Rationing of Medical Care and the Preservation of Clinical Judgment

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It is inevitable that efforts to contain medical care costs will increase. Approaches to cost containment vary substantially and have different effects on access, equity, and professional performance. Cost sharing primarily affects the behavior of patients, while other types of regulation are intended to influence how physicians practice. While some types of physician regulation such as prospective budgeting are intended to constrain physician decision making without dictating clinical judgment, other approaches are more intrusive on physician autonomy. Physicians should contribute to the development of regulatory approaches consistent with the responsible exercise of clinical judgment and professional autonomy.

With medical care costs constituting a large and growing component of gross national income, greater efforts are being made to control how medical care is allocated. Medical care costs are an increasing burden for local and national government, for industry and unions who must negotiate increases in health fringe benefits simply to stay in place, and for consumers who indirectly must pay for massive health expenditures through their purchases and taxes. While rationing (ie, control over the allocation process) is inevitable, the mode of regulation and its consequences are not. Professionals thus have a considerable opportunity to insure that rationing, however achieved, is consistent with quality of patient care and preservation of clinical judgment.

There are many who question whether rationing is necessary at all, despite the fact that medicine has always been rationed by the ability to pay, by the availability and distribution of medical personnel and resources, and by the decisions professionals make about the allocation of their efforts. Moreover, with advances in medical knowledge and technology, and the public's continued support for such endeavors, the possibilities for future increased expenditures are awesome. Also, as the proportion of elderly in the population grows—and the number of old people will significantly increase in the next several decades—the burdens on the health care system and the possibilities for heroic medicine are almost infinite. The successes of medical intervention will inevitably confront the nation with the need to consider more directly how to allocate care.[1]

There are three general approaches to rationing of medical care.[2] The market approach manipulates co-insurance and deductibles, and in this fashion requires consumers to share in the costs of medical care on the one hand, and to consider the marginal value of purchasing added units of medical care against other investments. While such rationing achieves some cost sharing as well as reductions in utilization, it also has some undesir-

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able effects. Most importantly, cost sharing has a larger impact on the behavior of those with little income, resulting in inequities in the distribution of care. Moreover, in imposing barriers to medical care, cost sharing screens out not only trivial and less serious problems from the health care system, but also conditions that should be appraised and treated. Also cost sharing is expensive and cumbersome to administer, encourages chicanery and manipulation of the system to avoid payment, and is unpopular among consumers. Whatever health services researchers may think about the benefits of cost sharing, co-insurance and deductibles are sufficiently disliked by consumers so that many purchase supplementary insurance to cover such charges and support strongly the availability of more comprehensive benefits in opinion surveys.[3] Thus, even if cost sharing was effective in inducing individual responsibility, the public's desire for full coverage would tend to reduce the impact of such an incentive.

A more extreme approach to allocation of medical resources is through the imposition of administrative in contrast to clinical decision making, and the term "explicit rationing" refers to such rationing. Explicit rationing is increasingly used, as in the exclusion of the availability of certain services from payment, administrative prereview of the use of expensive services, administratively determined intervals between the provision of specified tests and procedures, and limited total allowable expenditures. Federal programs such as Medicare incorporate some of these features of explicit rationing as do private and nonprofit health insurance programs.

Those who support explicit rationing measures find them attractive because they allow direct control over health care allocations, depending more on administrative authority than on persuasion or exhortation. Moreover, such administrative decision making can draw more easily than the practicing clinician on aggregate data, clinical trials, and large-scale evaluations. It offers an opportunity both to narrow the range of medical response to the same conditions and to set limits on clinical eccentricities. But controlled clinical trials are difficult to implement in many areas, often involve troublesome and debatable methodologies and conclusions, and offer no panacea to many of the uncertainties of medical practice.

Explicit rationing is the mode of control most resented by working professionals since it intrudes on their practicing autonomy and discretion in a direct way. Administrative authority frequently becomes insensitive to the human dilemmas and variabilities so obvious at the clinical level, and administrative rules meant to cover a variety of situations frequently are insensitive to important contingencies. Physicians and patients seek to manipulate and evade rules they view as irrational, and often such adaptive responses bring about subterfuge, perverse outcomes, and inequities in distribution.

Implicit rationing is the alternative most consistent with administrative needs on the one hand, and with professional autonomy on the other. Implicit rationing such as fixed budgets, capitation arrangements, and limitations on personnel and physical facilities set constraints on physician decisions without intruding on the physician's clinical judgment. Perhaps the most common example of implicit rationing in the United States is the prepaid group practice. In theory, financial constraints compel the physician to confront priorities and to more carefully consider the benefits and costs of alternative allocations. By separating the source of payment from clinical decisions, in theory clinical judgment can be brought into full play. Reality often departs from theory, however, and the imposition of constraints under the pressure of heavy patient demands can result in giving disproportionate services to more sophisticated and demanding patients as compared with less educated and more passive ones who from an objective standard require services more. Nor is there assurance that physicians will not pursue clinical agendas that are intellectually stimulating or personally satisfying as compared with priorities defined by objective indicators of "need" and likely benefits of treatment.

While implicit rationing puts an ethical burden on physicians by requiring that they possibly deny services when a patient may demand them in contrast to the ideal of acting solely on behalf of the patient,[4] it remains the rationing option most consistent with the protection of the physician's clinical discretion. If limits on action are to be imposed, it is perhaps more desirable for the physician to impose them on the basis of professional judgment than to have them imposed by administrative authority. However, if implicit rationing is to have constructive and not perverse effects,

physicians in their corporate capacity have a responsibility to establish norms within which responsible rationing can proceed.

Effective implementation of implicit rationing depends on three conditions. First, clinical settings must constrain large variabilities in practice that cannot be justified by clinical uncertainty or by differences in patient populations. Physicians must develop mechanisms to regulate physicians who pursue courses of action consistent with their personal inclinations that have no justifiable objective basis. Secondly, and linked to the prior point, is the need to develop effective means of review and encouragement that reinforce through remuneration policies and other rewards the patterns of care that are found to be most effective. Thirdly, means must be developed to insure that resources are allocated fairly, and not disproportionately to the most aggressive, sophisticated, and demanding patients. Each of these points requires some comment.

The implementation of the first point depends on the establishment of effective peer review but not with excessive expectations. The requirement is not to define small deviations from an established standard, but rather to enforce a standard in instances of large departures from a reasonable range. While there remains considerable uncertainty as to whether physicians will seriously monitor one another, the possibility is more promising in this limited area of resource allocation than in the more complex and diffuse area of quality assurance. To the extent that physicians feel a corporate responsibility and not simply concern about their own patients, they can exercise the necessary administrative authority.

Practice settings require incentives that facilitate strong professional commitment, effort, and responsiveness to the needs of patients. While fee-for-service is believed to encourage physician motivation and responsiveness, it also allegedly provides incentives for unneccessary but remunerative services. In any case, when physicians work with fixed budgets, and are paid by salary or capitation, other incentives must be introduced into the clinical setting to encourage desired forms of practice.[5] Physicians in their corporate capacity are the most legitimate source of such encouragement and they might exercise influence by offering merit bonuses, regard, and recognition to their fellows who best exemplify the outstanding physician. Capitation, in the absence of peer evaluation and rewards, may result in undesired behavior such as limited professional commitment and lack of responsiveness to patients. Physicians as a group must give attention to the development of non-monetary reward systems within new structures of physician organization. Even larger problems of few alternatives to financial incentives exist in office based practice, and developing non-monetary incentives in such settings is a formidable challenge.

The problem of fair allocation of fixed resources is perhaps the most difficult of all. Physicians are no less influenced by expectations, demands, and pressures than others, and the educated, sophisticated patient cannot only be persuasive but also intimidating. In contrast, those who are docile, inarticulate or unaware of possibilities can more readily be denied services without open strain or unpleasantness. Perhaps the best that can be done is to make physicians sensitive to these issues, and reinforce through peer support efforts to allocate fairly.

In sum, medicine need not await the inevitability of administrative rationing. A constructive stance would involve recognition of the forces that focus attention on cost containment, and participation in developing modes of allocation that protect the integrity of the physician's judgment and the quality of patient care. The task is clear. Physicians must decide whether they will resist all regulation or work constructively to develop regulatory approaches consistent both with social need and with good patient care.

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