Control over the Utilization of Medical Services

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During recent years, the health care industry has been characterized by rapid increases in the volume of services delivered. This escalation is in part unjustified by medical need, and has produced a variety of efforts on the part of payers and providers to restrict overuse. In this article the authors consider the issues and problems involved in the control of medical utilization. Five categories of control are considered in detail: supply limitations, financial disincentives, authorization requirements, review mechanisms, and legal action. The article suggests that the success or failure of these various control mechanisms hinges upon four factors: whose use is being regulated, who performs the control activities, whether the attempted control involves a judgment as to the appropriateness of treatment, and whether the attempt to control occurs before, after, or during treatment. It is concluded that most current forms of utilization control suffer from ambiguity of purpose, organizational inefficiency, and undesirable side effects. The authors offer several proposals to correct these shortcomings, but conclude that the only long-range solution to overutilization lies in a more integrated approach to medical resource allocation and a consequent change in the structure of provider and user incentives.

Introduction

Notwithstanding current Federal price controls, inflation in the medical sector is still very much an issue of public interest. In fact, concern over the *price* of medical services has tended to draw attention away from an equally important determinant of growth in health care expenditures, namely, *utilization*. The public is well aware that medical prices have risen dramatically over the past ten years but is less conscious of the fact that approximately half the total increase in medical expenditures during the 1960s was the result of increased utilization and not price inflation (Klarman et al., 1970). Normally, a rise in the use of service does not elicit the

same negative response as does a rapid escalation in price. But just as some price increases are unwarranted on economic grounds, certain types of health care usage are unwarranted on economic and medical grounds. It has been argued, for example, that the wastes associated with unnecessary laboratory tests, excessive days of hospitalization, and unnecessary surgery not only maintain medical costs at artificially high levels, but may also reduce the quality of service for those who need it most. It is the purpose of this article to review the various methods that either are or can be used to control the inappropriate use and overuse of medical services.

At the outset, it is important to realize that there are both practical and conceptual difficulties involved with the analysis of utilization controls. Because the best medical treatment is case-specific, it is difficult to set up hard and fast rules as to what constitutes "overutilization" or "unnecessary" treatment. This difficulty is one reason why insurance carriers as well as administrators of government health programs have shown a historical reluctance to come to grips with the question of appropriateness of care on a case-by-case basis. Medical providers have served to buttress this stance of nonintervention by being generally antagonistic to control mechanisms other than peer review—which, of course, is designed to maintain the primacy of health providers in cases demanding medical expertise.

It is obvious, however, that the issue of appropriateness of care (and hence, utilization control) also has a socioeconomic dimension quite distinct from the ability of health professionals to assess medical needs. This is perhaps best seen in the development of kidney dialysis and organ transplants where shortages of capital equipment, supplies, and trained personnel have forced providers to ration services on some basis other than medical necessity alone. Whether the rationing or utilization control mechanism is price, the age or social prominence of the potential recipient, or some other criterion, the fact remains that some "needy" persons are denied the service. As long as there are advances in medical technology, problems of resource allocation among competing demands for new services will continue.

Integrally related to this issue is the problem of defining an appropriate level of aggregate medical expenditures—in other words, of resolving the question of resource allocation between medical and nonmedical uses. No one seriously argues that every medical

need should be satisfied, for clearly there is a point at which the benefit of providing an additional medical service is more than offset by the sacrifice in other goods that must be made in order to purchase the service. Some forms of utilization constraints (such as benefit exclusions under a health insurance policy) may thus be viewed as allocative devices designed to hold in check the expenditures for less essential types of medical care. Whether such constraints are properly applied only to services reflecting a low economic priority is another matter. But whatever the judgment, it is clear that the appropriateness of medical services may be viewed from an economic as well as a medical perspective.

Classification of Utilization Controls

Unfortunately, it is nearly impossible to separate those utilization controls whose primary effect is to reduce medically unnecessary care from others designed to limit services with a low economic priority. For example, the most prevalent type of utilization control practiced in American hospitals takes the form of hospital-based utilization review (UR) committee decisions. As mandated under Medicare and most Blue Cross plans, the UR committees have the responsibility of reviewing individual cases on the basis of "medical need." But the criteria of "need" are usually defined so that reimbursement will be denied both for services clearly unnecessary from a medical point of view (for example, tonsillectomies in the absence of any current or past history of infection or inflammation) *and* for services that are not covered under the insurance contract (for example, hospitalization for certain diagnostic tests which could be performed on an outpatient basis). As demonstrated by these two examples, economic as well as medical concerns are involved in the same UR mechanism.

If the dichotomy of medical and economic goals represents an inadequate schema for classifying utilization controls, at least the controls may be distinguished according to the means employed in reaching these goals. Three considerations are useful in this regard. First, are the controls applied before, during, or after the actual treatment? Second, do the controls incorporate decision rules which require a judgment as to the appropriateness of treatment? And third, who applies the controls and to whom are they applied?

The first of these considerations relates to the time sequence of utilization control. Some control mechanisms are designed to limit access to medical resources on the assumption that, by making access more difficult, demand related to less serious or frivolous complaints will be reduced. These *antecedent* controls are instituted prior to any overt evidence of need and may assume either a direct or indirect form. Supply restrictions such as certificate-of-need laws for hospital construction or artificial limitations on the number of medical school graduates are examples of direct antecedent utilization controls. Indirect forms of antecedent control encompass an array of financial hurdles which a patient must overcome before service is authorized or provided. In the absence of insurance coverage, price is the most obvious of the indirect controls. But even with insurance, the consumer of medical care must cope with such constraints as benefit limitations, exclusions, deductibles, and coinsurance.

Once treatment has begun or is about to commence, there are further mechanisms to limit usage which may be called *in-process* controls. Basically, these attempt to insure careful monitoring of the patient's condition so that, when a choice of care is involved, the patient may be provided with less expensive but equally beneficial treatment. Most common among these controls are preadmittance screening for hospital patients, surgery authorizations, and periodic certification and recertification of inhospital treatment.

A third type comes into effect only after treatment has been completed. The *ex post facto* controls are of two kinds—those which involve review of patient utilization patterns and insurance claims experience (primarily with an eye to questionable claims, irregular use patterns, or excluded coverages) and those which involve an actual check of the appropriateness of treatment in specific cases. Claims review is relatively noncontroversial since its most important function (except in cases of fraud) is to decide who will pay a particular bill.

Far more sensitive are ex post facto review mechanisms such as professional or peer review and malpractice litigation which involve the issue of appropriateness of care. This leads to the second method of classifying utilization controls; namely, by whether or not the mechanism requires medical evaluation of the appropriateness of treatment. A number of controls require the use of judgmental criteria including certification and recertification of care re-

ceived under public programs and a variety of ex post facto review mechanisms (utilization review, peer review, professional society review, medical audit, etc.). In general, these judgment-related controls are among the most controversial found in the medical system. For example, it is possible that mechanisms like surgery authorizations or recertification of care requirements may work to the detriment of the patient if the physician is careless in his appraisal of need. On a different plane, because ex post facto analysis of care represents a potential threat to health professionals whose competence might be called into question, one can postulate a situation in which peer review would function primarily to cover up all but the most egregious cases of "inappropriate" care. This is not to suggest that either of these situations will necessarily arise, but rather to indicate the potential importance of a third characteristic of utilization control.

Any effort to limit the usage of medical services, be it of a judgmental or nonjudgmental nature, may be relatively effective or ineffective, according to who is in a position to control the regulatory mechanism. Conceptually, at least, utilization control may be exercised either by users, providers, third-party payers, or the courts. Needless to say, certain of these groups are in a better position to regulate or resist regulation than others. To take just one example, physicians can regulate the supply of services by raising fees, refusing to make house calls, and reducing accessibility during nonoffice hours. Users, on the other hand, have little control over physicians since their major weapon—the power to take their business elsewhere—is reduced by unposted fee schedules, closed practices, and the urgency of need. Such structural inequalities in the market for medical services are pervasive, but as yet there is little direct evidence as to what effect they actually have on the functioning of utilization controls.

The characteristics of utilization control are summarized in the following chart under the five general categories of supply limitations, financial disincentives, authorization requirements, review mechanisms, and legal action. The remaining sections of the paper describe briefly the historical development of these methods of limiting usage and then concentrate attention on the specific types of control employed in actual practice. Finally, alternatives to current practice are examined in the light of probable developments in national health policy over the next decade.

PATTERNS OF FORMALIZED UTILIZATION CONTROL

Category of control	Type of control	Time applied	Designed to regulate	Regulation by	Does regulation involve judgment as to appropriateness of treatment?
Supply limitations	Inavailability of service Queues	Antecedent	User	Provider	No
Financial disincentives	Price Benefit limitations Exclusions Deductibles Coinsurance	Antecedent	User	Payers	No
Authorization requirements	Certification Prior authorization Preadmittance screening Recertification	In process	Provider	Payer or provider	Yes
Review mechanisms	Claims review Professional standards review Institutional review Medical audit Service accounting	Ex post facto	Provider	Payer or provider	May or may not
Legal action	Malpractice litigation	Ex post facto	Provider	Courts	Yes

The Origin and Rationale of Utilization Control

Aside from the constraints imposed by the threat of malpractice litigation, formalized utilization controls may be traced back to 1918, when the American College of Surgeons (ACS) first initiated its hospital approval program. As the forerunner of hospital accreditation, the ACS program required that hospitals meet minimum standards for the provision of quality care to each patient. To receive approval, the hospital had to show that review and analysis of certain services (limited initially to surgery and obstetrics) were being conducted on a regular basis. While it is impossible to separate the impact of these review requirements from other aspects of the ACS program, one may infer their significance from the fact that review mechanisms were eventually required in all hospital service departments for ACS approval (and were later required for approval by the Joint Commission on Hospital Accreditation, which assumed primary responsibility for hospital accreditation in 1952).

Interest in the review of hospital services led directly, but gradually, to the development of professional service accounting. As first practiced, this accounting method involved little more than the use of simple statistical summaries to record the number of patients treated, the length of stay, death rates, autopsy rates, etc. In the early 1950s, the Southwestern Michigan Hospital Council expanded the concept to include the use of data from patient medical records (Slee, 1968). By 1955, methods for handling data had advanced to the degree that several organizations (the American College of Physicians, the ACS, and the American Hospital Association) joined with the Council to form the nonprofit Commission on Professional and Hospital Activities. This commission organized the Professional Activity Study (PAS) and made the data it collected available to all member hospitals.

Interest in utilization review was stimulated by independent studies throughout the 1950s and 1960s which showed an alarming overutilization of hospital beds. One such study, conducted in Michigan, indicated that in 1962, 6.8 percent of the patient-days in the state's hospitals were unnecessary (Fitzpatrick et al., 1962). An analysis undertaken in Massachusetts determined that between four and eight percent of all hospital admissions involved cases that could have been satisfactorily treated elsewhere (Anderson and Sheatsley, 1967). A study in Indiana concluded that 20 percent of

all Blue Cross hospitalization days were unnecessary (Becker, 1954). Among the most recent investigations is a 1972 report by the Pennsylvania Governor's Management Review Task Force which indicated that nearly half of 10,000 hospitalized Medicaid recipients were "hospitalized unnecessarily or stayed longer than was medically necessary," and that "$105 million in state funds and $82.5 million in federal funds could be saved yearly by eliminating the unnecessary hospital admissions and stays" (Hospital Week, 1972).

The realization that substantial savings can accompany control over unnecessary utilization is of obvious interest to hospitals. Just as concerned are the insurance companies who end up paying for unneeded services. The first hospital insurance plans—based on the early Blue Cross experiments in Dallas, Texas, and Sacramento, California—provided full service benefits (at least for hospital charges) and contained no mechanisms for the control of overutilization. Commercial hospital insurance did not become readily available until several years after the initial Blue Cross plans were established, but, by applying the indemnity concept to the underwriting of hospital expenses, the commercial carriers were able to introduce certain utilization restraints through partial coverage, deductibles, and coinsurance. Thus, while the actual review of patient records to determine medical necessity was not involved in any of the early insurance plans, the commercial carriers at least provided some incentives for the subscriber to control his own usage.

Until 1965, utilization restraints and utilization review mechanisms were found predominantly in the private sector. The enactment of the Medicare and Medicaid programs in that year produced the first serious governmental involvement in utilization controls. Four types of controls were incorporated into the Title XVIII and XIX legislation, including: (1) deductibles and coinsurance (under Medicare), (2) benefit limitations and exclusions, (3) a mandated requirement that participating hospitals establish utilization review committees to analyze patient admissions, duration of stays, and professional services furnished, and (4) requirements for certification and recertification of inpatient hospital and nursing-home stays. But expansion of control is not necessarily synonymous with successful regulation. Judged either in terms of limiting medically unnecessary care or reducing the use of services with a

low economic priority, the "success" of utilization control remains a hotly debated issue.

Control Through Supply Limitations

Perhaps the surest way to guarantee that a particular medical service will not be overutilized is to limit the physical availability of the service. As mentioned previously, almost any advance in medical technology is subject to restricted access because of limitations in supply. But limitations also affect utilization of traditional forms of medical treatment. These limitations run the gamut from policies which reduce the provision of marginal or clearly unnecessary services to actions which cut off the supply of care altogether.

At the one extreme, it might be noted that, in 1969, 134 counties in the United States had no practicing physicians (American Medical Association, 1970). While this situation obviously does not reflect any conscious attempt by American doctors to control "excess" utilization, it does indicate that a geographic maldistribution of physicians may have the effect of severely limiting the availability of services, particularly in rural areas. On a broader plane is the question of whether or not this country suffers from a general shortage of physicians. There are many views regarding the existence of a shortage (Fein, 1967; Hansen, 1970; Holtmann, 1965; Lynch, 1972; Ginzberg, 1966; Harrison and Nash, 1972), but there is a general consensus that, even if one does exist, it can be traced to professional concern over economic security rather than to any attempt to limit utilization per se (Burrow, 1966; Rayak, 1967; Kessel, 1970).

On the other hand, there are historical examples in which supply restrictions have been explicitly designed to reduce utilization. One such case was the decision by the British National Health Service (NHS) to authorize virtually no new hospital construction in the years following World War II, despite a rapidly increasing demand. The important point, however, is that if restrictions on supply do create shortages, the result will be the same whether the decision to limit usage is conscious or not; that is to say, either the price of the service will rise enough to clear the market or an increase in waiting times and difficulty in making appointments will serve to ration the scarce resource. In the case of the British NHS,

hospital services are still rationed through queues and waiting lists. Price has played a more important role in rationing physician services in the United States, but if M. S. Feldstein (1970) is correct in his assessment of a permanent excess demand for physician services, then nonprice rationing is involved in this example as well.

In both cases, the rationing mechanism represents a rather gross approach to controlling "inappropriate" utilization. Some writers, notably Pauly (1971), argue that price is an efficient method of controlling usage of medical services because it does not entail the dead weight losses associated with other forms of rationing. But, as will be shown in the next section, there is no guarantee that inappropriate utilization (measured either from an economic or a medical standpoint) will be the first to go in the face of a price increase. However, this is not to say that queues or waiting lists necessarily represent a superior approach to utilization control (Garfinkel, 1972, provides an argument to the contrary) because they, too, introduce distortions which may result in the curtailment of both appropriate and inappropriate usage.

Besides theoretical arguments, there are very practical reasons why supply limitations make poor utilization controls. Perhaps the best example of this can be seen in the Medicare experience with nursing home services. When extended care services were first introduced as a covered benefit in 1967, actuaries for the Social Security Administration (SSA) estimated that, in the first year, program costs would equal $25 million (U.S. Senate Committee on Finance, 1970: 34–35). This estimate was based upon the limited number of extended care facilities SSA felt were capable of supplying service under the program; and though representatives of the insurance industry considered the figure far too low (projecting instead that first-year costs would approximate $210 million), the SSA actuaries knew from past experience with the hospital industry that rapid changes in supply would be hampered by a lack of capital and decentralized management decisions. Little did they realize the speed with which supply would respond to the demand generated by the new program, for in 1967 over 4,000 nursing homes were certified to provide services, and total expenditures for the year reached $275 million (U.S. Senate Committee on Finance, 1970: 36). Not until 1969 was reliance on such an ephemeral supply limitation dropped in favor of more rigorous steps to control utilization.

If supply limitations are either ineffective or inefficient under

conditions of excess demand, there is some evidence that they may be useful in cases of excess capacity. Under "normal" business conditions, of course, the existence of excess capacity leads to a decline in profit rates which in turn is a signal to investors to find other outlets for their funds; new capital becomes scarce, and the industry goes through a period of disinvestment (i.e., depreciation exceeds net replacement of capital). Assuming that demand and supply are functionally independent, market forces will eventually eliminate excess capacity. But if demand and supply are *not* independently determined, such an adjustment process will either be hampered or cancelled out altogether. A situation akin to this arises whenever "supply creates its own demand." Although, technically speaking, excess capacity cannot exist if demand is totally dependent upon supply, the adequacy of capacity may be viewed in terms of some criterion other than demand (need, for example). It is on this basis that a number of studies have purported to show that excess capacity is a problem in the medical sector, particularly for hospitals ["a built bed is an occupied bed" (Roemer and Shain, 1959a; U.S. Department of Health, Education, and Welfare, 1968)] and for certain medical specialties such as general surgery (Fuchs, 1969; Bunker, 1970; Maloney, 1970; Owens, 1970; Hughes et al., 1972). It is worth noting, without attempting to support such claims, that some twenty states have considered hospital overbedding to be a serious enough problem to enact certificate-of-need laws which require prior approval by the state before new construction or facility additions may be initiated (Ingbar, 1972). The 1972 amendments to the Social Security Act extended this power to the Department of Health, Education, and Welfare (HEW) by authorizing the Secretary to deny Medicare and Medicaid payments for capital expenditures which are not in accord with area-wide planning board decisions regarding construction and expansion. Much less has been done in the field of manpower, although it has been suggested that licensing statutes be redefined on the basis of medical specialty. If, as has also been suggested, specialty licensing were combined with the power to establish regional quotas, then licensing boards would be able to prevent oversupply in professional specialty areas. There is precedent for such action. In Britain, for example, certain overdoctored areas are closed to new practices (Great Britain, Department of Health and Social Security, 1969).

Aside from the legal ramifications surrounding these forms of

supply limitation, there is no question but that they represent a potentially powerful type of utilization control. Moreover, if overutilization or unnecessary usage can be traced to lack of "legitimate" business opportunities for health facilities or professional providers (i.e., an insufficient number of medically necessary procedures to meet minimum operating requirements), then this type of control might be a most efficient means of reducing "inappropriate" utilization.

Control Through Financial Disincentives

The one serious (and to some, fatal) disadvantage with any form of overt supply limitation is that it may interfere with the consumer's ability to choose for himself what is necessary or unnecessary. According to the staunchest advocates of consumer sovereignty, an individual should be allowed to purchase any medical service he pleases—even one which is considered worthless by medical experts. One need not go this far to appreciate the argument for freedom of choice; after all, it is the individual who must live with the consequences of any decision to use or forgo medical services. The question, however, is how this philosophy can be reconciled on efficiency grounds with the need to curtail inappropriate usage. It is clearly not enough that individuals make all their own decisions regarding the necessity of care if substantial social costs are incurred in the process.

The traditional economic solution is found in the financial disincentives to overuse contained within the price mechanism. The notion that price may act as an effective utilization control is based upon the simple but plausible assumption that when the price of medical care is high, an individual will demand only the most essential services but, when the price gets progressively lower, his demand increases for less essential services. Under these circumstances one need merely raise the price to reduce both the absolute and relative level of "unnecessary" utilization for the population as a whole. The reason the price mechanism is considered superior to other, more direct methods of limiting usage is that the individual is still free to choose what to buy and is restrained only by his income and the value he places on other goods and services. This also represents its major weakness. Because the mechanism is dependent upon the way people with different incomes react to a change in price, it is entirely possible that a general increase in price will re-

duce poor peoples' demand for medically "necessary" services by as much or more than it will reduce the utilization of less appropriate services by the rich.[1] Under "normal" conditions (that is, when demand is inversely related to price), a rise in price must lead to a decline in overutilization to whatever extent it exists, but if this is accomplished at the expense of extreme vertical inequity then one must question the efficacy of the approach.

The price mechanism, however, is a highly flexible tool. Because each medical procedure may be individually priced, it is possible to use selective increases in areas where overutilization is a known or potential problem. While selective pricing does not eliminate the distributional problems associated with a general shift in the price level, at least it offers one way of reducing the economic burden on low- and middle-income groups without necessarily reducing the effectiveness of the price constraint facing the well-to-do.[2] The importance of this fact has not been lost on the health insurance industry, where selective pricing techniques (which take the form of benefit limitations, restrictions, exclusions, deductibles, and coinsurance) represent the most common form of utilization control. It would be naive, of course, to assume that profit-making firms are guided by the principle of minimizing the social costs of inappropriate usage (although this may represent an appropriate goal for nonprofit and governmental insurers). In fact, such techniques allow the carriers to offer considerably lower premiums than would otherwise be the case, and to increase the marketability of their policies in the process. However, differences in motivation need not compromise the value of the end result.

Deductibles

Of all the types of selective pricing, deductibles are applied to the widest variety of medical services and are found under both private

[1] For this to occur, one need only assume (1) that an individual's aggregate demand for all forms of medical care reflects an increasing proportion of "essential" services as price rises, and (2) that the demand for medical care by the poor is more price-elastic than the demand for care by the rich.

[2] Whether a price constraint will affect the rich depends upon the price-elasticity of their demand for the service in question. Since it is likely that their demand for most services will be inelastic at low price levels, only a relatively "expensive" constraint will force the rich to forgo consumption. On the other hand, if their demand for nonessential or "unnecessary" care is elastic, then a price constraint may prove effective.

insurance and government medical programs. Deductible payments are required for coverage under the Hospital Insurance and Medical Insurance portions of Medicare. They form the basis for coverage under the various state Medicaid programs for the medically indigent, and are becoming increasingly evident in medical assistance programs for welfare recipients. Although not a prevalent feature of Blue Cross–Blue Shield plans, they are contained in a number of contracts including the largest—the "high-option" plan of the Federal Employees Health Benefits Program. In terms of commercial health insurance, virtually all individual and group major medical plans contain deductibles as do a few basic benefit plans.

The economic rationale in every case is to allow the free market to determine the distribution of health services until the amount of the deductible has been exceeded. Because a patient's decision to seek medical advice must take into account the fact that he will pay the full price up to the amount of the deductible, the usefulness of the control is greatest for relatively nonessential or price-elastic services. In practice, however, deductibles are applied to essential as well as nonessential services, and in both cases the patient-pay amounts are usually set low enough to have little effect on all but the poor. The deductible provisions under most group major medical plans are so minor, in fact (typical figures are between $50 and $100 per year), that the practical significance of the control is limited to the reduction of small claims. Unfortunately, there is very little data available, and it is impossible to tell whether deductibles actually cut the use of service or simply reduce indemnity payments to users (Hall, 1966).

There is somewhat more evidence of the impact of deductibles in the case of basic plans covering hospitalization, but it tends to be of dubious analytical value. For example, one report concludes that "the use of a deductible provision in Blue Cross policies has many advantages but the disadvantages probably outweigh the proposal" (State of Maryland, 1964:92). Some of the disadvantages cited are the shifting of costs to insured persons, the loss of services when a person cannot afford the deductible, and the possible transformation of minor ailments into serious illnesses when treatment is not received. A study conducted by Michigan Blue Cross showed that utilization by members with deductible contracts was 50 to 75 percent lower than utilization by members with comprehensive policies (Vaughn, 1965). The study concluded, however, that this could be

a spurious relationship since the former group was composed of lower-risk members who may have preferred deductible coverage and the lower premiums that go with it (Andersen and Riedel, 1967).

Coinsurance

Insurance policies which use deductibles also typically include elements of coinsurance. An example is the $18 paid by hospitalized Medicare patients for each day in excess of 60 (and up to 90) days spent in a hospital during the year. As opposed to a deductible which allows the price that patients pay for covered medical services to drop to zero after the deductible is met, coinsurance guarantees that a certain positive price is associated with service use. This in turn may influence the consumption or utilization of care at all levels of expenditure.

Various types of coinsurance are in use today, and they vary widely in the burden placed upon the patient. In some, the insured pays a fixed price per unit of service; in others, he pays a fixed percentage of all insured expenses; and in a third type, he pays all expenses over and above a fixed price per unit of service. Michael Crew (1969) has shown that under conditions of monopoly, coinsurance is necessary for a socially optimum output of health services. But even under relatively competitive conditions, the effect of coinsurance depends upon the manner of application. In an unpublished paper, Karen Davis (undated) has analyzed each of the three basic methods and concludes that only the third would result in an optimum output. The fact that under this scheme the patient is concerned with the upper limits of his total bill provides him with an incentive to reduce utilization (particularly high-cost treatment) to whatever extent he is able.

There have been a number of empirical investigations into the effects of coinsurance. A study of Blue Cross of Western Pennsylvania (Hardwick et al., 1971) concluded that a five-dollar-per-day copayment had no significant impact on hospital use as measured by average length of stay, average benefits per admission, average benefits per day, and admissions and patient days per 1,000 members. A Connecticut Blue Cross study (Heaney, 1969) found that subscribers with full coverage enter a hospital more frequently and stay longer than if they are forced to pay part of the expenses them-

selves. A third study (Hyman, 1972) using patient discharge data from 27 Iowa hospitals in 1965 and 1966, suggests that coinsurance may act as a deterrent to overutilization in cases of nonserious illnesses or in which only minimal "psychologically disturbing" factors are associated with a medical condition. When intensive care is required, copayments are likely to have little effect.

Two recent inquiries suggest that coinsurance has a positive influence in reducing the utilization of physician services. A. A. Scitovsky and N. M. Snyder (1972) found that after the introduction of a 25 percent coinsurance provision under a comprehensive prepaid plan, the per capita use of all physician services declined by 24.1 percent while per capita costs went down by 23.8 percent. In this study, physician services to hospital inpatients declined the least, while home health visits dropped the most. C. P. Phelps and T. P. Newhouse (1972) used multivariate analysis to isolate the effects of the same 25 percent coinsurance provision analyzed in the Scitovsky-Snyder study. The results again showed a significant reduction in use with the greatest decline registered in the demand for physician services and the least effect on the demand for ancillary services such as laboratory and x-ray procedures. In general, however, such evidence does not allow any definitive conclusion as to whether coinsurance inhibits the legitimate use of medical services or in fact limits abuse.

Benefit Limitations, Restrictions, and Exclusions

Benefit limitations have long been used by the health insurance industry; in such arrangements (depending on policy coverage), reimbursement is given only if services are rendered in a prespecified form (e.g., for hospital inpatient care) or up to a certain time or dollar limit. These policy provisions require that the insured absorb any loss above the specific limits. The Medicare Hospital Insurance program, to cite a previous example, covers up to only 90 days of inpatient hospital care per year. Almost all private insurance policies include such limits—frequently according to schedules, such as fee schedules for surgical procedures and the scheduled coverage of hospital extras in many Blue Cross plans (Dickerson, 1968).

Another type of limitation, and one commonly found in prepaid group programs such as the Kaiser and United Mine Worker

plans, places no direct restriction on the use of medical care but requires that all services be channeled through a designated primary physician chosen by the patient. This process not only systematizes delivery, but also prevents duplication by other physicians who may not even know they are treating the same patient. A variant of this system, known as a "lock-in," is found in the Kentucky Medicaid program. Under a pilot project begun in January, 1971, 36 Medicaid recipients in 10 counties were restricted to the use of a single primary physician and one pharmacy (of the patient's choice) during each 30-day period. But, unlike the prepaid plans, the Kentucky project also set limits on utilization at four physician visits and four prescriptions per month (additional services were permitted, but only after prior authorization by the physician). Before the lock-in, patients averaged 19.4 prescriptions and five physician visits per month. During the first six months of the program, utilization dropped to 6.3 prescriptions and 4.0 visits, and, in the next six-month period (when 26 additional patients were added to the program), it dropped further to 2.03 prescriptions and 1.0 visits.[3] As a result, the dollar cost per Medicaid beneficiary per month fell from $91.56 to $46.51 and finally to $10.43 at the end of the first year. This latter figure was substantially below the statewide average Medicaid expenditure of $17.00 per enrollee for comparable services during 1971 (Kentucky State Department of Health, 1972).

Although the Kentucky program represents a limited experiment, it may be expanded to cover the whole state, in which case a more reliable estimate of its effectiveness can be made. The alleged abuses under Medicaid and Medicare provide a rationale for such limits, but there are problems with the approach. First, there is a question of equity in imposing limits on but a single group of patients. Second, limitations must be flexible enough to assure that services will always be available to those with a clearly demonstrable need. Finally, limits must not encourage use of a more expensive service than necessary, simply because it is fully covered by the policy while a less expensive service is not covered or is severely

[3] Although it is probable that the reduction in Medicaid claims for drugs and physician visits represented an actual reduction in use, it is possible that certain individuals in the group purchased additional services from their own funds. Such out-of-plan use has been noted under the Medicare program, but in this case the poverty of the individuals involved certainly precluded extensive non-Medicaid medical service purchases.

limited. This last problem, of course, is most serious when certain services are excluded from insurance coverage altogether.

In the public sector, substantial benefit exclusions are found in most state Medicaid Assistance programs and under Medicare (which excludes such services as private duty nurses, private rooms, routine checkups, eye refractions, hearing examinations, immunizations, and drugs prescribed to ambulatory patients). Private insurance typically excludes services associated with a high probability of occurrence such as dental care. In addition, almost all policies contain exclusions on voluntary procedures such as cosmetic surgery.

The principal economic effect of an outright exclusion is to divide the industry into two markets, one for covered and the other for noncovered services. In the first market, insurance lowers the user price and tends to increase the quantity of services utilized; in the second, price becomes the primary allocative device. The implications of such a division are obvious. From an equity standpoint, the most important implication arises when the excluded services are of an essential nature, for then low-income groups may be deprived of needed care because of their limited purchasing power. This argument was recently employed by the Senate in its unsuccessful attempt to include certain prescribed drugs as covered Medicare benefits in the 1972 Social Security amendments (Commerce Clearing House, 1972a: 48–49).

From the point of view of efficiency, the primary problem (as mentioned above) is that the exclusion of certain medical services from insurance coverage induces a substitution of covered for noncovered care (Somers and Somers, 1967). In this way, although the use of some services is discouraged, overutilization of other services may result. A Medicare patient, for example, may well prefer a prolonged hospital stay to home care because under the latter he must pay for drugs, biologicals, and meals which would be covered if he remained in the hospital. Failure to consider the ability of patients and physicians to employ this form of substitution may help explain why the early actuarial projections of Medicare hospital costs were so low relative to actual expenditures (U.S. Senate Committee on Finance, 1970). For these reasons, exclusions (with the possible exception of cosmetic surgery) represent the least desirable form of financial disincentive.

Control Through Authorization Requirements

Aside from the issue of form, financial disincentives will fail to curb the inappropriate use of medical services whenever individuals follow the dictates of physicians who themselves are unconcerned with overutilization or misutilization. While this argument should not be overdrawn, it is generally true that when a patient decides to visit a physician, he makes an implicit decision to do as the physician recommends. Under these circumstances, selective pricing techniques are relevant only for initial patient-physician encounters and cannot be relied upon to ensure the appropriateness of prescribed treatments.

There are, of course, a number of ways in which the appropriateness of treatment may be controlled. At the extreme is the threat of malpractice litigation should negligence be involved in the treatment procedure. A second and less severe method entails peer review to pinpoint questionable procedures. Both of these mechanisms rely upon negative incentives (penalties), but it is also possible to exercise control through positive inducements (for example, the "profits" that a prepaid group practice obtains by lowering the level of unnecessary surgery). A final method, and by far the most direct (as well as the most controversial) is control through authorization requirements.

Authorization requirements are of two basic types. The first and most common is certification, whereby payment for a medical procedure is made only if the attending physician testifies in writing that the procedure is medically necessary. Limited primarily to hospital and nursing-home admissions, certification requirements are often extended to encompass the entire inpatient stay. In such cases, the physician must recertify the continued necessity of care at periodic intervals throughout the treatment process. In any event, the general approach is characterized by the fact that the physician who provides the treatment is also responsible for attesting to its necessity. This arrangement clearly violates an intrinsic principle of regulation, and apart from acting as a potential deterrent to fraudulent practices, certification requirements have not been noted for their success in limiting overutilization (Fitzpatrick, 1966; Commerce Clearing House, 1972a: 9897–9912).

The second basic type of authorization requirement operates

through an administrative body whose purpose is to review a patient's condition before treatment is applied (and/or at periodic times thereafter) and to decide whether the attending physician's regimen is both medically sound and economically efficient. Included in this category of controls are preadmittance screening for hospital admissions, surgery authorizations, and committee review of recertification decisions. At least theoretically, such mechanisms can eliminate both unnecessary treatments and instances in which expensive care (such as hospitalization) is given when less costly alternatives (outpatient or home care) are in keeping with sound medical practice. But there are significant practical impediments to this approach to utilization control. The difficulty and expense of establishing a body to authorize treatment is the first. It is possible, in fact, that the administrative costs could be higher than the potential savings to society resulting from reduced utilization (Flashner et al., 1972). Second, since a panel of physicians would presumably play the central role in deciding upon the appropriateness of treatment, there is the problem (common to utilization review committees) of how divergence in medical opinion should be settled. Finally, the effectiveness of the control may depend on the composition of the authorizing body. Domination by any one body—the insurance industry, government, or the medical profession—could conceivably produce results quite different from those of the other authorizing bodies in terms of the extent and type of reduced utilization.

Prior Authorization and Preadmittance Screening

The concept of prior authorization for treatment is most appropriate to nonemergency institutional care. Not only are the costs of overutilization highest in the institutional setting, but for surgical procedures in particular, expenditures might well be reduced if the attending physician had to seek authorization from a panel of doctors committed to avoiding unnecessary use of surgical facilities. Such prereview mechanisms have proven successful in the health systems of other countries, but the approach has seen only limited application in the United States. There has been no systematic attempt to promote or encourage the concept in the private sector, and even in the public sector the approach is far from common. Several states, however, do employ the techniques of prior approval in their Medicaid programs. Of these, California has gone the furthest. Starting

in 1970, Medi-Cal required prior authorization from a state-employed physician or medical consultant for all nonemergency hospital admissions. In the beginning, only admissions were subject to prior authorization, but at present the expected length of stay is also set prior to admission and any extensions are subject to recertification. During its first few months, the program did reduce the incidence of hospitalizations. After this initial period the number of admissions rose, but at a far lower rate than the increase in the number of persons eligible for Medi-Cal benefits. Despite a 23 percent increase in eligibility, the Medi-Cal program paid for only 3.5 million patient days in 1970, as opposed to 3.6 million in 1969. Overall, the admission rate dropped from 17.4 per 100 eligible persons in 1969 to 16.1 in 1970 (Brian, 1971; California Health Data Corporation, 1971). Although criticized for its occasional harshness and its political motivation (Gordon, 1972), the California program has shown that prior authorization can achieve more effective control over hospital utilization. Such evidence should provide a hopeful sign to administrators of public medical programs elsewhere, even though the approach may have limited applicability to private insurers.

Insurance carriers do have alternatives in this regard. In Michigan, for example, Blue Cross has experimented with a modified preadmittance screening procedure for hospital admissions. The procedure (though never implemented on an ongoing basis) worked through the hospital, which called upon a special clerical division of the Michigan Hospital Service to ensure that the patient to be admitted had the required coverage. Such a review process was unique, but it also represented an extremely limited form of prior authorization because the use of services was not determined on the basis of medical necessity, nor were the most important alternatives to inpatient care (notably clinic and outpatient benefits) covered under most Blue Cross subscriber contracts at the time of the experiment.

A modified approach to prior authorization which does not rely upon any overt administrative structure is found in United Mine Workers health plan. The United Mine Workers (UMW), which provides comprehensive medical care to about one-half million coal miners and their dependents, has a dual incentive to insure high quality care and to reduce unnecessary utilization because it is both provider and beneficiary. In achieving these ends, the union

requires that each covered family select a plan-approved physician to be its primary provider. This doctor becomes a "managing physician" through whom all treatment is then channeled.[4] Not only does the managing physician make or approve all specialist referrals, but each specialist in turn is expected to report on any treatment provided and to consult on recommended treatment procedures. Care provided by nonaffiliated physicians or specialists customarily requires the written approval of the managing physician. Instituted in the mid-1950s, this program (along with other innovations such as reimbursing physicians on a fee-for-time rather than fee-for-service basis) succeeded in reducing utilization in certain areas by up to 25 percent (Kerr, 1971).

Recertification

Recertification represents a logical extension of prior authorization or preadmittance screening for institutional services. In principle, recertification requirements are designed to bring to the attention of the physician the necessity for periodic evaluation of the need for inpatient care (Fitzpatrick, 1965). In practice, this method has proved to be of limited effectiveness in curtailing overutilization both because the attending physician usually recertifies his own patients and because of wide variations in the timing of recertification requirements. In 1965, for example, 30 Blue Cross plans required recertification: seven used a 30-day limit, eight used a 21-day limit, and only two required recertification in less than 10 days (Bailey and Riedel, 1968). Under Medicare, hospitals are allowed to define their own "thresholds of recertification" within certain broad intervals specified by program regulations. In the first year of the program, 57 percent of 6,738 Medicare-certified hospitals set the limit at over 20 days, and, while current regulations specify an 18-day limit for the first recertification, relatively few institutions set limits low enough to ensure that even a small percentage of acute-care cases will be reviewed. This represents a potentially serious departure from regulatory intent because there is no a priori reason why overutilization should be any more prevalent in long than in short

[4] It might also be noted that a study commissioned by the U. S. Senate Committee on Finance (1970: 128–129) recommended the adoption of the primary or managing physician concept as a cost-saving device under Medicare and Medicaid.

stays.[5] Therefore, any method of recertification which excludes the majority of hospital cases from review on the basis of length of stay compromises the effectiveness of this utilization control.

The experience of most Blue Cross plans indicates that recertification programs have little or no net effect on the average length of stay (Fitzpatrick, 1966). One study of the New Jersey Blue Cross Approval by Individual Diagnosis (AID) program, however, is of special interest. Recertification limits under AID were established by diagnosis, and the resultant lengths of stay were analyzed for 308 types of treatment representing 94 percent of the 313,000 Blue Cross–paid claims in all New Jersey hospitals during 1963 (Bailey and Riedel, 1968). The study showed that although length of stay decreased during the first two quarters of the experiment, the effects of the AID program largely disappeared after six months as physicians reverted to old and established patterns of care. This short-term trend (which has been observed elsewhere) may be credited to the "Hawthorne effect," meaning that the results were not produced by the test factor (recertification) but by the fact that the subjects knew they were being observed and altered their behavior accordingly. An alternative and equally plausible explanation is that at the beginning of the program physicians believed that recertification decisions would be actively reviewed. When it became clear that utilization review committees were either unable or unwilling to apply sanctions, behavior returned to "normal."

The issue of Committee review of physician recertification has recently been cited as a major administrative problem facing the Medicare program. In a 1971 report, the U.S. General Accounting Office (GAO) concluded that although committee review of Medicare patients tended to be more impartial than the attending physician's determination of need for continued care, many questionable cases slipped by because "neither utilization review committees nor the administrative staffs at hospitals and extended care facilities (ECF) had taken timely action" (Commerce Clearing House, 1972a: 9897). The GAO study recommended a tightening of re-

[5] It has been argued that recertification is appropriate only in the case of long stays and that other controls should be used to reduce overutilization in shorter stays. However, since the admitting physician usually determines the length of stay in any event, logic would suggest that the same control mechanism be used in both cases.

sponsibility regarding both review committee activities and physician recertification. Attempts to improve this type of utilization control may eventually prove more effective under Medicare than Blue Cross, but success will depend upon how well the program administrators understand the limits associated with any form of review procedure.

Control Through Review Procedures

Utilization control through the review of medical treatment is an obvious complement to authorization requirements in the sense that the one typically provides the standards of "appropriateness" of care which the other applies. And just as there are various ways in which standards can be enforced, there are several basic methods by which they may be established. These include: (1) institutional review, which involves the evaluation of services rendered, facilities utilized, prices charged, and quality of care provided through the examination of records by a designated committee; (2) professional standards or peer review, whereby a committee of health professionals evaluates the services rendered by one of its own members; and (3) claims review, in which a third-party intermediary examines bills it has received for reasonableness of fee and appropriateness of service. There are obvious similarities in the issues considered under these review processes, but there are also substantial differences in the way each method is applied and the success that each has shown in containing medical utilization.

Institutional Utilization Review

Institutional review is practiced in virtually every type of medical facility, but its most common manifestation is seen in the hospital (U.S. Department of Health, Education, and Welfare, 1969). Hospital utilization review (UR) committees are composed typically of physicians but they differ from institution to institution. In some hospitals, doctors perform all of the tasks leading up to the utilization review meeting; in others, clerks, medical librarians, and nurses help in gathering data, filling out forms, and deciding which cases to bring before the physician members of the review committee.

Differences in committee structure are reflected in the various ways that hospitals perform the review function. Dr. Theodore Scurletis (1969) has outlined five approaches in common use:

1. Internal study of medical records, i.e., analyzing all records or a sample of discharges or admissions.
2. Ongoing studies of selected diagnoses or therapeutic categories. Studies of the more common diseases or treatment procedures found in the facility are often used as a UR technique.
3. Use of the services of organizations with computer facilities to compile pattern statistics, design profiles, and provide comparative data. Professional Activity Study–Medical Audit Program (PAS-MAP) is an example.
4. Cooperation with a fiscal intermediary. Blue Cross and Blue Shield are able to accumulate data through claims processing, which can help UR committees.
5. Any combination of the above. The selection of the method will depend upon data available and the type of study being made. Staff time and the availability of clerical help are other considerations.

Whichever approach is employed, the normal procedure involves evaluation of both in-process and post-treatment cases. The typical procedure for in-process review is the medical audit in which a clerk in the admitting office flags patients' medical records for recertification review. Nurses or ward clerks then fill in the charts to be reviewed and, either directly or through the medical records librarian, call to the doctors' attention those which require recertification.

Post-treatment review typically begins when supervised personnel in the medical records department record and review the charts of all discharged patients. The medical records librarian brings to the UR committee any questionable charts, a sample of patient records, or any cases which are significantly different from predefined norms such as those provided by PAS-MAP. The UR committee then proceeds to evaluate those cases, problems, and discharged patients' records brought to its attention.

The traditional approach to utilization review is for the UR committees to examine individual cases, sometimes sampled randomly, without using any uniform methods of evaluation and often without having any predetermined criteria at hand. Under such conditions, UR represents a hit-or-miss affair. A far superior method is the patterns-of-care approach which involves a review of selected categories of disease or operations. Under the patterns system, the UR committee first examines hospital practices in the aggregate, then looks at the clinical department, the diagnosis or oper-

ation group, and finally the individual case. With this method, the PAS-MAP system can be used to provide an overview of all hospital patients and a breakdown of disease categories by such factors as length of stay, sex, and age. The advantage of the patterns approach is that the physician can delegate to ancillary personnel the task of collecting and presenting the information on which he is to pass judgment. The doctor is still the evaluator, but the process minimizes his work in compiling data.

The use of computers in the patterns-of-care approach is quite common, in large part because it represents a mechanism that is "within the capabilities of most hospitals, both as to cost and physician time involved" (Turner, 1969: 352). Its greatest value is that it allows the hospital to use screening mechanisms to indicate what disease and operative categories should be audited (Williams, 1967). Programs can be designed to signal when predetermined diagnostic parameters are exceeded. Control of bed utilization is also facilitated by automated analysis of admission rates by diagnoses, length of stay, and services provided.

There is scant indication, however, that such efforts affect awareness by physicians and hospitals of their responsibility to help reduce unnecessary utilization. It is true that in recent years hospital admissions per thousand, days of care per thousand, and average length of stay have leveled off. Although the causal factors for these trends are not clear, advocates of utilization review claim credit for the long-range educational aspects of the UR effort.

But in spite of such trends, and in spite of the advancements in UR techniques, the effectiveness of utilization review is still highly variable. As mentioned, meaningful utilization control depends upon the motivation of the hospital staff. As long as there is a scarce supply of beds and an excess demand, UR committees will probably have adequate motivation; however, where supply exceeds demand, motivation may well decline correspondingly. As one observer (Anderson, 1971: 98-99) concluded:

> As long as the budget remains flush, the utilization review committees . . . will reflect what the economy will bear in relation to public and medical expectations rather than some abstract criterion of appropriate use. . . . It does not seem likely that these committees can cut back use appreciably unless the hospital budgets are reduced quite arbitrarily.

There is some empirical evidence to this effect. Bonner, Decker, and Kasten (1972), in their study of 46 medical facilities, found that UR was much more successful in those institutions with high occupancy, low rate of turnover, and high initial length of stay. It proved less successful where facilities were being underutilized. Roemer and Shain (1959a; 1959b) examined the same phenomenon and concluded that 70 percent of the differences in hospital utilization rates by state and county could be explained by bed supply, and that, beyond a certain point, bed use becomes less and less reflective of illness levels.

In addition to the question of institutional motivation, the effectiveness of UR depends both on the quality of medical records and the ability of review committees to agree upon what constitutes appropriate usage. It is generally conceded that deficiencies in medical record keeping are pervasive enough to seriously hamper UR activities (Tufo and Spiedel, 1971; Peterson et al., 1956). But even when adequate records are kept, the concept of appropriateness of care can change from context to context and is usually defined, as Donabedian (1966: 167) points out as "almost anything anyone wishes it to be." At the outbreak of World War II, for example, when England was anticipating heavy war casualties, British hospitals were told to accelerate discharges, retaining only those patients for whom "institutional treatment is essential" (Titmuss, 1950: 153). As a result of this directive, between 40 and 50 percent of all patients were discharged immediately.

An empirical study done in Michigan (Riesser, 1969) points up another aspect of the same problem: Two pairs of doctors were asked to review 100 cases of hyperbilirubinemia, a blood disease related to Rh blood factor. Though care was deemed inappropriate in 15 cases, not one case was singled out by more than one physician.

Overcoming this inability to agree upon common criteria of evaluation is critical to the success of utilization review activities. Basically, the problem hinges upon two difficulties common to many if not most review efforts. First, the concept of "appropriateness" is ultimately based upon the individual physician's own value system, so that a great deal of variation exists among reviewers. This problem is exacerbated by the fact that the rules of evaluation are often imprecise. Reviewers may be simply told (as were those who conducted a special study for the Teamsters) to "use as a

yardstick . . . whether you would have treated this particular patient in this particular fashion during this specific hospital admission" (deRouville, 1971: 1544; Morehead, 1967). Under these circumstances, one would expect the degree of variation among reviewers to be as great as among the original providers. Furthermore, in the absence of formal criteria of evaluation, reviewers are subject to influence from outside information sources, such as knowledge about a particular hospital's reputation, or the reviewer's level of expertise regarding the specific case at hand.

A second basic problem is that whereas physicians are professionals in their own occupation, they are often amateurs at review. As amateurs they may never fully develop the skills necessary to properly evaluate cases. Typically, reviewers are recruited on a short-term basis, serve rotating memberships, work full time in addition to their review activities, and receive little or no remuneration (deRouville, 1971). In addition, some physicians resent the demands made upon their time and feel that the whole UR activity is an intrusion into their professional prerogatives. It is scarcely any wonder, given these conditions, that inter-reviewer disagreement rates on particular committees may average between 20 and 30 percent.

Numerous attempts have been made to increase the reliability of evaluative reviews. While none has produced a foolproof system, these attempts are suggestive of ways that UR efforts might be improved. Richardson, who was instrumental in organizing the Rochester Perinatal Study (in which inter-reviewer disagreement rates were 19 percent), suggested after analyzing his results that review should concentrate on an objective evaluation of medical treatment processes and procedures, and that reviewers should be given a detailed list of appropriate treatments which "provides an operational definition of the quality of clinical care that is relatively easy, comparatively inexpensive, and allows between-case comparisons of quality based on relative positions on an unidimensional scale ranging from very good to very bad" (Richardson, 1972: 462). In applying such a technique, Richardson found that nurse-evaluators produced a level of agreement similar to that of physician-evaluators. A second Teamster study, using a form of objective evaluation, indicated that intercoder disagreements could be reduced to only 8 percent of all cases by having judges re-review any points of difference (Morehead, 1967). Other studies (Zimmer, 1972;

McClain, 1972) have also shown that an examination of intra-reviewer unreliability can be useful in locating the source of most errors.

But even if the problem of defining common evaluative criteria can be overcome, there are other practical shortcomings evident in the operation of review committees. These shortcomings are clearly seen in an analysis of utilization review in 35 short-term Connecticut general hospitals three years after UR requirements were mandated under the Medicare program (Berman, 1969). The study found a high degree of heterogeneity among UR techniques in the hospitals and suggested that a majority were intent upon justifying patient admissions and extended lengths of stay. Other problems noted were a lack of communication between members of the utilization review committees, a tendency to concentrate on one segment of the patient population (such as Medicare patients) to the exclusion of other segments, inefficient use of physicians' time due to an inadequate use of paraprofessional and other medical personnel, and an ineffective use of computerized statistics due to a general lack of understanding of these statistics. The study concluded that few of the hospitals were receiving benefits commensurate with the cost of physician energy expended and that most failed to use UR committee findings in a way designed to change hospital policy or to improve the efficiency and quality of patient care.

Two other studies analyzing the effectiveness of utilization review in Pennsylvania hospitals offer a somewhat more optimistic view. The first (Marcom, 1965: 11), based upon an analysis of hospitals in Pittsburgh over a 10-year period ending in 1963, reached the following conclusion:

> If one accepts the premise that a high occupancy rate and lower average length of stay constitute more effective utilization of hospital facilities, there can be little doubt that intense utilization committee activity can contribute to more effective utilization of hospitals. There is no evidence whatever to indicate that utilization committees have succeeded in curbing the quantity of utilization, as measured in admissions per thousand persons and patient days per thousand persons.

The second study, conducted in 1969, analyzed the operation of 23 hospitals in central Pennsylvania and concluded that most UR committees have been successful in reducing the overall length of pa-

tient stay but that the UR programs "can be considered somewhat ineffective due to certain inconsistencies that exist among hospitals concerning maintenance of high-quality care, effective utilization of hospital services, and effective and continuing educational programs and health care planning" (Grimes, 1970: 48).

These as well as other similar findings indicate that the effectiveness of UR varies considerably from place to place. It is noteworthy also that two of the studies (the Connecticut study and the second Pennsylvania report) found that UR guidelines under Medicare were being largely ignored by a number of the sampled hospitals. The General Accounting Office (GAO) study of 1971 reached a similar conclusion (Commerce Clearing House, 1972a: 9904). Based on a sample of 1,735 extended-duration Medicare cases in 49 nursing homes and 41 hospitals in five states, physician consultants for the GAO questioned whether a full 25 percent of the cases reviewed met the required criterion of "necessary" care:

> From their reviews of the same medical records which had been available for examination by the providers' utilization review committees, our consulting physicians questioned in 465 cases whether the care provided should have been paid for under the Medicare program. Of the 465 cases, 351 had also been reviewed, but not questioned by the providers' utilization review committee.

The GAO recognized the problem of legitimate differences in professional judgments but went on to add that "these differences . . . point up a number of significant problem areas which require the further attention of SSA in its efforts to achieve an effective utilization review function as part of the controls exercised over the Medicare program" (Commerce Clearing House, 1972a: 9905). Given that the supervision and control over UR procedures tends to be even less unified in nonpublic programs, a similar appraisal could well be made of utilization review efforts in general.

Professional Standards Review

Professional standards review (or peer review) shares many of the essential characteristics of hospital utilization review, and in fact, most hospital UR functions are conducted on a peer review basis. However, both the conceptual and organizational forms of peer review may differ from those applicable to utilization review. The

American Medical Association's *Peer Review Manual,* for example, argues that "quality control is the prime objective of Peer Review and cannot be allowed to become secondary to cost control" (American Medical Association, 1972, ch. 3: 16). In contrast to this rather narrow interpretation, the AMA Council of Medical Service has stated that peer review represents "medicine's efforts to assure high quality of health services at reasonable cost, slowing the rate of escalation in health care charges, stimulating health insurance organizations to make broader protection available to more people, and regaining professional control in patient-physician fiscal and economic relationships" (Delaware Medical Journal, 1970: 248).

Some form of peer review is practiced by virtually all health-related professional societies including dentistry, pharmacy, and physical therapy. The professional society undertakes review either when the professional's place of business does not perform such a function (i.e., for work performed outside the hospital) or as a "court of appeals" for decisions reached by an institutional UR committee. Peer review is typically initiated with the referral of a complaint from a patient, physician, insurance carrier, or government agency to a local committee which acts as a fact-finding board. In most cases this board has no disciplinary power but can make recommendations for action. If no decision is made or if one of the parties objects to the decision, the case may be referred or appealed to a regional or even a state peer review committee.

In recent years, most physician organizations have come to accept and support the concept of peer review. To an undetermined but probably significant extent, this acceptance has been motivated by a desire to preclude government regulation or supervision. The AMA Committee on Health Insurance Legislation, for example, concluded that "if medicine does not provide for a mandatory review procedure . . . this responsibility will pass to government by default" (AMA, 1972, app. A: 12–13). In Mississippi (AMA, 1972, app. B: 2), the state medical association was even more direct:

> The private practice of medicine is under siege. Sadly, it is a focal point of public wrath, and consequently, politically an inviting target. Many advocate the wresting away of control from the physician. Peer Review is a positive program designed to establish and maintain control of medical practice in the hands of physicians.

Evaluating the effectiveness of peer review is difficult if not impossible because there are few empirical studies of its impact on utilization patterns. Although the literature is filled with articles concerning peer review, one finds only vague mention of "encouraging evidence" that the mechanism enhances long-term professional standards or administrative efficiency. This lack of hard evidence notwithstanding, Congress made provision in the 1972 Social Security amendments for an officially recognized and federally financed complex of review bodies (known as Professional Standards Review Organizations or PSROs) under the control of doctors of medicine and osteopathy.

Although the PSRO provision received little Congressional debate, it may well have a far-reaching impact on all aspects of utilization review. Basically, it provides for a county-state-national review apparatus through which groups of local doctors will be allowed *exclusive* control over Medicare and Medicaid utilization review. Committees currently authorized to perform UR activities for Medicare and Medicaid will be allowed to function on an interim basis for two years, but must then transfer these functions to the PSROs. If the doctors in a particular locality decide not to perform review activities, the Secretary of HEW can designate some other agency (such as a county health department), but the local physicians must approve such a delegation of responsibility. If a recognized PSRO is deemed ineffective it may be dissolved (after a vague but seemingly lengthy procedure) and its functions turned over to another body. The legislation grants PSROs many responsibilities but emphasis is put upon "assuring" high standards of care and "encouraging" effective utilization under public programs.

The intent of the PSRO legislation is perhaps best summarized by the U.S. Senate Committee on Finance (Commerce Clearing House, 1972b: 284):

> The committee believes that the review process must be based on the premise that only physicians are, in general, qualified to judge whether services ordered by other physicians are necessary. The committee is aware of increasing instances of criticism directed at the use of insurance company personnel and Government employees in reviewing the medical necessity of services.

The Committee generally agreed with the principles of peer review enunciated in the 1967 report of the President's Health Manpower

Commission which recommended that peer review be performed at the local level with professional societies acting as sponsors and supervisors (Commerce Clearing House, 1972b). The law as enacted, however, allows only physicians to form or hold memberships in PSROs even though the services of nonphysicians are subject to review. This creates the potential for a serious conflict of interest both within the health sector and between the medical profession and the public. While it is true that accountability for PSRO activities will be strengthened by a provision in the law for the development of sophisticated systems to detect inappropriate utilization, it is not at all clear that this benefit will outweigh the dangers inherent in providing to any group the statutory authority to regulate itself. Peer review is by most accounts a rather conservative UR device in any event, and there seems little reason to predict that the activities of PSROs will necessitate a change in this judgment. The provisions in the law for self-regulation, part-time and rotating memberships, and the exclusion of nonphysicians all suggest that PSROs may well give the appearance without the substance of control.

Claims Review

A final type of ex post facto control over utilization is claims review. All third-party payers (including Blue Cross–Blue Shield, commercial carriers, and the intermediaries for Medicare and Medicaid) employ some kind of claims review which typically involves the use of both prepayment edits and postpayment audits. Factors considered when claims are reviewed include completeness of information, internal consistency, lack of obvious error or misrepresentation, the extent of recipient coverage, the reasonableness of charges, and such utilization characteristics as appropriateness of admission, length of stay, and efficiency of scheduling procedures in the facility. In addition, some insurers use manual or computerized prepayment screens to scan providers and subscribers for unusual patterns of care, such as the physician who gives the same type of x-ray or pathology tests to a large number of patients, or the patient who receives an unusual number of physician visits while in a nursing home.

Although claims review clearly involves many functions besides utilization review, it is difficult to isolate such functions as the detection of fraud, improper billing, and the identification of unnecessary utilization. For example, a claim may be rejected by the insur-

er because the person receiving a service did not have coverage for that service. In such a case there may or may not be a determination of whether the service is "necessary." Similarly, prepayment screens designed to determine the "appropriateness" of care are aimed as much at uncovering fraud as they are at deterring unnecessary usage (or provision) of services. Perhaps the best example of utilization review through claims review involves the use of post-payment audits. Third-party intermediaries like Blue Cross (Fitzpatrick, 1966: 5) will occasionally reject a claim subject to an affirmative decision by a hospital UR committee or physician peer-review group:

> [T]he utilization review programs of Blue Cross Plans are generally a three or four level activity routed in the routine processing and validating of all claims and rising to branch out into various forms of review and appeal. Somewhere along the line a great deal more information than any claim form can reveal usually must be obtained. Although final authority and responsibility for payment or denial of claims rests with the Plan board, some process of medical review and advice is always involved. At the top level of review activity, physician review committees, medical societies' utilization committees, other county society committees, and hospital utilization committees are involved.

From the standpoint of controlling utilization, this process has shown a positive but limited degree of effectiveness. The Nebraska Blue Cross Hospital Service Association points out that the relationship between Blue Cross and hospital UR committees has resulted in documented savings, but that the "real value" of the approach has been to create an awareness of the problems of overutilization and thereby indirectly reduce unnecessary care. In Cincinnati, Blue Cross representatives note that review has reduced length of stay and has been responsible for a more effective use of personnel and facilities in several hospitals. But they go on to note that the activities of such committees have been "spotty." The New Jersey AID program mentioned previously was a Blue Cross innovation. The limited success of the program, however, suggests that referral of utiliization review functions to participating hospitals may result in only short-run benefits (Fitzpatrick, 1966).

In terms of claims review activities under Medicare and Medicaid, one finds further evidence of positive but very limited results.

In Michigan, for example, Blue Shield review of Medicaid expenditures in 1971 led to the recovery of almost $23 million or 7.4 percent of total payments (Michigan Blue Shield, 1972). Review of utilization, however, represented a relatively small component of this recovery process, amounting to only 3.3 percent of all monies recovered or 0.2 percent of all monies paid out. Moreover, even this figure is high, since utilization review as defined by Blue Shield includes recoveries from both unnecessary treatment and fraudulent claims. During the same year, Michigan Blue Cross surveillance of Medicaid expenditures led to the recovery of $1.3 million (of a total payout to hospitals of $112 million) from claims rejected on the basis of program exclusions and limitations (Michigan Blue Cross, 1973). According to Blue Cross, "Many questionable hospital cases are referred to hospital utilization review committees for their review and recommendations as to the level or type of care provided" (Michigan Blue Cross, 1973: 3). But again, something less than the full savings of $1.3 million can be attributed to claims for "unnecessary" care.

Part of the problem arises from the fact that few third-party payers have integrated systems designed both to provide full-scale surveillance of patient utilization and provider performance, and to provide the policing necessary when irregularities are discovered. A step in this direction was taken several years ago when New York City developed its "Watchdog" program over Medicaid expenditures. The "Watchdog" system, based on a rather complex combination of standard setting, committee and professional review, complaint procedures, spot checks, and other methods of surveillance has been credited with saving the city millions of dollars annually (U.S. Senate Committee on Finance, 1970: 249-252). In recent years, interest in supervision and surveillance over public expenditures has moved toward the development of sophisticated computer programs of claims review designed to far surpass the capabilities of such predecessor systems as the PAS-MAP approach to data generation and information retrieval. The 1972 amendments to the Social Security Act call for the creation of regional and national data-processing centers which will provide this type of computer analysis to federal and state agencies. At the state level, several Medicaid agencies have shown an independent interest in systems development. Illinois, for example, has just recently developed a program known as the Hospital Admission and Surveillance Program

(HASP) to ascertain both the necessity for and the quality of inpatient care supplied to state medical assistance patients (Flashner et al., 1972). Other states, such as Michigan, are in the process of designing systems which will monitor all provider activities including diagnosis, services performed, and medication prescribed.

Although there can be no doubt that such surveillance systems are necessary given the ever-growing complexity of the health services industry, it should be obvious from what has already been said that control over utilization is not merely a question of technological precision, but hinges as much (or more) on the incentives, values, and perceptions of medical providers and patients alike. The computer provides an essential tool to monitor behavior, but other mechanisms are required to change behavior patterns.

Control Through Malpractice Litigation

The oldest form of utilization control, and one designed explicitly to have an impact on behavior, is the threat of legal action should a provider of medical services be accused of malpractice. As previously discussed, there are two approaches to utilization control, one based on considerations of economic effectiveness and efficiency, the other based on questions of medical need. Malpractice litigation (or more precisely the threat of litigation) provides an interesting example of how these two approaches may work against one another in actual practice.

In one sense, malpractice litigation represents the patient's ultimate control over the quality of services provided. The threat of legal redress serves as a constant reminder to physicians to avoid substandard work and nonaccepted treatment procedures. It may also improve the quality of medicine by encouraging standardized medical records and bookkeeping practices. If the current rate of increase in malpractice suits is taken as any indication (U.S. Senate Subcommittee on Executive Reorganization, 1969), patients themselves are becoming more "suit conscious" with regard to physicians whom they perceive to have failed in the provision of adequate medical treatments.

But, in another sense, the threat of legal action may produce quite unintended results. In particular is the argument that the fear of malpractice litigation has led to an increase in "defensive medicine," and a consequent rise in unnecessary treatments and diagnos-

tic tests. Defensive medicine, according to Hershey (1972: 72), consists of two undesirable patterns of behavior:

> First, when a test or procedure is performed because the physician fears that if he does not perform it, and the patient has a bad result, some medical expert might testify that it was unnecessary, and . . . second when a test or procedure is not performed because the physician believes that the risk of legal difficulty from a complication arising from the procedure is substantial, although the physician's view is that the patient would be better off if it were performed.

The extent to which defensive medicine is practiced in America is debated by knowledgeable observers, but almost all agree that such a phenomenon does exist. A study of the attitudes and opinions of 500 physicians in the late 1950s is indicative (Brenner, 1960). The physicians sampled were asked whether fear of malpractice suits led to any change in their own practices. The results were dramatic: 54 percent said they kept more detailed office records; 47 percent said they ordered more x-rays; 43 percent used more consultations; 37 percent ordered more diagnostic tests; 40 percent gave less telephone advice; and 36 percent permitted fewer prescription refills. Other effects cited by less than 30 percent of those interviewed related to caution with new procedures (28 percent), more frequent hospitalization (20 percent), and screening of new patients for legal reasons (25 percent).

A more recent survey of physician attitudes conducted by the staff of the *Duke Law Journal* (1971) suggests that the threat of malpractice has a relatively small effect on *positive* defense practices (i.e., ordering excessive laboratory tests), but has a potentially greater impact in terms of *negative* defensive practices (such as the failure to apply new technological advances in diagnosis and treatment). However, in the case of both these and other studies (U. S. Department of Health, Education, and Welfare, 1973; Rice, 1971; U. S. Senate Subcommittee on Executive Reorganization, 1969) it is important to realize that a physician's stated behavior may not correspond with his actual practices. As Hershey notes, "[m]ost physicians point out specialities other than their own as examples of those most influenced by liability considerations. These same physicians also seem to imply that others within their own specialty are generally practicing with more concern about liability than them-

selves" (Hershey, 1972: 90). No one has yet measured the actual cost of liability-induced defensive medicine, and it is doubtful if any satisfactory measure can be devised. It thus remains an open question whether the negative aspects of malpractice outweigh the usefulness of the mechanism as a utilization control.

Alternative Suggestions for Control

The progression from supply limitations to malpractice litigation covers a wide array of current approaches to control, but before this experience is summarized, it should be realized that various alternative methods of control have also been suggested. These alternatives would, for the most part, require rather substantial changes in current methods of health financing and delivery, and for this reason their effects on the utilization of medical services cannot be estimated with any degree of precision. This caveat notwithstanding, three categories of proposed controls deserve brief examination: (1) the major Congressional national health insurance bills, (2) proposals for variable subsidy insurance, and (3) suggestions for expanding the scope of prepaid health care centers.

National Health Insurance

The purpose of national health insurance is to extend to all people the opportunity to receive medical services by eliminating or reducing the financial barriers to use. To many, this represents an important goal from an equity perspective, but it also creates an efficiency problem when the barriers to "inappropriate" (as well as appropriate) utilization are lowered. Of the bills either introduced or awaiting introduction in the 93rd Congress, five in particular warrant mention. They are the Kennedy-Griffiths Health Security bill supported by organized labor, Representative Ullman's National Health Care Services Reorganization and Financing proposal backed by the American Hospital Association, the Burleson-McIntire National Healthcare bill sponsored by the private health insurance carriers, the AMA's Medicredit plan, and the Nixon Administration's Health Partnership proposal. These have received considerable attention in the literature (Berki, 1972; Spontz, 1972; Stuart and Bair, 1971; Stuart, 1972; Burns, 1971; Fein, 1971), and there is little reason here to reiterate the various coverage provi-

sions and financing mechanisms contained in each. What is of interest is how they propose to limit unnecessary utilization.

Taken as a group, these national health insurance proposals contain surprisingly little in the way of innovative approaches to utilization control. With the single exception of the Health Security plan, they all contain the deductibles, coinsurance, benefit limitations, and other features so common to private insurance polices (and, in fact, the Medicredit and National Healthcare bills are explicitly designed to subsidize private health insurance). Every one of the proposals requires utilization review procedures similar if not identical to those mandated under current Medicare and Medicaid regulations. Two of the bills (the AMA and Nixon proposals) specify payment mechanisms (such as full cost reimbursement for health facilities and payment of customary and prevailing fees for physicians) which offer no new incentives for providers to reduce unnecessary utilization. There are, however, some new twists. The Ullman bill, for example, would create a network of "health care corporations" or HCCs to coordinate community health resources. Depending upon local circumstances, these HCCs might be in a position to apply some of the more positive forms of supply limitation considered previously. Several of the bills (including the Burleson-McIntire proposal and the Kennedy-Griffiths plan) make provision for experimentation with incentive reimbursement schemes. When this is combined with support for alternative delivery mechanisms (a primary element in the Kennedy-Griffiths plan), the result might eventually serve to reverse the incentive to overprovide certain types of medical services. Of all the bills, the Health Security proposal offers the most innovative package of utilization controls, including prospective budgeting for hospitals, preferential treatment for physicians operating in prepaid groups, the establishment of a quasi-independent Commission on the Quality of Health Care to establish standards, and a Federal Health Security Board with responsibility for determining spending priorities.

Variable Subsidy Insurance

The utilization controls envisaged under the Health Security proposal are also likely to be extremely complex from an administrative standpoint. In part, this complexity reflects the price one must pay when consumers are not forced to regulate their own demand

for medical services. While there is no economic reason why the social costs should necessarily be any greater under administrative regulation than under a system of self-regulation, there are those who favor self-regulation on philosophical grounds. Furthermore, as several writers have shown, it is conceptually possible to design utilization controls which maximize consumer responsibility and at the same time satisfy the equity requirements of national health insurance. The approach is known as variable subsidy insurance (VSI) and finds limited application in the Nixon Family Health Insurance Plan[6] and in proposals developed by M. S. Feldstein (1971), P. Feldstein (in Fein, 1971), and M. V. Pauly (1971).

Variable subsidy insurance is based upon the principle that for any given quantity of medical services supplied, an individual (family) should be subsidized only to the extent of the difference between the actual market price and the price he (they) would have been willing to pay in the absence of the subsidy. Assuming that demand is positively related to consumer income, the VSI approach would require that the patient-pay amount (either a deductible or copayment) be scaled to income, with high-income individuals receiving little or no subsidy (i.e., a deductible which approaches the actual price of the service) and individuals with very low incomes required to pay only a nominal amount for services received. The advantage of VSI over flat-rate deductibles and copayments is that the control of unnecessary usage need not result in income discrimination. If properly scaled, VSI could make the avoidance of overutilization of medical services as financially "attractive" to the rich as to the poor. The problem, of course, is in finding the proper scale of patient-pay amounts. And even if this could be accomplished (which is unlikely since income is but one of the determinants of demand for medical care), variable subsidy insurance is no more equipped than any of the other forms of financial disincentives to handle provider-induced overutilization. However, in defense of the concept, it should be noted the effectiveness of deductible and coinsurance mechanisms in any national health insurance plan could be improved (if not perfected) by scaling on the basis of income.

[6] The deductibles and coinsurance under Nixon's Family Health Insurance Plan (FHIP) are, to a very limited extend, scaled to income. The deductible, for example, does not apply to families in the lowest income group and then increases in two steps ($50 and $100) for families in the highest eligible income groups. Copayments also increase from zero to 25 percent in the highest income group.

Prepaid Health Care Centers

While most proposals for reducing overutilization are designed to operate within the context of the present fee-for-service delivery system, there are alternative models which suggest that a change in provider reimbursement, together with a change in the delivery mechanism, is the most promising approach to utilization control. The model most commonly considered in this regard is the prepaid health care center—or in more popular terms, the health maintenance organization (HMO). An HMO may be defined as a group of medical providers which offers a comprehensive package of health services at a centralized location to a defined population for a fixed monthly fee per enrolled individual or family. It is argued that an HMO can reduce overutilization and unnecessary treatments through an alteration in provider incentives: (1) because providers receive a fixed income regardless of the amount of services offered, there is no incentive to provide treatments not dictated by medical need; (2) because the organization is responsible for comprehensive care, there is likely to be more preventive care, more early diagnosis, and therefore greater savings in curative treatments than is the case in a fee-for-service system; and (3) because of the principle of shared risk, there is an incentive to prescribe less expensive methods of treatment when the choice arises.

Each of these assumptions regarding provider incentives has been questioned (Roth, 1972; Greenberg and Rodburg, 1971), and, particularly in the case of preventive treatments, there does appear to be reasonable doubt whether an HMO can be expected to produce better results than more traditional modes of delivery. But the incentive for preventive practices notwithstanding, there is ample evidence from a number of matched-population studies that the HMO can be quite effective in reducing hospital admissions and inpatient stays (Gaus et al., 1972; Donabedian, 1969; Saward, 1969; Shapiro, 1964). The savings obtained in this one area alone are enough to warrant giving serious consideration to the HMO model as a utilization control. Furthermore, the fact that the savings generated are the result of the delivery system itself rather than of some external rule or regulatory body increases its attractiveness from an administrative point of view. But the HMO has the disadvantage of being limited in practice to urban and suburban areas with relatively stable populations, and even in these places the start-up costs associated with new HMOs are substantial enough to

make this particular approach to prepaid medical care at best a long-range solution to the problem of overutilization.

Summary and Conclusions

It should be clear from the above discussion that most forms of utilization control in current practice suffer from one or a combination of shortcomings that include ambiguity of purpose, organizational inefficiencies, and the presence of undesirable or unanticipated side effects. It should also be clear that the relevance of available research findings in the area of utilization control is nearly as varied as the controls themselves. The problem in each case may be traced to the fact that control devices are usually designed to serve multiple functions. This allows the expositer of a particular point of view to classify a control mechanism as a "success" because it cuts costs even though it may be a "failure" in the sense that the reduced costs reflect a decline in the demand for "medically necessary" services. Similarly, a control device may be considered successful by some because it "ensures a uniformly high quality of inpatient care," even when the appropriateness of hospital admissions is not questioned.

Differences in opinions among health professionals regarding the efficacy of utilization control should not, of course, be taken to suggest either that current forms of control are worthless or that feasible alternatives are lacking. In the case of utilization review, to take just one example, it may be that the most significant effects are educational and that the absence of any rapid change in utilization patterns means only that improvement is gradual. But such optimistic interpretations notwithstanding, it does appear possible to design a system or combination of utilization controls which is both more effective and equitable than is now the case. To this end, the following points deserve consideration.

First, the use of supply limitations to control unnecessary usage must be approached with caution. From past experience it is known that controls over the supply of medical practitioners and facilities can produce highly uneven patterns of provision and use of services unless the distributional aspects of supply (both geographic and by type of specialty) are also subject to regulation. Moreover, before limitations can be considered as a recommended course of action, additional research is required to identify the minimum pro-

ductive capacity necessary to meet the medical needs of a given population. Because this represents a very difficult task even without consideration of technological advances in medical science, it is unlikely that present efforts to use supply limitations for utilization control (such as certificate-of-need requirements for hospital construction) will succeed except in instances where overcapacity is an obvious problem.

Second, financial disincentives to overuse may have an appropriate place in a system of utilization controls, but they must not be considered as surrogates for mechanisms designed to contain provider-induced overutilization. Also, it should be realized that the form of financial disincentive imposed upon the consumer is an important determinant in whether these control devices can be relied upon to serve their proper function. The present widespread use of flat-rate deductible and coinsurance provisions in public medical programs and private insurance contracts probably has little effect on the overutilization of the rich but may serve to curtail the demand for necessary care on behalf of the poor. While there is no administratively feasible way to eliminate such differential impacts, the process could be made both more efficient and more equitable by scaling the disincentives on the basis of income class through a system of variable subsidy insurance.

Third, efforts to control unnecessary utilization through administrative devices such as review boards or UR committees have demonstrated a rather checkered pattern of success and failure which can be expected to continue unless corrective steps are taken. Where the administrative approach has proven ineffective, failure may be attributed to one or more of four factors: the lack of adequate surveillance systems, the inability of UR committee members to agree upon a course of action, role confusion and conflict of interest when review members are drawn from the group to be regulated, and a general lack of enforcement powers. With the exception of the first factor (which requires substantial sophistication in computer technology) these problems are more political than technical in nature, and thus may be amenable to improvement through organizational change.

One organizational approach specifically applicable to public medical programs involves the creation of teams of professional career review agents assigned to each hospital service area in a state. These agents could be government-employed physicians or else em-

ployees specifically trained in medical review procedures and advised by physicians. Assuming that the educational functions of current UR activities could be maintained through a process of routine communication between review agents and hospital staff physicians, such an arrangement would serve two important functions. On the one hand, it would free valuable hospital staff time for patient care and would also free staff physicians from the unpleasant task of judging the work of close colleagues. On the other hand, it would better satisfy the requirements of accountability for care provided with public funds than either current methods of in-house review or the peer review process envisaged for Professional Standards Review Organizations.

Another possibility is for hospital review committees themselves to preview and certify nonemergency admissions and surgical operations. Such prior authorization might reduce the incidence of questionable surgery and would free doctors from suspicion concerning the advisability of operations after the fact. In addition, it would tend to make the hospital administration more cognizant of and responsible for what happens in the institutional setting.

A quite different approach to improving the administrative review process entails strengthening the enforcement mechanism through the elimination of patient financial responsibility whenever a properly constituted UR committee finds that unnecessary medical procedures are performed upon the recommendation of a physician. Under Medicare and Blue Cross contracts, the carrier can refuse to reimburse a provider if the services are found to be "unnecessary," but the patient must then assume the liability. The one major exception to this rule is the 1973 contract between Blue Cross of Greater Philadelphia and its participating hospitals which specifically prohibits the provider from charging a subscriber in such cases. The advantage of a "hold harmless" clause is that it provides a strong financial incentive for hospitals and physicians alike to ensure that treatment is justifiable on medical grounds—and for this reason it would mesh well with the establishment of prior authorization committees at the hospital level. It is possible that the combination of prior authorization with limited patient liability might also lessen the incidence of malpractice litigation.

The fourth and final point takes a much broader perspective regarding the future of utilization control. A simplified but largely accurate description of prevailing modes of health financing and delivery suggests that neither patients, providers, nor insurers are sig-

nificantly motivated to control utilization levels because the fee-for-service payment mechanism together with the spread of health insurance have created a situation where "someone else" assumes the burden of unnecessary medical treatment. Arguments in favor of changing the basic incentive structure are thus intuitively appealing to those concerned with the proper allocation of medical resources.

Perhaps the best, and certainly the most discussed alternative in this regard is the concept of the prepaid health care center. Such organizations have demonstrated that the utilization of hospital services may be significantly reduced through a holistic, coordinated approach to treatment; and, even more important, they have shown that a delivery system can operate successfully under the constraints imposed by a predetermined and fixed income base. A logical extension of this last point is regional and federal budgeting for health expenditures under national health insurance. Given the ever-increasing proportion of gross national product which goes for health services, this may prove to be the only long-range solution to the question of utilization control.

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