversial decisions that PSROs and other current cost-control efforts are primarily focused. It is possible to distinguish among various actual or possible decision-making mechanisms on the basis of their relative capacity to make due allowance for cost as well as quality considerations.

As earlier discussion suggests, the relevant questions in appraising a particular mechanism's capacity for responsibly addressing quality/cost

212. One obstacle is the presence of private insurance carriers, which allow savings to accrue only to their insured groups and not to beneficiaries of public programs. Some NHI proposals contemplate the disappearance of private insurance (*See, e.g.*, S. 3, 94th Cong., 1st Sess. (1975)), while others would preserve it but subject all care to PSRO oversight. A public takeover would permit savings from any reduced utilization to be transferred directly to meeting other needs without imposing an obvious new tax. Thus, a hidden tax on the middle class is potentially involved—reduced benefits without reduced contributions. *Cf.* the “community-rating” requirement imposed on certain HMOs by § 1301(b)(1)(C) of the Public Health Service Act, 42 U.S.C. § 300e(b)(1)(C) (Supp. III, 1973). It should also be noted that enlarging the insured group dilutes private incentives to control costs and improve quality since the benefits of such efforts are shared with others. Maintaining private group insurance allows employers, unions, and insurers to exert pressures in accordance with the groups' expectations. *See* notes 220 and 236 *infra*. A single comprehensive NHI program would put the entire cost-control responsibility on government and PSROs, although one such proposal (S.3, *supra*) contemplates use of the fixed-budget approach, both by HMOs and by the region's fee-for-service providers, to decentralize control.

213. It is not yet clear how far social policy should go in seeking to discourage health care expenditures occurring in the quality/cost no man's land. If health care has become a kind of secular religion—Victor Fuchs recently referred to it as “the new opiate of the people” (*see* Institute of Medicine, Nat'l Academy of Sciences, *Conference on Quality Assurance in Medical Care*, Nov. 6-7, 1974), much of the analysis herein may have missed the point. Perhaps spending which has doubtful net utility when judged by the specific medical results achieved nevertheless yields compensating benefits for the society as a whole. We may all, for example, sleep a little better in the knowledge that the government or Blue Cross will buy any sick person everything the attending doctor says may help. One may hope, however, that our society does not need large doses of unproductive health care as a kind of placebo to keep ourselves going.

214. *See* text accompanying notes 59-62 *supra*.

215. *See* notes 49-58 and accompanying text *supra*.

issues are of the following type: By whom are the decisions made and to what or whom is the decision maker responsive or accountable? Does the decision maker have any reason to be (or not to be) cost-conscious? How politically visible are the decisions reached? Is it politically possible to say "no" if a plausible claim of increased quality has been advanced? What positive benefit, if any, does the decision maker perceive from a "no" answer? Are issues presented more in "either/or" or "yes/no" terms? Are the affected patients identified individuals or merely statistical future patients?

On many of these counts, regulatory approaches to the control of health care costs present great difficulties. Like earlier efforts at utilization review, implementation of the PSRO program of self-regulation by peers has already revealed the powerful impact of professional preferences and the quality imperative in altering congressional cost-control priorities. Capital investment regulation, though its impact is hard to evaluate, seems difficult to administer with great stringency, in part because of the regulators' inability to say "no" whenever a colorable claim of quality is advanced.²¹⁶ Finally, hospital rate regulation, which is only beginning to take hold in a number of places, is also unlikely to prevent outlays which can be plausibly defended on quality-of-care grounds.²¹⁷ Thus far, government has been content to impose only these relatively unthreatening regulatory restraints on the system's capacity to absorb resources, and it seems clear that such tinkering will fall well short of achieving optimal resource use. Since regulators will be evaluated primarily by their success in slowing down inflation rates in the health sector, any present inappropriate spending is not likely to be reduced through regulatory means. Moreover, in a regulatory environment, organized consumer pressure is likely to be opposed to stringency and to favor increased quantities and quality of care, especially where such care is at public expense. Provider interests would of course take similar positions.

Because the functioning of governmental and professional decision-making mechanisms is impaired, though in varying degrees, by the quality imperative and cost-escalating pressures from interest groups, there would be an important positive benefit—namely, a closer approach to optimality in the volume and quality of health services consumed—from strengthening the role of private decision making and individual consumer choice.²¹⁸ This can be done only by a fundamental departure from the health care system's current dependence on a largely fortuitous mix of private consumption decisions and collective financing. Whereas the current policy drift is in the direction of circumscribing private decisions by restricting the availability of resources and by ever more detailed regulatory specification of the

216. See notes 89-95 and accompanying text *supra*.

217. See Havighurst, *Certificate of Need*, *supra* note 93, at 1178-94; Noll Paper, *supra* note 211.

218. For a recent study proposing a greater role for consumer choice, see J. KRIZAY & A. WILSON, *THE PATIENT AS CONSUMER: HEALTH CARE FINANCING IN THE UNITED STATES* (1974). See also Starr, *supra* note 66.

nature and quality of services, an attractive alternative would be to restore consumer cost consciousness and reliance on individual choice in areas where net benefits are in question.²¹⁹ As long as measures are taken to make income discrepancies affect choices only where they can legitimately be regarded as primarily dependent on individuals' preferences,²²⁰ the consumer, acting wherever possible with professional advice and improved information, is more capable than other potential decision makers of realistically confronting the many difficult trade-offs among quality, economy, and other important values inherent in medical care.²²¹

Reintroduction of the cost factor into private decisions is not likely to be easy in the context of substantial public payment for care, since beneficiaries must be put in a position to gain personally from their economizing choices.²²² Nevertheless, important allocative improvements could be expected from expanding self-supporting consumers' opportunities and incentives to choose a provider and an insurance or prepayment plan (as well as certain marginally productive procedures) on the basis of cost as well as quality, convenience, and other factors.²²³ Greater freedom for HMOs to compete for the consumer's dollar would be one essential feature of such a choice-oriented system.²²⁴ Other possible measures

219. See note 88 *supra*.

220. Because preferences concerning health care vary widely (see notes 41 and 65-67 and accompanying text *supra*), rational individuals or households with identical incomes may choose to spend different amounts to obtain particular health benefits. Open-ended collective financing forces those who would prefer to spend their money on other things to subsidize those with a preference for consuming health care. Moreover, collective financing reduces individuals' incentive to stay as healthy as they can, while compelling those who do take care of themselves to take care of their less health-conscious neighbors as well. Although a substantial amount of public and private collective financing is inevitable to protect individuals against expenses which are catastrophic in relation to their income, there are good reasons to confine coverage of such financing to those things about which there is a broad consensus in the covered group that benefits are no less than costs. This insight suggests the desirability of collective financing mechanisms which cover smaller, more homogeneous groups. *But see* note 212 *supra*.

221. See note 41 *supra*.

222. One way this could be accomplished is by giving the federal beneficiary a voucher convertible to cash by the insurance or prepayment plan in which he chooses to enroll and permitting the plan to give rebates or pay dividends as a means of attracting enrollment. The predictable objection is that poor people would elect low-quality plans offering cash rebates, a choice which nevertheless should be respected up to the point where the public's interest in providing care in kind (see note 59 *supra*) would suffer. Although regulation might be used to ensure that voucher-accepting plans meet minimum standards, an alternative would be to limit the percentage of federal beneficiaries in any plan so that its acceptability would be established by the economizing judgments of self-supporting consumers. *Cf.* Havighurst, *Health Maintenance Organizations*, *supra* note 101, at 729-32. Other inducements to consumers to join more efficient or lower-quality plans include giving additional benefits for the same federal payment, but such additional benefits may be worth substantially less to the consumer than the cost of providing them. Another approach is to invite plans to establish lower deductibles and coinsurance rates, thus perhaps encouraging overutilization but holding out a visible cash saving.

223. Any changes in practice induced by increasing the cost consciousness of the majority of consumers could be extended by PSROs to care rendered under public programs. This insight goes counter to the trend toward giving PSRO jurisdiction over all care.

224. See generally HMOs: TOWARD A FAIR MARKET TEST, *supra* note 99; HEALTH MAINTENANCE STRATEGY, *supra* note 98; Havighurst, *Health Maintenance Organizations*, *supra* note 101.

include the imposition of appropriately tailored deductibles and coinsurance requirements²²⁵ and the use of cash indemnity payments to insureds instead of paying actual charges or reimbursing provider costs.²²⁶ It would also be desirable to facilitate and encourage a multiplicity of competing insurance plans featuring a variety of privately developed and administered cost controls, including coverage limitations and mechanisms similar to PSROs to exclude from coverage those items not likely to be worth their cost.²²⁷

If the health insurance market could be reconstituted to give consumers a range of appropriate choices, some cost-conscious consumers would prefer lower-priced plans which provide fewer and/or lower-quality services. If such plans were regulated to prevent fraud and to protect consumers against care which was clearly inadequate,²²⁸ it should not concern government that some citizens would elect not to pay the extra money needed for a "better" plan. Society's responsibilities to its less fortunate members would be met by subsidies toward the purchase of such basic care, and, once such subsidies were provided, the argument for buying more care for the poor—in the hope of eliminating "second-class" medicine and achieving true equality in this highly symbolic area—would seem hard to make without ignoring alternative uses of the additional resources which would be required.²²⁹ It is far from clear that the major deficiencies of ghetto medicine to date are a fair sample of what could be expected if ghetto dwellers were provided with both the means of choosing and a range of choice, including community-sponsored HMOs and neighborhood health centers as well as a variety of nonprofit and proprietary providers.

For the immediate future, HMOs are probably the most promising way of obtaining serious attention to the myriad quality/cost trade-offs in medical care. The opportunity to join an HMO rather than participating in a governmental or private third-party payment scheme could have economic as well as qualitative advantages if individual consumers could benefit themselves by economizing. If consumers' opportunities were not stifled by

225. See text accompanying notes 77-79 *supra*. Changing the tax treatment of health insurance premiums would reduce incentives to provide first-dollar coverage. See note 35 *supra*.

226. See Newhouse & Taylor, *How Shall We Pay for Hospital Care?*, PUB. INT., Spring, 1971, at 78.

227. On the problems of improving market functioning in this regard, see Testimony of C. Havighurst, *Hearings on Competition in the Health Services Market Before the Subcomm. on Antitrust and Monopoly of the Senate Comm. on the Judiciary*, 93d Cong., 2d Sess., pt. 2, at 1039-40, 1049-51, 1074-77 (1974) [hereinafter cited as Havighurst Testimony].

228. There is of course a risk that regulation, reflecting the quality imperative, would set standards which were inappropriately high. For recommendations which reflect a balance between quality and cost considerations, see HMOs: TOWARD A FAIR MARKET TEST, *supra* note 99, at 51-61.

229. See notes 59 and 222 *supra*; Blumstein & Zubkoff, *supra* note 23, at 407-12. See also Feldstein, *The Feldstein Plan* in NATIONAL HEALTH INSURANCE: CONFERENCE PROCEEDINGS 223-24 (R. Eilers & S. Moyerman eds. 1971) ("free care necessarily creates a two-class system").

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homogenizing or anticompetitive PSRO regulation of HMOs,²³⁰ competition would focus not only on the quality of care provided but also on its cost and style of delivery, and this might be sufficient to generate increased attention to quality/cost trade-offs not only in HMOs themselves but also in the system as a whole.

PSROs: A Final Balancing of Their Benefits and Costs

As the PSRO program is currently constituted, PSROs are likely to enhance the quality of care and to produce some other significant public benefits. Such activities as the policing of gross abuses in overtreatment and underservice by aberrant professionals, intensive data collection and analysis, continuing education of the profession, and encouragement of the spread of new knowledge are all likely to benefit the public and find general acceptance in the medical profession. The public could also expect to gain from PSRO efforts to eliminate costs producing no appreciable benefit to health, but the profession will frequently find it impossible to agree that a particular measure can be eliminated without a significant adverse effect. Moreover, it will be particularly difficult to effectuate cost savings by challenging reputable practitioners' judgments in particular cases. Nevertheless, PSROs' educational activities should influence physicians' decision making prospectively, while avoiding the unpopular element of second-guessing and the necessity for denying an arguable benefit to an identified patient. In all of these activities, it seems likely that the PSRO will have some success in moving the health care system in the direction dictated by the public interest. In addition, PSROs may have certain intangible benefits in raising the general level of professionalism and encouraging greater awareness by physicians of alternative modes of treatment and the relative merits of each.

Although the PSRO program will have some benefits, it is impossible to know whether its benefits will exceed its costs. Many observers have doubted that a net benefit will appear even if one counts only the costs of PSRO administration, which are likely to be very large.²³¹ There are, moreover, some possible additional costs. For instance, quality enhancement, the PSRO activity most likely to be received with enthusiasm by physicians, could add greatly to the cost of health care by mandating many small increments of quality whose substantial price tags make them poor investments from a societal point of view. Indeed, instead of serving as watch-dogs on behalf of the public at large, PSROs might well become potent, and virtually unopposed, political instruments for increasing rather than containing costs.²³² Perhaps the most striking lesson from the PSRO

230. See text accompanying notes 233-34 *infra*. This hazard is examined in detail in Havighurst & Bovbjerg, *Are PSROs and HMOs Compatible?*, 1975 UTAH L. REV. (forthcoming summer issue) [hereinafter cited as Havighurst & Bovbjerg].

231. See note 136 *supra*.

232. For a discussion of this point and a comparison of the PSRO program with its German counterpart, see Stone, *Professionalism and Accountability: Controlling Health Services in the United States and West Germany* (Working Paper No. 8742, Duke Institute of Policy Sciences and Public Affairs, August, 1974).

program's early development is that implementing decisions at every point have reduced the likelihood that hard quality/cost questions will be addressed forthrightly by PSROs. Even though government might have created conditions under which PSROs could have at least begun to attack these questions, professional self-interest and the quality imperative still load the scales in which the benefits and costs of medical care are balanced.

Another potential, though hidden and unquantifiable, cost of the PSRO program lies in the possibility that PSROs may discourage innovation and experimentation by propagating a "one-right-way" approach to medical practice. A PSRO is in a position to declare substandard any effort to substitute different methods for orthodox approaches, and it is likely to be most suspicious of changes requiring fewer doctors' services or arguably sacrificing quality of care to obtain a cost saving. In resisting such innovations, PSROs can claim to represent the interests of federally subsidized patients in higher-quality care, and they will have no occasion to account for the costs which are entailed in honoring these preferences.

HMOs, with qualitative features not fully appreciated by fee-for-service physicians and a unique ability to balance quality and cost, are particularly likely victims of PSROs' anticipated hostility to different, particularly cheaper, ways of doing things. Because PSROs are charged with regulating the quality of care in HMOs,²³³ they have the power to inflate HMOs' costs and thus to limit their ability to engage in effective quality/cost competition with traditional fee-for-service medicine. Even if a PSRO did not exclude HMOs from the market or persecute them overtly, there is a danger that it would become a forum in which fee-for-service doctors and HMOs would negotiate the forms which competition would be permitted to take. Any competition which remained after such cartel-like discussions would not focus significantly on price but would stress amenities and the quality of care. While such a "pluralistic" but noncompetitive environment maintained under PSRO control would offer consumers the right to choose between fee-for-service medicine and some varieties of HMO care, it would deny them many of the other benefits of competition, particularly the opportunity to invest fewer of their resources in health care which is marginally productive from their point of view.²³⁴

In view of these problems, great importance should be attached to adopting measures guaranteeing HMO autonomy.²³⁵ In addition to remov-

233. See generally Havighurst & Bovbjerg, *supra* note 230.

234. Eliminating price competition while preserving other kinds may be among the least desirable solutions since it stimulates wasteful expenditures on frills, product promotion and differentiation, and excessive quality. The problem has been serious in such regulated industries as the airlines, where fixed fares cause competition to focus on scheduling, equipment, and amenities, with the result that very expensive planes fly half empty. See, e.g., W. JORDAN, AIRLINE REGULATION IN AMERICA (1970).

235. This thesis is developed in Havighurst & Bovbjerg, *supra* note 230, proposing either replacement of PSROs as regulators of HMOs or major changes in the PSRO program to promote reasonable HMO autonomy.

ing a substantial obstacle to the growth of a promising mode of health care delivery, such measures would permit the development of a badly needed competitive stimulus for better PSRO performance.²³⁶ Given such an incentive to control costs, PSROs' participating doctors would perceive a need to improve the system's ability to give value for money. They should then be much more willing to take the collective action needed to keep health insurance premiums down, according quality of care its due but not without substantial regard to cost. Under the guise of policing "unnecessary care" and "overutilization," they should be able to minimize the nonprice competition among doctors which currently makes it difficult to deny a patient any benefit which another doctor might prescribe at third-party expense.

Given the will to control costs intelligently, PSROs could surely achieve a great deal. The primary message of this article, however, is that the PSRO legislation alone does not supply the incentive needed to make PSROs achieve more than minor improvements over "business as usual"; in particular, PSROs cannot be expected, without more, to venture bravely into the quality/cost no man's land, which is where the battle for resource reallocation must be won. A subsidiary message is that relatively autonomous HMOs, with experience in the quality/cost battle, could prod the PSROs into action where the generals and politicians at OPSR cannot.²³⁷ We see nothing else in the health care system at the moment or on the legislative horizon which can induce the system to begin coping effectively, either directly or indirectly, with quality/cost trade-offs.

236. The PSRO is a monopolistic solution to the problems of health care costs and can be criticized on that account. See Havighurst, *Speculations on the Market's Future in Health Care*, in REGULATING HEALTH FACILITIES CONSTRUCTION 249, 257-63 (C. Havighurst ed. 1974). Unlike the typical cartel or monopolist, this monopoly does not restrict output to increase prices but expands output to increase returns, which it can do by virtue of consumers' ability and willingness to pay (through third parties) and physicians' control of demand. HMOs, freed of PSRO domination and burdensome regulatory restrictions, would supply some competition for the monopolized fee-for-service sector and might induce PSROs to achieve a reasonable level of control. See note 106 *supra*. Nevertheless, other approaches to the problem of balancing quality and cost considerations may be preferable. See notes 222-27 and accompanying text *supra*. In particular, if competing third-party payers could be counted on to control costs aggressively, there would be more experimentation with cost-control methods and a wider range of choice than under PSROs. For a brief review of market-oriented strategies for dealing with health care costs, see Havighurst Testimony, *supra* note 227, at 1036-89.

237. HMOs are as yet a weak competitive threat because of regulatory restrictions imposed upon them and other factors. See, e.g., HMOs: TOWARD A FAIR MARKET TEST, *supra* note 99. Nevertheless, the PSRO program, with strengthened national oversight, could assist in generalizing the impact of even a small number of competing HMOs by enforcing broadly those standards developed by cost-conscious PSROs in competitive markets. The doubtful effectiveness of such oversight suggests that high priority should be given to amending the Health Maintenance Organization Act of 1973, P.L. 93-222, codified in 42 U.S.C.A. § 300e *et seq.* (1974), to improve HMOs' market opportunities.