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Physicians' Beliefs and U.S. Health Care Reform — A National Survey

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In an address to the American Medical Association on June 15, 2009, President Barack Obama acknowledged that he needed physicians' support on health care reform and offered to work with physicians to achieve the reform he believes is essential. In recent months, commentators have called on physicians to be "our most credible and effective leaders of progress toward a new world of coordinated, sensible, outcome-oriented care"[1] and to "find a brave voice" for changing health care's funding structures in a way that "puts quality of care before financial gain."[2] Are U.S. physicians prepared to play such a part?

Previous research suggests that physicians endorse a public role for the profession and believe they have an obligation to care for people with limited resources. But it remains unclear whether physicians in 2009 see participation in the formation of health policy as part of their professional responsibility or accept the potential consequences of reform. Furthermore, individual physicians may have strong financial incentives to downplay their responsibility for caring for the uninsured and underinsured. Although physicians tend to agree in the abstract that health care resources should be distributed fairly, they may be unwilling to endorse concrete policies that expand coverage for basic health care by limiting reimbursement for costly interventions. And despite widespread discussions about using cost-effectiveness data or comparative-effectiveness research to guide clinical decisions, physicians may remain skeptical about such practices.[3–4] Thus, physicians may not be willing to take on the role that the President and health policy advocates want them to play.

In May 2009, we mailed a confidential questionnaire to 2000 practicing U.S. physicians, 65 years of age or younger, from all specialties in order to explore these issues. (Detailed information about our methods appears in the Supplementary Appendix, available with the full text of this article at NEJM.org.) As part of a study of moral and ethical beliefs in medical practice, physicians completed four items relevant to health care reform. They were asked to indicate their degree of agreement or disagreement with the following statements: "Addressing societal health policy issues, as important as that may be, falls outside the scope of my professional obligations as a physician"; "Every physician is professionally obligated to care for the uninsured and underinsured; and "I would favor limiting reimbursement for expensive drugs and procedures if that would help expand access to basic health care for those currently lacking such care." Then, as part of a longer list of potentially controversial medical practices, we asked physicians to indicate whether they had no moral objection, a moderate moral objection, or a strong moral objection to "using cost-effectiveness data to determine which treatments will be offered to patients."

The key predictor measures we considered were physicians' self-characterization as "conservative," "moderate," or "liberal" on "social issues"; their demographic characteristics (age, sex, race, and region); and their clinical specialty (subsequently

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categorized as primary care, surgical or nonsurgical procedural specialty, other nonsurgical specialty, nonclinical, and other; our coding scheme can be found in the Supplementary Appendix).

Of the 2000 potential respondents, 61 (3%) could not be contacted. Of the remaining 1939 participants, 991 returned completed surveys, for a response rate of 51%. The characteristics of the respondents are shown in Table 1. Response rates varied somewhat by region (South, 50%; Midwest, 58%; Northeast, 50%; West, 47%; Other, 50%; P=0.03) and by age category (<50 years, 48%; 50 years, 56%; P = 0.0004) but not by sex or specialty. Results presented below are from unweighted analyses.

As Table 2 shows, a large majority of respondents (78%) agreed that physicians have a professional obligation to address societal health policy issues. Majorities also agreed that every physician is professionally obligated to care for the uninsured or underinsured (73%), and most were willing to accept limits on reimbursement for expensive drugs and procedures for the sake of expanding access to basic health care (67%). By contrast, physicians were divided almost equally about cost-effectiveness analysis; just over half (55%) reported having a moral objection to using such data “to determine which treatments will be offered to patients.”

In multivariable logistic-regression models, age, race, and region were not significantly associated with any particular position. Female physicians were more likely than male physicians to object to using cost-effectiveness data to guide treatment decisions (odds ratio, 1.4 [95% confidence interval, 1.0–2.0]) but did not differ from male physicians on other questions.

Both specialty and political self-characterization were associated with physicians’ beliefs related to health care reform. As shown in Table 3, surgeons, procedural subspecialists, and those in nonclinical specialties were all significantly less likely than primary care providers to favor reform that expands access to basic health care by reducing reimbursement for expensive drugs and procedures (odds ratios, 0.6 [95% CI, 0.4–0.8], 0.6 [95% CI, 0.4–1.0], and 0.3 [95% CI, 0.1–0.9], respectively). There were also consistent differences between self-described liberals and conservatives (see Table 3).

These data offer several messages. First, the President, lawmakers, and reform advocates can vigorously engage physicians in health care reform deliberations cognizant that most physicians see it as part of their professional responsibility. However, more controversial elements of reform, such as limiting reimbursement under Medicare (i.e., expanding the ranks of the underinsured), using cost-effectiveness data in treatment decisions, and limiting reimbursements for expensive drugs and procedures — all of which are elements of current reform proposals — may face serious opposition from segments of the medical profession.

Why would the majority of U.S. physicians object to using cost-effectiveness analysis in clinical decision making? Both lack of familiarity and principled objections may be involved. The current health care system reimburses providers primarily on the basis of the quantity of services provided, which favors higher volume of care and greater numbers of procedures rather than care management. Under the current system, fashioned in large part by long-standing Medicare legislation, there is little incentive to use evidence-based information such as cost-effectiveness data to guide treatment decisions.[4] Only recently has the Centers for Medicare and Medicaid Services attempted to use evidence to guide determinations about whether services should be provided.[5] Thus, a lack of familiarity with such reimbursement practices or fear of change may influence physicians’ acceptance of cost-effectiveness data. But many physicians may also have more principled grounds for their objections, viewing the use of cost-effectiveness data as implicit rationing or

unwelcome intrusion on both their professional autonomy and the physician–patient relationship. To gain widespread support from the physician community, advocates of such reform initiatives will need to address such concerns.

Since surgeons and procedural specialists were less willing than other physicians to accept policies that would limit reimbursement for expensive medications and procedures, reformers can expect opposition to reimbursement reform from such groups unless proposed reforms create incentives that benefit those who currently get paid for providing these goods and services. We did not inquire about physicians' views of policies that might result in lower payment for their own services more generally.

Finally, the 27% of physicians who consider themselves conservative were consistently less enthusiastic about professional responsibilities pertaining to health care reform. These physicians must be engaged if reform is to be successful.

Of course, associations found in a cross-sectional study cannot establish causal relationships. Moreover, it is possible that the attitudes of the physicians who did not respond to the survey are different from those who did respond, and physicians' responses to the survey questions do not necessarily reflect their likely responses to specific proposals before Congress. Nevertheless, our data suggest that efforts to mobilize physicians can build on their sense of professional responsibility — but also that such efforts may encounter considerable opposition from some quarters of the profession, particularly to elements of reform that impinge on physicians' decision-making autonomy or threaten to reduce reimbursement for the costly interventions they provide. Politicians and policymakers should work directly with these groups of physicians to achieve the consensus necessary for comprehensive and sustainable reform.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Characteristics of the 991 U.S. Physician Survey Respondents.

Characteristic	No./Total No. (%)
Female sex	274/970 (28)
Age (yr)	
< 50	454/970 (47)
50	516/970 (53)
Race or ethnic group	
White	756/972 (78)
Asian	139/972 (14)
Other	49/972 (5)
Black	24/972 (2)
American Indian or Alaska Native	4/972 (<1)
Region *	
South	322/991 (32)
Midwest	243/991 (25)
Northeast	216/991 (22)
West	202/991 (20)
Primary specialty	
Primary care	388/991 (39)
Surgery	209/991 (21)
Procedural specialty	197/991 (20)
Nonprocedural specialty	165/991 (17)
Nonclinical	22/991 (2)
Other	10/991 (1)
Political self-characterization	
Moderate	413/978 (42)
Liberal	270/978 (28)
Conservative	276/978 (28)
Other	19/978 (2)

*Eight responding physicians were from Puerto Rico.

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Table 2

Agreement or Disagreement with Three Elements of Health Care Reform and Objection to Using Cost-Effectiveness Data to Limit Treatments, among 991 U.S. Physicians.

Survey Item and Response Options	Percent of Respondents			
Please rate your degree of agreement or disagreement with the following statements:	Strongly disagree	Moderately disagree	Moderately agree	Strongly agree
Addressing societal health policy issues, as important as that may be, falls outside the scope of my professional obligations as a physician.	34	44	17	5
Every physician is professionally obligated to care for the uninsured and underinsured.	10	17	35	38
I would favor limiting reimbursement for expensive drugs and procedures if that would help expand access to basic health care for those currently lacking such care.	11	22	48	19
Please indicate the degree to which you object (if at all), for moral reasons, to the following medical practice:	No moral objection	Moderate moral objection	Strong moral objection	
Using cost-effectiveness data to determine which treatments will be offered to patients.	45	40	14	

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Table 3

Odds of Endorsing Three Health Care Reform Principles and of Objecting to the Use of Cost-Effectiveness Data to Limit Treatments, According to Physician's Clinical Specialty and Political Self-Characterization among 991 U.S. Physicians.*

Variable	Agree Physicians Are Obligated to Address Health Policy Issues	Agree Physicians Are Obligated to Care for the Underinsured	Favor Limiting Reimbursement for Expensive Treatments to Expand Access to Basic Health Care	Object to Using Cost-Effectiveness Data to Limit Treatments
	odds ratio (95% confidence interval)			
Specialty				
Primary care	1.0 (referent)	1.0 (referent)	1.0 (referent)	1.0 (referent)
Surgery	0.7 (0.5–1.1)	0.7 (0.5–1.0)	0.6 (0.4–0.8)†	1.4 (1.0–2.0)
Procedural specialty	1.0 (0.6–1.5)	0.9 (0.6–1.3)	0.6 (0.4–1.0)†	1.0 (0.7–1.5)
Nonprocedural specialty	1.0 (0.6–1.7)	0.6 (0.4–1.0)†	0.8 (0.5–1.2)	1.3 (0.9–1.9)
Other	0.8 (0.2–3.2)	0.5 (0.1–1.9)	0.5 (0.1–1.8)	3.4 (0.7–17.0)
Nonclinical	1.3 (0.4–4.8)	1.0 (0.3–3.2)	0.3 (0.1–0.9)†	0.9 (0.4–2.3)
Political self-characterization				
Conservative	1.0 (referent)	1.0 (referent)	1.0 (referent)	1.0 (referent)
Moderate	1.6 (1.1–2.2)†	1.2 (0.9–1.7)	1.9 (1.4–2.7)†	0.7 (0.5–0.9)†
Liberal	2.8 (1.8–4.5)†	2.0 (1.3–3.1)†	3.8 (2.5–5.6)†	0.5 (0.4–0.8)†

*Odds ratios are from multivariate logistic regression, with adjustment for age, sex, race, and region.

†P 0.05