

8-1-1979

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Recommended Citation

Kenneth R. Wing & Burton Craige, *Health Care Regulation: Dilemma of a Partially Developed Public Policy*, 57 N.C. L. REV. 1165 (1979).Available at: <http://scholarship.law.unc.edu/nclr/vol57/iss6/3>

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HEALTH CARE REGULATION: DILEMMA OF A PARTIALLY DEVELOPED PUBLIC POLICY

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Significant government attempts to regulate or control health facilities are remarkably recent phenomena. Except for state programs of health facility licensure,¹ which have generally required only that facilities meet minimal standards of quality and safety,² and the incidental planning activities associated with the Hill-Burton construction program,³ American health facilities have until recently been free from any serious government efforts to regulate the quality of patient care, affect the cost of services, or determine the allocation of resources. In the past decade, however, the increasing concern of the general public about the costs of health care⁴ and, more importantly, the concerns of local, state, and federal governments about the impact of health care

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1. See generally text accompanying notes 148-152 *infra*.

2. See A. SOMERS, HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY 118-32 (1969); Worthingham & Silver, *Regulation of Quality of Care in Hospitals: The Need for Change*, 35 LAW & CONTEMP. PROB. 305, 308 (1970).

3. See text accompanying notes 160-66 *infra*.

4. Estimates of the costs of health care in this country vary with the source of information relied upon and with the definition of health care used. The most often cited and among the most reliable statistics are those prepared by HEW and periodically published in SOCIAL SECURITY BULLETIN.

The most recent HEW estimates of national health expenditures indicate that the nation spent approximately \$163 billion for health care in fiscal year 1977. See Gibson & Fisher, *National Health Expenditures, Fiscal Year 1977*, SOC. SEC. BULL., July 1978, at 3, 5 (Table 1). This represents an increase of 12% over the spending for the previous year, and an increase from approximately 8.7% of the gross national product to 8.8%. *Id.* at 3.

These figures indicate a continuation of an inflationary trend that has extended over the last decade. Health care expenditures increased at an average annual rate of over 12% from 1965 to 1970, and have increased over 13% annually since 1970. *Id.* at 5 (Table 1).

Recent estimates indicate that spending for fiscal year 1978 may exceed \$180 billion and may reach over \$200 billion by 1980.

costs on government budgets,⁵ have created a political climate favoring increases in public control of health care in general and health facilities in particular.

Since 1964, thirty-eight states have attempted to regulate capital expenditures by health facilities through "certificate of need" programs.⁶ Federal efforts to establish health resource planning programs, originally billed as financial support for voluntary efforts,⁷ have increased and taken on a markedly regulatory character. The 1974 federal health planning legislation⁸ provides financial support for an elaborate scheme of state and local health planning agencies with the authority to influence, and in some cases to determine, federal funding decisions.⁹ The 1974 legislation also provides extensive authority to regulate capital expenditures by health facilities and related institutions.¹⁰ In addition, government reimbursement policies and the requirements of participation under Medicaid and Medicare have been used increasingly to influence facility costs,¹¹ maintain the quality of patient care,¹² and encourage, if not coerce, changes in the manner in which care is delivered.¹³

That the Ninety-Fifth Congress, under the urging of the Carter Administration, gave serious consideration to the imposition of mandatory cost controls for the nation's hospitals¹⁴ demonstrates both

5. As the overall costs of health care have inflated, so have the costs of government health care programs. Public spending for personal health services, primarily expenditures for the Medicare and Medicaid programs, exceeded \$57.1 billion in 1977 and represented over 40% of all spending for personal health care. *Id.* at 7 (Table 3). Of this total, about \$40 billion or 28% of the total cost of health care came from federal programs, and about \$17 billion or 12% came from state and local government. *Id.* at 7 (Table 3). This also is a continuation of an inflationary trend that began in 1965, the year that the Medicare and Medicaid programs were enacted. *Id.* at 5 (Table 1).

While the federal share is larger, inflation in government health care programs has had a serious impact on state and local governments as well. Federal health programs are now over 10% of federal spending, OFFICE OF MANAGEMENT AND BUDGET, THE BUDGET OF THE U.S. GOV'T: FISCAL YEAR 1978, at 52; state expenditures for health average over 7% of state budgets, see BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 303 (Table 489) (1978).

6. See text accompanying notes 176-79 *infra*.

7. See text accompanying notes 173-75 *infra*.

8. National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k-300t (1976).

9. *Id.* § 300l-2(e)(1)(A).

10. See *id.* § 300m-2(a)(4)(A).

11. See Wing & Sifton, *Constitutional Authority for Extending Federal Control Over the Delivery of Health Care*, this Symposium, at notes 11 & 12 and accompanying text.

12. *Id.* at text accompanying note 30.

13. See text accompanying notes 155-200 *infra*.

14. See Wing & Sifton, this Symposium, at note 41.

the emerging importance of the health care cost problem and the recent dramatic change in the nation's political attitudes towards government regulation of health care providers.

While concern about rising costs has resulted in a climate that is favorable to regulation, it is not clear that regulation is the most appropriate response. Indeed, some experts argue that public policy should be quite the opposite¹⁵ and that government should intervene in the health care industry only to the extent necessary to ensure that there is an adequate level of competition among health care providers and that market forces control cost. These free market theorists contend that public regulation will only exacerbate inflation, stifle competition and innovation, and result in a less rational distribution of facilities and resources.

Whatever the merits of market solutions, both state and federal governments have shown a preference for regulatory strategies. Until those strategies prove to be unworkable, it is unlikely that there will be a major shift in this policy. Quite to the contrary, current legislative and administrative proposals do not involve choices between regulation and (enforced) competition; the only consideration is whether to extend regulation beyond current programs. There is still substantial political support for maintenance of the basically private character of the health care industry and, as the defeat of hospital cost containment demonstrates, there are limits on our willingness to extend government control.¹⁶ It is clear, however, that we have entered an era in which government is seeking to extend its influence over health care delivery by expanding the scope of existing controls and making existing regulatory mechanisms more effective.

It is, therefore, appropriate to examine existing regulatory controls in an attempt to assess their successes and to reflect on the future of public control. Before examining particular experiences with regulation, however, it is necessary to look at the nature of the industry itself and the history of government intervention. Critical evaluation of regulatory strategies is impossible without a basic understanding of the affected institutions, the role they play in service delivery and their

15. Strong arguments have been made, in both public debate and in the literature, in favor of an "antitrust" approach to controlling health care costs, and the current trend towards government regulation is sometimes criticized as both ineffective and philosophically inappropriate. For a collection of recent articles on this topic, see *Symposium on the Antitrust Laws and the Health Services Industry*, 1978 DUKE L.J. 303. For a good summary of related references see Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 304, 304 n.1.

16. See Wing & Sifton, this Symposium, at text accompanying notes 65-69.

financial structure. Equally important is an understanding of the historical context out of which the current regulatory efforts have emerged and the peculiar character of the programs that have evolved.

I. THE HEALTH CARE INDUSTRY

The American health care delivery system is composed of a variety of public and private, individual and institutional actors, linked by complex and rapidly changing financial and administrative arrangements.¹⁷ Regulatory efforts have been directed primarily at *institutional* providers of health services. *Individual* providers (physicians, pharmacists, dentists) have for the most part remained free from government control.

Political considerations account for the relative immunity enjoyed by individual providers. Well-organized associations of health professionals, traditionally dominated by conservative fee-for-service practitioners, have drawn from a large reservoir of public trust, as well as private finances, in their struggle to resist public control.¹⁸ And while opposition to regulation has been stronger among individual, as opposed to institutional, providers, the need for public intervention has not seemed as urgent. As more (and more expensive) services are rendered in institutional settings, individual providers are responsible for a declining proportion of total health care costs.¹⁹

This analysis will reflect current regulatory priorities and concentrate on institutional providers, specifically hospitals and nursing homes. Together, these institutions account for half of the total health-related expenditures.²⁰ During the past fifteen years hospitals and nursing homes have experienced spectacular growth and have increas-

17. See generally HEALTH CARE DELIVERY IN THE UNITED STATES (S. Jonas ed. 1977); F. WILSON & D. NEUHAUSER, HEALTH SERVICES IN THE UNITED STATES (rev. ed. 1976).

18. R. ALFORD, HEALTH CARE POLITICS: IDEOLOGICAL AND INTEREST GROUP BARRIERS TO REFORM (1975); R. HARRIS, A SACRED TRUST (1966); E. RAYACK, PROFESSIONAL POWER AND AMERICAN MEDICINE (1967); Comment, *The American Medical Association: Power, Purpose, and Politics in Organized Medicine*, 63 YALE L.J. 937 (1954).

19. See text accompanying notes 41-43 *infra* (noting decline in proportionate expenditures for physicians' services). Dentists and pharmacists also receive a smaller share of health expenditures than they once did. The proportion of total health expenditures for dental services declined from 13.3% in 1929 to 6.2% in 1977; expenditures for drugs consumed 16.7% of the total in 1929 and only 7.7% in 1977. Gibson & Fisher, *supra* note 4, at 15 (Table 5).

20. In the fiscal year ending September 1977, expenditures for hospital care totalled \$65.6 billion. Nursing home care expenditures were \$12.6 billion. These figures represented 40.4% and 7.8%, respectively, of total national health expenditures. An additional 3.1% (\$5.1 billion) was spent on medical facilities construction, much of it for hospitals and nursing homes. Gibson & Fisher, *supra* note 4, at 15 (Table 5).

ingly become the objects of critical public attention. Discussions of regulation, however, all too often ignore the variety of forces and actors within the regulated sector. An overview of the development, structure and dynamics of the hospital and nursing home industries will at least suggest the complexity of the regulatory task.

A. Hospitals

Ten years ago an astute observer wrote,

The hospital is to modern America what the cathedral was to Europe in the Middle Ages: a complex social institution serving simultaneously a variety of purposes—welfare center, object of civic pride, major source of employment, market for artists, artisans, and architects, inspirer of saintly deeds and beneficiary of repentant sinners, occasional “cover-up” for hypocrites and exploiters, source of power, and object of political conflict.²¹

In the last decade the hospital has assumed even greater importance. Provider of a growing array of services, consumer of an increasing proportion of resources, it has solidified its dominant position in the American health care system. At the same time, it has become the focus of ever more intensive scrutiny and criticism. As the belief in technological salvation declines, its institutional embodiment, the hospital, can no longer depend on the veneration of the faithful to protect it from public control.

Only relatively recently have hospitals been identified with medical cure for the acutely ill. The medieval hospital, operated by the Church, provided a refuge for the poor, the aged, the homeless and the sick. Its purpose was more philanthropic and spiritual than medical.²² In the sixteenth century, the hospital was secularized and subjected to governmental authority.²³ While its mission was reformulated in social terms, it retained its character as a shelter for the unfortunate, with only an incidental medical function.²⁴

In the late eighteenth and early nineteenth centuries, English and American hospitals began to assume more specialized roles. Private “voluntary” hospitals, financed by subscription and bequest, arose to

21. A. SOMERS, *supra* note 2, at ix.

22. Rosen, *The Hospital: Historical Sociology of a Community Institution*, in *THE HOSPITAL IN MODERN SOCIETY* 1, 2-13 (E. Freidson ed. 1963).

23. *See id.* at 13-19.

24. In 1551 a council of citizens set admissions quotas for St. Thomas' Hospital in London: 300 orphans, 400 aged, 650 “decayed householders,” 200 idle vagabonds, 350 “poor men overburdened with children” and 20 “sore and sick persons.” J. FREYMAN, *THE AMERICAN HEALTH CARE SYSTEM: ITS GENESIS AND TRAJECTORY* 21-22 (1974).

supplement and supplant the public institutions. The voluntary hospital provided care for patients who had some prospect of recovery. The incurables, the insane, the blind and those with infectious diseases were sent to public almshouses.²⁵

The early hospitals, both public and private, catered almost exclusively to the poor. Patients with adequate means were treated by their physician at home. The abysmal hygienic conditions, the overcrowding of the wards and the primitive state of medical knowledge made the hospital the choice of only the most desperate.²⁶

In the latter part of the nineteenth century, scientific advances transformed the institution. Surgical anesthesia and asepsis, new diagnostic and therapeutic techniques, and improved standards of general hygiene reduced hospital mortality rates. In 1900 a patient admitted to a general hospital had for the first time a better than even chance of leaving alive.²⁷ The public began to view the institution as a place of hope rather than despair. The rate of growth was astonishing: in 1873 there were only an estimated 178 hospitals in the United States; by 1909 there were 4,359.²⁸

Although hospitals proliferated in the early part of this century, the solo medical practitioner remained the dominant actor in the health care system.²⁹ It was only after World War II that several forces converged to effect another fundamental change in the institution and to shift the balance of power from the private physician to the modern hospital industry.³⁰ Rapid advances in medical knowledge and technology caused patient care to become more fragmented and costly.³¹ Physicians increasingly relied on hospital facilities and resources to supplement their own services.³² The growth of Blue Cross plans³³ and the postwar boom in commercial health insurance,³⁴ typically covering

25. *Id.* at 22-24; Rosen, *supra* note 22, at 24-25.

26. Rosen, *supra* note 22, at 26, 29-30.

27. Enright & Jonas, *Hospitals*, in *HEALTH CARE DELIVERY IN THE UNITED STATES* 164, 166 (S. Jonas ed. 1977).

28. *Id.* (citing R. STEVENS, *AMERICAN MEDICINE AND THE PUBLIC INTEREST* 52 (1971)).

29. B. EHRENREICH & J. EHRENREICH, *THE AMERICAN HEALTH EMPIRE: POWER, PROFITS, AND POLITICS* 30 (1970).

30. *Id.* at 30-33.

31. Knowles, *The Hospital*, *SCIENTIFIC AM.*, Sept. 1973, at 128, 130-32. *See generally* S. REISER, *MEDICINE AND THE REIGN OF TECHNOLOGY* (1978).

32. Knowles, *supra* note 31, at 130.

33. S. LAW, *BLUE CROSS: WHAT WENT WRONG?* 6-11 (2d ed. 1976); H. SOMERS & A. SOMERS, *DOCTORS, PATIENTS, AND HEALTH INSURANCE* 252 (1961).

34. HEALTH INSURANCE INSTITUTE, *SOURCE BOOK OF HEALTH INSURANCE DATA 1977-78*, at 8, 23 (1978).

only inpatient services,³⁵ accelerated the displacement of the solo practitioner and, along with Hill-Burton construction funds,³⁶ provided a solid financial base for hospital expansion.³⁷ The enactment of Medicare³⁸ and Medicaid³⁹ in 1965 fueled a second round of growth and consolidated the dominance of the larger hospitals.⁴⁰

Statistics reflect the hospital industry's ascendancy in the health care sector. In 1929 expenditures for hospital care⁴¹ comprised 19.2% of all national expenditures for health services and supplies. By 1977 the figure had risen to 42.6%. During the same period, the proportion of expenditures paid for physicians' services declined from 27.7% to 19.8%.⁴² Hospitals are also consuming an increasing proportion of government spending for health care. Their share of public expenditures climbed from 48.4% in 1965 to 57.8% in 1977.⁴³

Expenditures for health services only partially reflect the modern hospital's preeminence. While the hospital's primary function is still the provision of personal medical care, its role has become much broader. Most medical students, interns, and residents, as well as many other health professionals, are trained exclusively in hospitals.⁴⁴ The

35. *Id.* at 21; see H. SOMERS & A. SOMERS, *supra* note 33, at 250 (explanation of enrollment categories).

36. See text accompanying notes 160-66 *infra*.

37. The number of community hospitals grew from 4444 in 1946 to 5736 in 1965, and bed supply increased from 473,000 to 741,000. AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS: 1978, at 5 (Table 1) (1978). For a definition of "community hospital," see text accompanying note 49 *infra*.

38. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified in scattered sections of 26, 42, 45 U.S.C.). For an early appraisal of the legislation's impact, see H. SOMERS & A. SOMERS, MEDICARE AND THE HOSPITALS (1967).

39. Social Security Amendments of 1965, Pub. L. No. 89-97, §§ 1901-05, 79 Stat. 343 (1965) (codified at 42 U.S.C. § 1396 (1976)). For a good early analysis, see Stevens & Stevens, *Medicaid: Anatomy of a Dilemma*, 35 LAW & CONTEMP. PROB. 348 (1970).

40. B. EHRENREICH & J. EHRENREICH, *supra* note 29, at 37-39.

Although the number of community hospitals has grown only slightly since 1965, the number of beds has increased by 31%. Small hospitals have experienced an absolute and relative decline. The number of community hospitals with less than 100 beds dropped from 3489 in 1965 to 2833 in 1977. During the same period the number with more than 400 beds increased from 292 to 554. These large institutions accounted for about one-fourth (25.2%) of all community hospital beds in 1965 compared to about one-third (33.2%) in 1977. AMERICAN HOSPITAL ASSOCIATION, *supra* note 37, at vii-viii (Text Table 5, Text Table 6) (1977 figures); AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS: 1977, at vii-viii (Text Table 3, Text Table 4) (1977) (1965 figures).

41. "Hospital care" expenditures cover all spending for both inpatient and outpatient care, including all services by hospital staff (including physicians salaried by the hospital) and the purchase of drugs and other supplies. Self-employed physicians' services in hospitals (those of surgeons, for example) are not included. Gibson & Fisher, *supra* note 4, at 17-18.

42. See *id.* at 15 (Table 5).

43. See *id.* at 11 (Table 4) (1977 figures); Hanft, *National Health Expenditures, 1950-65*, Soc. SEC. BULL., Feb. 1967, at 3, 4 (1965 figures).

44. For a critique of the close relationship between the teaching hospital and the medical

hospital is also the site of continuing medical education programs.⁴⁵ At the major medical centers a large portion of institutional resources are devoted to medical research.⁴⁶ Finally, some hospitals have attempted to extend their reach into the community by establishing satellite health centers and programs of community health education.⁴⁷ While not all these services are produced solely by the hospital, the hospital is unique in that "there exist no services which are not produced within, or under its institutional aegis."⁴⁸

1. Variation Among Hospitals

The hospital industry is composed of an enormous variety of institutions. The long-term psychiatric hospital and the college infirmary, the decaying municipal institution and the suburban proprietary facility, the huge medical school complex and the fifty-bed rural outpost: all share a common label. In an effort to define the most important part of the industry more specifically, the American Hospital Association has developed a hybrid descriptor, the "community hospital." Although the term excludes long-term and federal hospitals, as well as hospital units of institutions such as prisons and college infirmaries,⁴⁹ it still encompasses more than 80% of all hospitals⁵⁰ and tends to mask important differences among them. The usefulness of the definition is thus limited by its breadth.

From 1967 to 1977, the average number of beds per community hospital increased from 135 to 165.⁵¹ Yet the industry continues to be characterized by small institutions. In 1977 close to one-half of all community hospitals had less than 100 beds.⁵² Yet most health economists believe that substantial economies of scale are associated with larger hospital size, at least up to about 200 beds.⁵³ From the

school, see Ebert, *Medical Education in the United States*, in *DOING BETTER AND FEELING WORSE* 171 (J. Knowles ed. 1977).

45. See Gaintner, *Continuing Medical Education in the Community Hospital*, 51 BULL. N.Y. ACAD. MED. 739 (1975); Stearns, *Positive Approaches to Continuing Medical Education in Community Hospitals*, 277 NEW ENGLAND J. MED. 1341 (1967).

46. Glaser, *The Teaching Hospital and the Medical School*, in *THE TEACHING HOSPITAL* 7, 27 (J. Knowles ed. 1966).

47. Knowles, *supra* note 31, at 136.

48. S. BERKI, *HOSPITAL ECONOMICS*, at xviii (1972).

49. AMERICAN HOSPITAL ASSOCIATION, *supra* note 37, at xxii.

50. *Id.* at 4, 7 (Table 1).

51. *Id.* at vii.

52. *Id.* This group is gradually shrinking. See note 40 *supra*.

53. See, e.g., V. FUCHS, *WHO SHALL LIVE? HEALTH ECONOMICS AND SOCIAL CHANGE* 82 (1974).

standpoint of economic efficiency, it seems impossible to justify the continued existence of so many small hospitals.⁵⁴

At the opposite end of the spectrum from the small, typically rural, hospital lies the "teaching hospital," site of undergraduate and graduate training for physicians.⁵⁵ While only comprising 13.1% of all community hospitals, teaching hospitals account for a disproportionate, and increasing, share of beds, admissions and outpatient visits.⁵⁶ Drawing prestige and resources from the medical schools with which they are affiliated, teaching hospitals exert a large influence on the rest of the hospital industry.⁵⁷

Seventy percent of community hospitals are privately owned.⁵⁸ In accord with the hospital's religious and philanthropic origins, more than four-fifths of these private institutions are operated on a nonprofit basis.⁵⁹ Investor-owned, for-profit institutions constitute a small, but growing portion of the industry.⁶⁰ The rapid expansion of proprietary hospital chains in the 1970s has inspired considerable controversy. Some see proprietaries as a source of healthy competition; others perceive a grave threat to the hospital's community service mission.⁶¹

The remaining community hospitals are owned and operated by state and local governments. Many urban public hospitals are beset with serious financial difficulties. Serving a large proportion of indigent patients, inadequately reimbursed by third-party payors, and

54. *Id.* at 82-84. This is particularly true of hospitals in urban areas. Fuchs estimates that in 1973 there were more than 1000 metropolitan hospitals with less than 200 beds. *Id.*

55. See Enright & Jonas, *supra* note 27, at 168, 170.

56. AMERICAN HOSPITAL ASSOCIATION, *supra* note 37, at 20 (Table 5A), 186 (Table 10A). In 1977 community hospitals affiliated with medical schools accounted for 35.0% of community hospital beds, 34.3% of admissions, and 45.7% of outpatient visits. The average affiliated hospital had 439 beds, compared with 123 for nonaffiliated hospitals. *Id.* at 180 (Table 8), 20 (Table 5A). For a view of the rapid rate of growth of teaching hospitals compare these figures to 1972 data. AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS: 1972, at 34, 190 (Table 5, Table 9) (1973).

57. See generally Glaser, *supra* note 46.

58. AMERICAN HOSPITAL ASSOCIATION, *supra* note 37, at 20 (Table 5A).

59. *Id.* On voluntary hospitals generally, see A. SOMERS, *supra* note 2.

60. Between 1972 and 1977, the share of community hospital beds held by proprietary hospitals increased from 6.5% to 8.3%. See AMERICAN HOSPITAL ASSOCIATION, *supra* note 37, at 20 (Table 5A) (1977 figures); AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS: 1972, at 4 (Table 5) (1973) (1972 figures).

61. For a good early discussion of the issues, see Steinwald & Neuhauser, *The Role of the Proprietary Hospital*, 35 LAW & CONTEMP. PROB. 817 (1970). For an early critical view, see A. SOMERS, *supra* note 2, at 198-200. Proprietary hospital chains have been the subject of several recent journalistic reports. See, e.g., Miller, *Dying for Dollars*, 6 SOUTHERN EXPOSURE, Feb. 1978, at 105, 107-09; Shabecoff, (N.Y. Times News Service), *For-Profit Hospitals Growing Fast Despite Public, Medical Criticism*, News and Observer (Raleigh, N.C.), Sept. 17, 1978, at 1, col. 4; Shabecoff (N.Y. Times News Service), *Private Hospital Chain Is Proving Successful*, News and Observer (Raleigh, N.C.), Sept. 18, 1978, at 10, col. 1.

victims of municipal fiscal crises, they are engaged in a constant struggle for survival.⁶² Surprisingly, the great majority of public hospitals are rural; in their clientele, staffing and financial position, they do not differ significantly from other rural community hospitals.⁶³

Hospital characteristics vary significantly by region. As one might expect, hospitals are largest in the urban Middle Atlantic States and smallest in the predominantly rural Mountain States.⁶⁴ Proprietary hospitals are concentrated in the Pacific and Southern regions; they are of only negligible importance in the New England and North Central States.⁶⁵ Public institutions account for about one-third of community hospital beds in the Southern States; in the Northeast, the figure is only about 10%.⁶⁶

In recent years per capita hospital expenditures in the Northeast have exceeded those in the South by 50% and those in the West by 30%.⁶⁷ Differences in labor costs account for most of the disparity between the Northeast and the South, but cannot explain the Northeast-West differential. Hospital utilization appears to be the critical distinguishing factor: the entire gap in per capita expenditures between Northeast and West can be traced to the difference in length of stay.⁶⁸ A person admitted to a community hospital in the State of Washington can expect to be out in 5.5 days, but his or her cousin in New York can look forward to a stay of 9.8 days.⁶⁹ Only a small part of the gap is caused by differences in age composition of the population: at given

62. HOSPITAL RESEARCH AND EDUCATIONAL TRUST, *THE FUTURE OF THE PUBLIC-GENERAL HOSPITAL* 6-7 (1978). For a guardedly optimistic view, see Craig & Koleda, *The Urban Fiscal Crisis in the United States, National Health Insurance, and Municipal Hospitals*, 8 INT'L J. HEALTH SERVICES 329 (1978). See generally Dumbaugh, Bentkover & Newhauser, *Public Hospitals: An Evaluation*, in *HEALTH SERVICES: THE LOCAL PERSPECTIVE* 148 (A. Levin ed. 1977).

63. HOSPITAL RESEARCH AND EDUCATIONAL TRUST, *supra* note 62, at 7-8. See generally M. ROEMER, *RURAL HEALTH CARE* 77-79 (1976).

64. See AMERICAN HOSPITAL ASSOCIATION, *supra* note 37, at 22-39 (Table 5B). In 1977 community hospitals in the Mountain States averaged 107 beds; the average in the Middle Atlantic States was 260.

65. *Id.* At the upper extreme, 18.7% of community hospital beds in the West South Central States were in proprietary institutions in 1977. The comparable figure was only 0.6% in the East North Central States.

66. *Id.* In the subregions, the range was from 38% (East South Central) to 5.3% (New England). *Id.*

67. V. FUCHS, *supra* note 53, at 89. In 1977 per capita community hospital expenditures in the Northeast were 39.3% higher than in the South and 21.6% higher than in the West. Thus the gap has narrowed since Fuchs wrote in 1974. These figures are derived from AMERICAN HOSPITAL ASSOCIATION, *supra* note 37, at 152-71 (Table 6), and 1977 population estimates by the Census Bureau, BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, *STATISTICAL ABSTRACT OF THE UNITED STATES* 14 (1978).

68. V. FUCHS, *supra* note 53, at 89.

69. AMERICAN HOSPITAL ASSOCIATION, *supra* note 37, at 104, 134 (Table 5C).

ages and for given diagnoses, stays are significantly shorter in the West.⁷⁰ The regional variations in length of stay, without any associated difference in health outcomes, suggest that hospital services are frequently overutilized.⁷¹

2. Rise in Hospital Costs

Hospitals are an extraordinarily diverse breed. One characteristic, however, seems common to all: costs are rising at an alarming rate. In 1950 Americans spent \$3.7 billion for hospital care or about \$24 per capita. In 1977 the aggregate reached \$65.6 billion and per capita expenditures climbed to \$297.⁷² During this twenty-eight year period, expenditures for hospital care grew more than two and one half times as fast as the Gross National Product.⁷³ Since 1965, the annual rate of increase has averaged a staggering 14.3%.⁷⁴

A small but significant portion of the increase in per capita expenditures can be attributed to increased rates of hospital use.⁷⁵ A much greater part—close to ninety percent—is the result of the rise in the average daily cost of hospital care.⁷⁶ The average cost per patient day in community hospitals increased from \$15.62 in 1950 to \$48.15 in

70. V. FUCHS, *supra* note 53, at 89.

71. For a discussion of the forces that encourage overutilization, see notes 81-92, 103 and accompanying text *infra*.

It is not clear why the average length of stay is so much shorter in the West. It cannot be said that overutilization has been discouraged by more rational capital investment; community hospitals in the Pacific States have the lowest occupancy rate in the nation. AMERICAN HOSPITAL ASSOCIATION, *supra* note 37, at 22-39 (Table 5B). A more plausible explanation is the prevalence of prepaid group practices. Physicians working for health maintenance organizations (HMOs), in contrast with fee-for-service practitioners, have every incentive to make a patient's hospital stay as expeditious as possible. See generally Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMP. PROB. 716, 720-22 (1970). For a discussion of data comparing hospital utilization among matched HMO and fee-for-service populations, see W. MCCLURE, REDUCING EXCESS HOSPITAL CAPACITY 22-23 (DHEW Pub. No. HRP-0015199, Oct. 1976).

72. See Gibson & Fisher, *supra* note 4, at 6 (Table 2), 15 (Table 5).

73. See *id.* at 14 (Chart 2), 15 (Table 5).

74. See *id.* at 15 (Table 5).

75. The number of patient-days in short-term hospitals rose from .855 per capita in 1950 to 1.21 per capita in 1975, an annual rate of increase of 1.2%. COUNCIL ON WAGE AND PRICE STABILITY, THE RAPID RISE OF HOSPITAL COSTS 4 & n.1 (Staff Report 1977) [hereinafter cited as THE RAPID RISE OF HOSPITAL COSTS].

76. *Id.* Two different measures of the daily cost of hospital care are commonly used: (1) the Bureau of Labor Statistics' Index of Hospital Service Charges (IHSC); and (2) the American Hospital Association's Average Cost Per Patient Day (ACPPD). The IHSC attempts to measure the changing price of a *fixed* bundle of common hospital services. The ACPPD, calculated by dividing total hospital operating expenses by the number of inpatient days of care provided, reflects the changing mix and volume of services as well as changes in the price of each type of service. The ACPPD is the more appropriate indicator of the total increase in hospital cost. *Id.* at 5-6.

1966 and \$175.08 in 1976.⁷⁷ Inflation in the general economy accounts for less than half of the increase. Measured in constant dollars, the average cost per day increased fivefold from 1950 to 1976.⁷⁸

While the seriousness of hospital cost inflation is generally acknowledged, little consensus exists on the underlying causes.⁷⁹ At least eight contributing factors are widely cited in the literature: (1) insurance coverage; (2) cost-based reimbursement; (3) excess capacity; (4) labor costs; (5) technological advances; (6) the expanding role of the community hospital; (7) physician control of demand; and (8) lack of competition among providers. The choice of an appropriate cost containment strategy largely depends on which inflationary factors are seen as most important—and which are most amenable to government intervention.

a. Insurance coverage

Evidence strongly suggests that increases in insurance coverage, coupled with rising incomes, have played a major part in hospital cost inflation.⁸⁰ Private insurance coverage grew rapidly from 1950 until the mid-1960s and then more moderately in the ensuing decade; public financing of hospital care has mushroomed since the advent of Medicare and Medicaid in 1966. As a result of these developments, consumers are now largely insulated from the cost of hospital care at the time of illness. In 1950, 50% of community hospital costs were covered by out-of-pocket patient payments. By 1975, the figure had dropped to 12% with public and private insurance splitting the remainder.⁸¹ While the average cost per patient day rose by a factor of ten from 1950 to

77. See *id.* at 7 (Table 1). These figures include outpatient costs and thus overstate the cost of an inpatient day. An adjusted index, developed by the AHA in 1963, excludes outpatient costs and is about 12% lower than the unadjusted index. The less sensitive indicator has been used in order to allow pre-1963 comparisons. The two indices have risen at very similar rates since 1963. *Id.* at 5 n.2.

78. See *id.* at 8.

79. For discussions of different theories of hospital cost inflation, see OFFICE OF RESEARCH AND STATISTICS, SOCIAL SECURITY ADMINISTRATION, REPORT NO. 41, COMMUNITY HOSPITALS: INFLATION IN THE PRE-MEDICARE PERIOD (1972) [hereinafter cited as COMMUNITY HOSPITALS]; Davis, *Rising Hospital Costs: Possible Causes and Cures*, 48 BULL. N.Y. ACAD. MED. 1354 (1972); McCarthy, *Supply and Demand and Hospital Cost Inflation*, 33 MED. CARE REV. 923 (1976).

80. See THE RAPID RISE OF HOSPITAL COSTS, *supra* note 75, at 29-38; M. FELDSTEIN, THE RISING COST OF HEALTH CARE (1971). Feldstein's views have been corroborated by other researchers. McCarthy, *supra* note 79, at 940-44. See, e.g., Davis, *Hospital Costs and the Medicare Program*, SOC. SEC. BULL., Aug. 1973, at 18. See also COUNCIL ON WAGE AND PRICE STABILITY, THE COMPLEX PUZZLE OF RISING HEALTH CARE COSTS: CAN THE PRIVATE SECTOR FIT IT TOGETHER? 83-88 (1976) [hereinafter cited as THE COMPLEX PUZZLE].

81. THE RAPID RISE OF HOSPITAL COSTS, *supra* note 75, at 31 (Table 8).

1975, the out-of-pocket cost of care, excluding third-party payments, experienced a much more modest increase. Relative to the cost of all other goods and services, the overall net cost of hospital care to the consumer has remained virtually unchanged since 1950.⁸² With constant out-of-pocket costs, and increasing disposable income, patients demand more services and higher quality care. As explained in a recent staff report of the Council on Wage and Price Stability, "Hospitals respond by raising their cost per patient day and using the extra revenue to provide a more expensive style of care. This change in the apparent quality of care further increases demand, setting off another round of price and quality increases."⁸³ In order to protect themselves from the increasing costs of hospitalization, consumers purchase more insurance, refueling the cycle.

b. Cost-based reimbursement

Instead of focusing on the extensiveness of third-party coverage, some economists have stressed the nature of third-party reimbursement. Many public and private health insurance plans, covering a large majority of hospital services, reimburse institutional providers on the basis of costs.⁸⁴ The inflationary impact is obvious; since increased costs are simply passed on to third-party payors, hospitals have little incentive to restrain capital expenditures or to operate efficiently.⁸⁵

c. Excess capacity

It has now become clear that excessive investment in hospital equipment and facilities is a major inflationary factor.⁸⁶ Trustees, physicians and administrators, particularly in nonprofit institutions, are

82. See *id.* at 33-34.

83. *Id.* at 36 (footnote omitted).

84. Klarman, *Approaches to Moderating the Increases in Medical Care Costs*, 7 MED. CARE 175, 185 (1969). Cost-based reimbursement was already widespread before Medicare: services for more than three-fourths of Blue Cross enrollees were reimbursed at cost. Yet cost-based reimbursement was not the dominant mode until Medicare increased the number of patient days reimbursed at cost by more than 75%. *Id.* See also THE COMPLEX PUZZLE, *supra* note 80, at 11-13, 86.

85. Empirical studies that have tested the cost-reimbursement hypothesis are evaluated in McCarthy, *supra* note 79, at 933-35.

For an excellent analysis of the failure of private insurers to restrain costs, see Havighurst, *Controlling Health Care Costs: Strengthening the Private Sector's Hand*, 1 J. HEALTH POL. POL'Y & L. 471, 474-82 (1977). The intimate ties between the hospital industry and Blue Cross are analyzed in S. LAW, *supra* note 33.

86. See W. McCLURE, *supra* note 71. See also B. ENSMINGER, THE \$8 BILLION HOSPITAL BED OVERRUN (1975); INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, CONTROLLING THE SUPPLY OF HOSPITAL BEDS (1976); Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need,"* 59 VA. L. REV. 1143, 1156-59 (1973).

often more interested in prestigious additions than inexpensive patient care.⁸⁷ Unwarranted expansion of hospital bed capacity and unnecessary equipment purchases result in higher fixed costs, which are eventually borne by consumers in the form of increased service charges and insurance premiums.⁸⁸

Given current rates of hospital use, it is estimated that 5 to 10% of the existing beds could be eliminated with no adverse effects on health.⁸⁹ Moreover, considerable evidence indicates that present rates of use are excessive. Great international, regional and small area variations in per capita rates of hospital use cannot be explained by any known health risk factors and are not associated with any ascertainable differences in health outcomes.⁹⁰ As Roemer and Shain first demonstrated, excess capacity itself appears to induce overutilization.⁹¹ Physicians, paid on a fee-for-service basis, and hospital administrators, conscious of high fixed costs, share a common interest in keeping beds filled.⁹²

d. Labor costs

Other students of hospital cost inflation have emphasized the rapid increase in labor costs. Since 1955, hospital wages have risen faster than earnings in other parts of the economy.⁹³ Part of the differential in the rate of increase in the early years may reflect a "catching up" of wages for workers who have traditionally been underpaid.⁹⁴ Unionization, a tight labor market in the mid-1960s and a change in the skill-mix of hospital employees have also been cited as explanatory

87. Bovbjerg, *Problems and Prospects for Health Planning: The Importance of Incentives, Standards, and Procedures in Certificate of Need*, 1978 UTAH L. REV. 83, 85; Havighurst, *supra* note 86, at 1160-63. See generally B. ENSMINGER, *supra* note 86, at 42-43.

88. See Havighurst, *supra* note 86, at 1157.

89. W. McCURE, *supra* note 71, at 19-20.

90. *Id.* at 22-27.

91. Shain & Roemer, *Hospital Costs Relate to the Supply of Beds*, MOD. HOSPITAL, April 1959, at 71. See Klarman, *supra* note 84, at 177-79. McCURE offers a rough estimate of the strength of the relationship: holding other factors constant, a 10% increase in beds per 1000 persons is associated with a 4% rise in patient days per 1000 persons. W. McCURE, *supra* note 71, at 15.

92. Bovbjerg, *supra* note 87, at 87; Havighurst, *supra* note 86, at 1158.

93. THE RAPID RISE OF HOSPITAL COSTS, *supra* note 75, at 13.

94. *Id.* at 56-57. According to a 1977 staff report of the Council on Wage and Price Stability, hospital workers achieved parity with employees in the same occupations in other industries by the early 1970s. Since then, however, hospital wages have continued to rise more rapidly than wages in other industries. *Id.* at 39-63. The report identified the rise in hospital employment, the use of "relative wage scales," the role of hospital unions and "philanthropic wage setting" as possible inflationary factors. *Id.* at 62, 64-65.

factors.⁹⁵ Regardless of the reason for the rapid rate of increase in wages, its impact on hospital cost inflation is relatively insignificant, accounting for only about one-fourth of the increase of hospital costs in excess of the general rise in consumer prices.⁹⁶ Moreover, labor costs have not increased as fast as expenditures for other inputs. The payroll component of the community hospital budget has declined from 62% in 1965 to 51% in 1977.⁹⁷

e. Technological advances

There is no doubt that increasingly sophisticated medical technology has raised the cost of hospital care. CT scanners, intensive care units, kidney dialysis facilities, heart-lung machines and other expensive diagnostic and therapeutic modalities have proliferated with astonishing rapidity.⁹⁸ Even if the enormous capital and operating costs simply represent the price we must pay for modern high-quality care, the duplication of expensive, underutilized facilities in neighboring hospitals cannot be justified.⁹⁹

f. The expanding role of community hospitals

Part of the rise in hospital expenditures can be attributed to the expanded scope of hospital services.¹⁰⁰ Community hospitals have assumed some of the roles traditionally filled by other providers. For example, hospital emergency rooms become increasingly important as private physicians restrict their practices to daytime office visits. Similarly, the growth of psychiatric inpatient and outpatient services in short-term hospitals is associated with the decline of mental hospitals.¹⁰¹

95. Davis, *supra* note 79, at 1357 (citing, but not endorsing, these explanations). Elsewhere, Davis does suggest that there was a slight shift toward more highly skilled personnel from 1960 to 1966. COMMUNITY HOSPITALS, *supra* note 79, at 31. But see THE RAPID RISE OF HOSPITAL COSTS, *supra* note 75, at 43-46 (evidence of a decline in the skill-mix).

96. THE RAPID RISE OF HOSPITAL COSTS, *supra* note 75, at 13.

97. AMERICAN HOSPITAL ASSOCIATION, *supra* note 37, at x (Text Table 11) (1977 figures); AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS: 1977, at xiii (1965 figures).

98. See Banta & Sanes, *How the CAT Got Out of the Bag*, in TECHNOLOGY AND THE QUALITY OF HEALTH CARE 175 (R. Egdahl & P. Gertman eds. 1978) (CT scanner phenomenon); Knowles, *supra* note 31.

99. See THE COMPLEX PUZZLE, *supra* note 80, at 9, 87-88; W. McClure, *supra* note 71, at 21.

100. See, e.g., Davis, *supra* note 79, at 1364-65 (noting increase in use of hospital outpatient services).

101. *Id.* at 1359.

g. Physician control of demand

The physician-patient relationship is characterized by a gross disparity in power and knowledge.¹⁰² The control exercised by the physician contributes to the escalation of health care costs in general, and hospital costs in particular. Consumers of health services are unable to make informed, independent decisions based on price and quality. The choice of hospitalization and hospital, laboratory tests, prescription drugs, surgical procedures and length of stay remain in the physician's hands. The patient rarely dares to question decisions made on his behalf. It is widely suspected that physician-directed demand results in excessive use of services.¹⁰³ At the least, it results in use that is insensitive to price.

h. Lack of competition among providers

Patients in rural areas have little choice of hospitals or physicians.¹⁰⁴ Even in large cities, a patient is typically restricted to the institutions where his or her physician has staff privileges.¹⁰⁵ Limitations on advertising, enforced by medical societies and sometimes by state law, inhibit the patient's choice of physician.¹⁰⁶ Furthermore, physicians exercise monopoly power by limiting entry into the profession¹⁰⁷ and controlling the delegation of tasks to other health workers.¹⁰⁸ Cost-effective innovations in the delivery and financing of

102. McCarthy, *Financing for Health Care*, in *HEALTH CARE DELIVERY IN THE UNITED STATES* 247, 275 (S. Jonas ed. 1977). See also *THE COMPLEX PUZZLE*, *supra* note 80, at 85-86; see generally E. FREIDSON, *PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE* (1974).

103. See, e.g., Evans, *Supplier-Induced Demand: Some Empirical Evidence and Implications*, in *THE ECONOMICS OF HEALTH AND MEDICAL CARE* 162 (M. Perlman ed. 1975); Fuchs, *The Supply of Surgeons and the Demand for Operations*, 13 *SUPP. J. HUMAN RESOURCES* 35 (1978); Havighurst, *supra* note 86, at 479-81.

104. See M. ROEMER, *supra* note 63, at 73-79; Cordes, *Distribution of Physician Manpower*, in *RURAL HEALTH SERVICES: ORGANIZATION, DELIVERY, AND USE* 56 (E. Hassinger & L. Whiting eds. 1976).

105. See generally Ludlam, *Physician-Hospital Relations: The Role of Staff Privileges*, 35 *LAW & CONTEMP. PROB.* 879 (1970).

106. *THE COMPLEX PUZZLE*, *supra* note 80, at 87; see Canby & Gellhorn, *Physician Advertising: The First Amendment and the Sherman Act*, 1978 *DUKE L.J.* 543; Grad, *The Antitrust Laws and Professional Discipline in Medicine*, 1978 *DUKE L.J.* 443, 457-68.

107. See Kessel, *The A.M.A. and the Supply of Physicians*, 35 *LAW & CONTEMP. PROB.* 267 (1970). For an interesting historical and sociological analysis, see J. BERLANT, *PROFESSION AND MONOPOLY: A STUDY OF MEDICINE IN THE UNITED STATES AND GREAT BRITAIN* (1975).

108. Physician's assistants and nurse practitioners have only achieved a carefully circumscribed form of independence. See generally *THE NEW HEALTH PROFESSIONALS* (A. Bliss & E. Cohen eds. 1977).

services have been stymied by organized provider opposition.¹⁰⁹

Each of the factors mentioned above offers a partial explanation of the rapid rise in hospital costs. The cumulative effect is powerful indeed. Given the complexity of the phenomenon, it is hardly surprising that the proposals for governmental action have been so varied and at times contradictory. Nor is it surprising that hospital cost inflation has so far remained impervious to tentative regulatory initiatives.

B. Nursing Homes

1. Growth of Nursing Home Industry

While students of health care regulation have appropriately focused on the hospital, it is unfortunate that they have given so little attention to the nursing home. Fueled by Medicare and Medicaid, the nursing home industry has grown spectacularly since the mid-1960s. It continues to be the most dynamic part of the burgeoning health care sector.¹¹⁰ Once typified by the independent "Mom and Pop" operation, the industry is now the domain of the investor-owned proprietary chain. With change has come increasing controversy. Sensational revelations about abuses of patients¹¹¹ and finances,¹¹² and bitter struggles between health planners and nursing home entrepreneurs,¹¹³ have become staple features of the industry.

Specialized institutions to provide care for the elderly are of

109. See Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 304, 306-19. See also Havighurst, *supra* note 86, at 1204-15; Kissam, *Health Maintenance Organizations and the Role of Antitrust Law*, 1978 DUKE L.J. 487.

110. In 1977, expenditures for nursing home care rose 16.5%. Hospitals were the second most inflationary category in the health care industry; expenditures for hospital care increased by 14.1%. See Gibson & Fisher, *supra* note 4, at 7 (Table 3), 8 (Table 3). See also Butler, *Assuring the Quality of Care and Life in Nursing Homes: The Dilemma of Enforcement*, this Symposium.

111. See, e.g., F. MOSS & V. HALAMANDARIS, *TOO OLD, TOO SICK, TOO BAD: NURSING HOMES IN AMERICA* 15-37, 306 n.1 (1977).

112. See, e.g., *id.* at 73-102; M. MENDELSON, *TENDER LOVING GREED* (1974).

113. Nursing homes initiated four of the five constitutional challenges to state certificate of need laws. *Goodin v. Oklahoma ex rel. Okla. Welfare Comm'n*, 436 F. Supp. 583 (W.D. Okla. 1977); *Simon v. Cameron*, 337 F. Supp. 1380 (C.D. Cal. 1970); *Merry Heart Nursing & Convalescent Home, Inc. v. Dougherty*, 131 N.J. Super. 412, 330 A.2d 370 (1974); *Attoma v. State Dep't of Social Welfare*, 26 A.D.2d 12, 270 N.Y.S.2d 167 (1966). The only successful constitutional challenge was made by a hospital. *In re Certificate of Need for Aston Park Hosp., Inc.*, 282 N.C. 542, 193 S.E.2d 729 (1973).

Nursing homes have consistently had more difficulty than hospitals in winning approval for their capital expansion projects. See studies cited in D. Cohodes, C. Cerf & J. Cromwell, *A Review and Analysis of the Research Literature on State Certificate of Need Programs* 28 (June 1978) (draft prepared for Bureau of Health Planning and Resources Development, Health Resources Administration, Dep't of Health, Education and Welfare).

relatively recent origin.¹¹⁴ The extended family traditionally provided custodial and health care to the aged and infirm; those without family or resources were relegated to the public almshouse.¹¹⁵ The Depression vastly increased the number of elderly persons in need of assistance. Congress responded by passing the Social Security Act of 1935.¹¹⁶ The Act provided financial aid to the elderly, but excluded inmates of public institutions.¹¹⁷ The result, apparently unforeseen by those who drafted the legislation,¹¹⁸ was the dramatic and largely unregulated growth of the proprietary nursing home sector.¹¹⁹

In 1966, the infusion of funds from Medicare and Medicaid set off a second era of explosive growth. A few indicators suggest the dimensions of the phenomenon:

(1) In 1965, expenditures for nursing home care totaled \$1.3 billion, or 3.3% of all health expenditures. In 1977, expenditures had increased almost *ten* times to \$12.6 billion, and constituted 7.8% of all health spending.¹²⁰

(2) Nursing homes are absorbing an increasing proportion of health care expenditures made by the elderly; in 1966 15% of the money spent for health care by persons aged 65 and older went to nursing homes; by 1976 the figure had jumped to 23%.¹²¹

(3) Between 1963 and 1977, the number of nursing home beds and residents increased two and one-half times.¹²²

With the elderly population continuing to grow at a rapid rate during

114. Levey & Amidon, *The Evolution of Extended Care Facilities*, 16 NURSING HOMES 14 (1967).

115. *Id.* at 16-17. See also W. THOMAS, NURSING HOMES AND PUBLIC POLICY: DRIFT AND DECISION IN NEW YORK STATE 20-29 (1969).

116. Ch. 531, 49 Stat. 620 (1935) (codified in scattered sections of 42 U.S.C.).

117. *Id.* § 3(a); see W. THOMAS, *supra* note 115, at 49.

118. See W. THOMAS, *supra* note 115, at 45 (interview with draftsman of New York Old Age Security Act of 1930). Early New York legislation served as the model for the Social Security Act of 1935. *Id.* at 50-51.

119. See *id.* at 57-58 (New York experience).

120. Gibson & Fisher, *supra* note 4, at 15 (Table 5).

121. NATIONAL CENTER FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 1976-77, at 20-22 (1977) (DHEW Pub. No. HRA 77-1232) (Table E) [hereinafter cited as HEALTH].

122. NATIONAL CENTER FOR HEALTH STATISTICS, ADVANCEDATA FROM VITAL AND HEALTH STATISTICS, AN OVERVIEW OF NURSING HOME CHARACTERISTICS: PROVISIONAL DATA FROM THE 1977 NATIONAL NURSING HOME SURVEY 2 (Table 1) (1978) [hereinafter cited as ADVANCEDATA]; National Center for Health Statistics, *Utilization of Institutions for the Aged and Chronically Ill, United States, April-June, 1963*, 12:21 VITAL AND HEALTH STATISTICS 14, 21 (1966) (DHEW Pub. No. HRA 74-1706) (Table 1, Table 6) ("hospital care" data excluded from the total).

the coming decades,¹²³ further expansion of the industry is inevitable.

2. Variation Among Nursing Homes

Like hospitals, nursing homes exhibit considerable diversity. Nursing homes can be distinguished by the services they provide. *Skilled nursing facilities* are intended primarily for people requiring twenty-four hour nursing services. *Intermediate care facilities* offer less intensive nursing care.

Medicare covers services received in skilled nursing facilities for a limited period of time following a spell of illness;¹²⁴ similarly, Medicaid programs must cover services in skilled nursing facilities.¹²⁵ In addition, states have the option of offering Medicaid coverage for services in intermediate care facilities;¹²⁶ approximately one-third of the states currently do so.¹²⁷ A declining, but still significant number of homes are not certified by either Medicaid or Medicare. In 1977, 12.4% of nursing home beds fell into this category.¹²⁸

The nursing home industry is dominated by proprietary institutions. Of the homes represented in a survey conducted by the National Center for Health Services in 1977, only 26% were nonprofit or public institutions.¹²⁹ Most nursing homes are small. In 1977, 71% of all homes had less than 100 beds.¹³⁰

Differences in Medicaid coverage and eligibility requirements¹³¹ have caused interstate variations in nursing home use to be far more significant than regional variations. In 1973, there were at least 60 nursing home residents per 1000 elderly persons in 13 states; in 8 states there were fewer than 30.¹³² The state with the highest proportion of the elderly population in nursing homes was Minnesota (8.2%); the lowest was West Virginia (1.6%).¹³³

123. COMMISSION ON POPULATION GROWTH, POPULATION AND THE AMERICAN FUTURE 97-98 (1972).

124. See Butler, this Symposium, at text accompanying notes 18-25.

125. *Id.*

126. *Id.*

127. ADVANCEDATA, *supra* note 122, at 2 (Table 1).

128. *Id.*

129. *Id.*

130. *Id.*

131. See Butler, this Symposium, at text accompanying notes 18-25.

132. HEALTH, *supra* note 121, at 336-37 (Table 134).

133. *Id.* at 19.

3. Reimbursement Policies

State Medicaid reimbursement policies are of critical importance to the industry. In 1977 Medicaid paid for 51% of nursing home expenditures.¹³⁴ It is estimated that between 60 and 70% of nursing home patients have either partial or total Medicaid coverage.¹³⁵ Since reimbursement policies have a direct effect on profits, capital investment and quality of care, they have been the focus of intense lobbying efforts by the nursing home industry.¹³⁶

While Medicaid fostered the growth of the industry in the 1960s by vastly increasing effective demand,¹³⁷ its current impact is more ambivalent. State governments, as primary purchasers of nursing home services, have sometimes acted aggressively to limit cost increases by adjusting their Medicaid reimbursement policies and eligibility requirements.¹³⁸ The contrast with hospitals is instructive. With few exceptions, third-party payors have exercised little effective control over hospital costs.¹³⁹

The kind of incentives that encourage overutilization of physician and hospital services are largely absent in the nursing home industry. The nursing home operator has little direct influence on the demand for services.¹⁴⁰ Most physicians are not interested in increasing nursing home use since they characteristically relinquish responsibility for care when the patient enters the home.¹⁴¹ Allegations of financial ties between nursing homes and referring physicians are largely undocumented.¹⁴² When compared to those who use hospital services, the nursing home consumer is relatively more sensitive to the price of services. Almost all of the 40% of nursing home expenditures that come

134. Gibson & Fisher, *supra* note 4, at 7 (Table 3). Medicare accounted for only 3% of nursing home expenditures in 1977. *Id.*

135. See B. Spitz, Nursing Homes and Prospective Reimbursement 3, 5 (Nov. 1976) (Urban Institute Working Paper 5057-2).

136. See *id.* at 4-7, 33-34.

137. See *id.* at 3.

138. See W. Scanlon, A Theory of the Nursing Homes Market 1 (Apr. 1978) (Urban Institute Working Paper 5057-1A). Cf. B. Spitz, *supra* note 135, at 18-36 (case study of struggle over Medicaid reimbursement rates in Michigan; emphasis on political power of the nursing home industry).

139. See McCarthy, *supra* note 79.

140. Of course, the state trade association can have a considerable indirect impact on demand by negotiating a favorable reimbursement rate. See B. Spitz, *supra* note 135, at 4-6.

141. See W. Scanlon, *supra* note 138, at 6.

142. Scanlon implies that such ties are rare. See *id.* at 6-7. Yet the hypothesis is unsupported. It is undoubtedly true that "the vast majority of physicians probably do not have a substantial financial interest in nursing homes." *Id.* at 7. But this tells us nothing about the proportions of nursing homes that have financial ties with physicians. More research is clearly needed.

from private funds were paid directly out of patient or family resources; private insurance coverage was negligible.¹⁴³ Moreover, in contrast with consumers of hospital services, many prospective nursing home residents and their families are relatively more able to make informed decisions about whether to seek care and where to obtain it, and to effectuate their choices independently.¹⁴⁴

Because of the differences between the economics of hospital services and those of nursing homes, it may be inappropriate to apply a regulatory scheme designed for hospitals to institutions that respond to very different incentives. For example, in states where there is no evidence of excess capacity or overutilization of nursing homes, it may be inappropriate to establish certificate of need controls over nursing homes.¹⁴⁵ Yet in the same states, regulatory efforts may well be needed to deal with the well-documented and practically universal problems of financial fraud and abuse¹⁴⁶ and the continuing difficulties of maintaining adequate quality of care.¹⁴⁷

II. GOVERNMENTAL CONTROLS ON HEALTH CARE

As the health care industry has changed, so has the nature of government involvement. When the cost of health care started its dramatic rise in the 1960s, both federal and state government reacted by changing their traditional "hands-off" posture and attempting to impose a variety of regulatory controls.

At least since the 1940s, most states have maintained licensure programs requiring hospitals and other health care institutions to meet minimum standards of quality and safety.¹⁴⁸ Traditionally these standards were directed only towards the condition of the facility itself (for example, the number of beds to a room, size and number of exits) and rarely imposed requirements affecting staffing patterns, admission practices or services delivered.¹⁴⁹ After the enactment of Medicaid and Medicare, federal law required health facilities to be certified for par-

143. Gibson & Fisher, *supra* note 4, at 7 (Table 3).

144. See W. Scanlon, *supra* note 138, at 4-6.

145. See W. Pollak, Medicaid Cost Containment Policy: Long-Term Care Reimbursement 39 & n.32 (rev. draft Apr. 1977) (Urban Institute Working Paper 986-11); Havighurst, *supra* note 86, at 1167-69.

146. See authorities cited note 112 *supra*.

147. See authorities cited note 111 *supra*.

148. See Worthingham & Silver, *supra* note 2, at 308. See also A. SOMERS, *supra* note 2, at 118-32.

149. Worthingham & Silver, *supra* note 2, at 308-09.

ticipation under conditions that were similar to, but somewhat broader than licensure standards.¹⁵⁰ In recent years certification requirements have become more rigorous,¹⁵¹ and some state licensing programs have been reoriented to have a more direct impact on service delivery.¹⁵²

There has also been an increasing governmental interest in utilization review. Concerned about the cost of services, but also about their quality and appropriateness, the federal government imposed limited utilization review requirements as conditions for participation in Medicaid and Medicare in the late 1960s.¹⁵³ Congress mandated more elaborate procedures in 1972 and authorized the creation of Professional Standards Review Organizations (PSROs) to review utilization by all Medicaid and Medicare providers.¹⁵⁴

The most serious efforts to regulate the health care industry, however, have been the establishment of programs to promote or, more recently, to require the planned distribution of health care resources. The concept remains controversial in theory and underdeveloped in practice.¹⁵⁵ Health planners are engaged in constant rearguard skirmishes with free market theorists and frustrating confrontations¹⁵⁶—or unseemly alliances¹⁵⁷—with powerful local interest groups. No one is happy with the result. Health planning efforts appear to have had only a marginal impact on the distribution of health

150. For a description of the certification standards as well as the process of enforcement, see Wing, *Title VI and Health Facilities: Forms Without Substance*, 30 HASTINGS L.J. 137, 163-68 (1978).

151. See Wing & Sifton, this Symposium, at note 12.

152. See Butler, this Symposium, at text accompanying note 174.

153. For a summary of utilization review requirements under both Medicaid and Medicare, see Price, Katz & Provence, *An Advocate's Guide to Utilization Review*, 11 CLEARINGHOUSE REV. 307, 309-313.

154. Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 1155-1170, 86 Stat. 1329 (codified as amended at 42 U.S.C.A. §§ 1320c to 1320c-22 (West 1974 & Cum. Supp. 1979)).

For a description of the PSRO program, see Price, Katz & Provence, *supra* note 153, at 318-27.

155. See, e.g., Havighurst, *supra* note 86, at 1153-54; Noll, *The Consequences of Public Utility Regulation of Hospitals*, in INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, CONTROLS ON HEALTH CARE 25 (1975); Posner, *Certificates of Need for Health Care Facilities: A Dissenting View*, in REGULATING HEALTH FACILITIES CONSTRUCTION 113 (C. Havighurst ed. 1974). Cf. Correia, *Public Certification of Need for Health Facilities*, 65 AM. J. PUB. HEALTH 260 (1975); Grosse, *The Need for Health Planning*, in REGULATING HEALTH FACILITIES CONSTRUCTION 27 (C. Havighurst ed. 1974); Sheps and Madison, *The Medical Perspective*, in REGIONALIZATION AND HEALTH POLICY 15 (E. Ginzberg ed. 1977) (DHEW Pub. No. HRA 77-623) (advocating planned distribution of health care resources).

156. See, e.g., Havighurst, *supra* note 86, at 1148-51.

157. See, for example, the allegations in *Hospital Bldg. Co. v. Trustees of Rex Hospital*, 425 U.S. 738 (1976).

services and little, if any, effect on health care costs.¹⁵⁸

The impetus behind health planning was originally local. In the 1940s voluntary planning agencies in several major cities were organized to encourage more rational development of local health facilities.¹⁵⁹ The federal government first became involved in health facility planning in 1946 when Congress established the Hill-Burton hospital construction program.¹⁶⁰ Hill-Burton was intended to remedy the critical shortage of hospital facilities that had developed during the Depression and the Second World War.¹⁶¹ Grants to states were authorized for surveying needs and developing state plans for the construction of hospitals and public health centers.¹⁶² Proposed facilities that conformed to federal standards and to the plan developed by the state Hill-Burton agency were eligible for federal assistance.¹⁶³ The requirement that a single state agency establish priorities based on "need" was a novel feature of the program.¹⁶⁴

Hill-Burton was remarkably successful in stimulating hospital construction and renovation, particularly in small communities in the poorer states.¹⁶⁵ Yet the program's achievements highlighted its limitations. The great bulk of Hill-Burton funds were channeled into hospital projects, while the need for ambulatory facilities was largely ignored.¹⁶⁶ Moreover, Hill-Burton agencies could only support construction that they deemed appropriate; they had no authority to curb unneeded projects.

158. For an early review of literature on certificate of need and other health planning programs, see O'DONOGHUE, EVIDENCE ABOUT THE EFFECTS OF HEALTH CARE REGULATION 59-69 (1974). The major studies of the effects of certificate of need programs are reviewed in Blumstein & Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 UTAH L. REV. 3, 23-30. For a more comprehensive review and analysis of the certificate of need literature, see D. Cohodes, C. Cerf & J. Cromwell, *supra* note 113.

159. Gottlieb, *A Brief History of Health Planning in the United States*, in REGULATING HEALTH FACILITIES CONSTRUCTION 7, 11-12 (C. Havighurst ed. 1974).

160. Hospital Survey and Construction Act of 1946, Pub. L. No. 79-725, 60 Stat. 1040 (codified in scattered sections of 24, 31, 33, 42, 46, 48, 49 U.S.C.). See generally J. LAVE & L. LAVE, THE HOSPITAL CONSTRUCTION ACT: AN EVALUATION OF THE HILL-BURTON PROGRAM, 1948-1973 (1974).

161. See J. LAVE & L. LAVE, *supra* note 160, at 7.

162. Hospital Survey and Construction Act of 1946, Pub. L. No. 79-725, §§ 612-13, 60 Stat. 1040.

163. *Id.* §§ 621-25.

164. See McCarthy, *Planning for Health Care*, in HEALTH CARE DELIVERY IN THE UNITED STATES 346, 354 (S. Jonas ed. 1977). The Hill-Burton formula for determining need, while increasingly criticized as expansionist in effect, remains influential. For an excellent critique of "demand-based" planning methods, see W. McCLURE, *supra* note 71, at 70-73. See also Bovbjerg, *supra* note 87, at 100-09.

165. See J. LAVE & L. LAVE, *supra* note 160, at 2.

166. *Id.* at 13-14.

While Hill-Burton established a federal presence in health facilities construction, the Regional Medical Program (RMP), created in 1965,¹⁶⁷ signalled an incipient federal interest in functional planning. The original Administration proposal contemplated a network of new "regional medical complexes," integrating research, education, and patient care, to combat heart disease, cancer, and stroke. After intense AMA lobbying, the bill was watered down beyond recognition.¹⁶⁸ RMPs were assigned the vague and circumscribed task of establishing "regional cooperative arrangements" among medical schools, research institutions, and hospitals for research, training and demonstration projects related to the "killer diseases." They were admonished to do so "without interfering with the patterns, or the methods of financing of patient care or professional practice, or with the administration of hospitals."¹⁶⁹ In practice, RMPs simply subsidized the pet projects of university medical centers.¹⁷⁰ After absorbing \$600 million in a decade,¹⁷¹ RMPs had little to show for their efforts.¹⁷²

In 1966, Congress authorized funding for the establishment of a national network of state and local Comprehensive Health Planning (CHP) agencies.¹⁷³ This "Partnership for Health" suffered from some of the same defects that crippled RMP: diffuse, poorly defined objectives and an explicit statutory mandate not to interfere with "existing patterns of private professional practice of medicine."¹⁷⁴ The local planning agencies were poorly equipped either to plan or to regulate. Their only comprehensive authority was to "review and comment" on requests for federal funds from institutions within their area. Chronically understaffed, excessively dependent on local sources of funding,

167. Heart Disease, Cancer, and Stroke Amendments of 1965, Pub. L. No. 89-239, 79 Stat. 926 (codified at 42 U.S.C. §§ 299-299i (1976)).

168. See B. EHRENREICH & J. EHRENREICH, *supra* note 29, at 218.

169. 42 U.S.C. § 299(d) (1976).

170. See B. EHRENREICH & J. EHRENREICH, *supra* note 29, at 219-31.

171. Ostow & Brudney, *Regional Medical Programs*, in REGIONALIZATION AND HEALTH POLICY, 60, 64 (E. Ginzberg ed. 1977) (DHEW Pub. No. HRA 77-623).

172. While admitting that RMPs had few demonstrable achievements, some commentators contend that the program's value lay in its "process." The "essential function of the successful RMP" was "catalyzing change in the patterns of planning and of interaction of competing provider institutions, and sensitizing them to regional health imperatives." These alleged successes were admittedly "unquantifiable," of "low visibility" and "impossible to demonstrate." *Id.* at 65. Another commentator identifies the accomplishment of RMPs as "facilitating cooperative health care planning." McCarthy, *supra* note 164, at 359. Again, supporting documentation is singularly weak.

173. Comprehensive Health Planning and Public Health Services Amendments of 1966, Pub. L. No. 89-749, 80 Stat. 1180 (codified as amended at 42 U.S.C. §§ 243, 246, 247a (1976)).

174. *Id.* § 2(a).

and dominated by provider representatives, CHP agencies were ineffective in exercising even this limited power.¹⁷⁵

While the federal government encouraged voluntary planning, several states turned to direct regulation of health facilities construction. New York adopted the first certificate of need (CON) law in 1964.¹⁷⁶ By September, 1978, CON statutes were in effect in thirty-eight states.¹⁷⁷

Certificate of need laws authorize a designated agency to regulate the construction or expansion of institutional health facilities.¹⁷⁸ State programs vary considerably in administrative structure, and procedures for review and appeal.¹⁷⁹ Almost all programs cover hospitals and nursing homes; most include some other facilities such as laboratories and outpatient clinics. Capital expenditures above a specific threshold (typically \$100,000) are subject to review. Most states delegate review authority to their local health planning agencies, but the final decision on approval or denial remains with the state agency designated to administer the program. In almost all states that have enacted such legislation, a certificate of need is a precondition to licensure.

In 1972, Congress adopted the certificate of need concept and gave state health planning agencies another potential source of regulatory control. Under section 1122 of the Social Security Act, states were given the option of establishing, by contract with HEW, a program to

175. See generally B. EHRENREICH & J. EHRENREICH, *supra* note 29, at 198-213; O'Connor, *Comprehensive Health Planning: Dreams and Realities*, 52 MILBANK MEM. FUND Q. 391 (1974); West & Stevens, *Comparative Analysis of Community Health Planning: Transition from CHPs to HSAs*, 1 J. HEALTH POL. POL'Y & L. 173 (1976).

176. Metcalf-McCloskey Act of 1964, ch. 730, 1964 N.Y. Laws 1883 (codified as amended in scattered sections of N.Y. PUB. HEALTH LAW (McKinney 1978)). See Curran, *A National Survey and Analysis of State Certificate-of-Need Laws for Health Facilities*, in *REGULATING HEALTH FACILITIES CONSTRUCTION* 85, 88 (C. Havighurst ed. 1974).

177. Bloom & Bernstein, *Report from Washington*, TRUSTEE, Sept. 1978, at 11. The tremendous rise in health care costs provided the impetus behind the certificate of need plan. Legislatures recognized that "unnecessary construction or modification of health care facilities increases the cost of care and threatens the financial ability of the public to obtain necessary medical services." Curran, *supra* note 176, at 85 (quoting Law of June 1, 1971, ch. 628, § 1, 1971 Minn. Laws 1165).

After initial opposition, the American Hospital Association (AHA) endorsed the certificate of need concept in 1968. With AHA support, CON statutes were passed in rapid succession. *Id.* at 87, 89. The AHA's interests in regulation are complex. Established hospitals undoubtedly see CON as an opportunity to solidify their control over the local market and to prevent the entry of vigorous competitors, especially proprietary hospitals and HMOs. Havighurst, *supra* note 86, at 1178-88. They may also hope that CON will strengthen the ability of administrators and trustees to resist excessive demands for capital expenditures by the medical staff.

178. See generally Havighurst, *supra* note 86.

179. LEWIN & ASSOCIATES, *NATIONWIDE SURVEY OF STATE HEALTH REGULATIONS* 50-54, 166-94 (1974); Havighurst, *supra* note 86, at 1169-78.

review institutional capital expenditures.¹⁸⁰ Health facilities engaging in such expenditures without the prior approval of the state's designated 1122 planning agency would receive a pro rata reduction in the reimbursement for services rendered under Medicaid and Medicare.¹⁸¹ By 1978, thirty-six states had opted to participate.¹⁸² Although this "federal certificate of need program" has never been fully implemented, it clearly indicated an increased federal interest in regulatory strategies.¹⁸³

In the early 1970s, a welter of federal, state and local agencies shared the task of planning and regulating the development of health facilities. The National Health Planning and Resources Development Act of 1974¹⁸⁴ was an ambitious attempt to bring order and direction to these disjointed efforts. CHP, RMP and Hill-Burton were effectively superseded by a single program combining planning, developmental and regulatory functions.¹⁸⁵ Certificate of need programs became integral parts of the system.

The National Health Planning Act has been reviewed in detail elsewhere.¹⁸⁶ The most important features that bear on health facilities regulation are noted below:

(1) The Act provides for a significantly greater role for the federal government. The Secretary of HEW is instructed to issue national health planning guidelines respecting the supply, distribution and organization of health resources and services.¹⁸⁷ State and area health

180. Social Security Amendments of 1972, Pub. L. No. 92-603, § 221, 86 Stat. 1329 (codified at 42 U.S.C. § 1320a-1 (1976)).

181. 42 U.S.C. § 1320a-1(d) (1976).

182. See Kopit, *Hospital Decertification: Legitimate Regulation or a Taking of Private Property?*, 1978 UTAH L. REV. 179, 181 (citing DIVISION OF REGULATORY ACTIVITIES, BUREAU OF HEALTH PLANNING AND RESOURCES DEVELOPMENT, DHEW, STATUS OF CERTIFICATE-OF-NEED AND SECTION 1122 PROGRAMS IN THE STATES (1978)).

The enactment of the National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (codified at 42 U.S.C. §§ 300k-300t (1976)), has made the future of 1122 programs problematical. For a prognosis, see Hanley, *Regulation of Health Facilities and Services Under Public Law 93-641*, in HEALTH REGULATION: CERTIFICATE OF NEED AND 1122, at 53, 58 (H. Hyman ed. 1977).

183. See Wing & Silton, this Symposium, at text accompanying note 39.

184. Pub. L. No. 93-641, 88 Stat. 2225 (1974) (codified at 42 U.S.C. §§ 300k-300t (1976)).

185. The earlier federal planning legislation was never repealed, but after a transitional period, no further appropriations were made to support the programs.

186. See K. WING, THE LAW AND THE PUBLIC'S HEALTH 137-42 (1976); Atkisson & Grimes, *Health Planning in the United States: An Old Idea With a New Significance*, 1 J. HEALTH POL. POL'Y & L. 295 (1976); Blumstein & Sloan, *supra* note 158, at 8-19. The authors are particularly indebted to Blumstein & Sloan's succinct, yet comprehensive, discussion.

187. 42 U.S.C. § 300k-300t (1976).

plans must be consistent with national standards.¹⁸⁸ While participation is in theory voluntary, states that fail to adopt a planning system meeting the Act's requirements risk losing federal assistance under a variety of health-related programs.¹⁸⁹

(2) Unlike the CHP agencies, which could merely review and comment, the Health Systems Agencies (HSAs) created by the Act have the power to review and *approve* or *disapprove* applications from their area for federal funds under specified programs.¹⁹⁰

(3) The Act requires each state to adopt an approved certificate of need program by 1980.¹⁹¹ According to federal regulations, the certificate of need law must cover "[t]he construction, development, or other establishment of a new health care facility or health maintenance organization."¹⁹² An expenditure above \$150,000 will trigger review by the HSA,¹⁹³ as will changes involving ten beds or ten percent of capacity.¹⁹⁴ General criteria for certificate of need review are established by regulation.¹⁹⁵ The HSA may pursue an administrative appeal if its recommendations are not accepted by the state planning agency.¹⁹⁶

Two other provisions of the Act are of limited immediate significance, but suggest possible directions for government intervention in the future. First, HSAs are required to review periodically *existing* institutional health services and make recommendations to the state agency regarding their "appropriateness."¹⁹⁷ There is no power, however, to eliminate services that are found to be unneeded.¹⁹⁸ Second,

188. *Id.* § 300f-2(b)(2).

189. *Id.* § 300m-(d). Failure to comply could entail loss of funding under the Public Health Service Act, the Community Mental Health Centers Act, and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. The courts have held that this use of the congressional spending power is not unduly coercive. *North Carolina ex rel. Morrow v. Califano*, 445 F. Supp. 532 (E.D.N.C. 1977), *aff'd mem.*, 435 U.S. 962 (1978).

190. 42 U.S.C. § 300f-2(e)(1)(A) (1976). Funds appropriated under the Public Health Service Act, the Community Mental Health Centers Act, sections 409 and 410 of the Drug Abuse Office and Treatment Act, and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 are subject to HSA review.

191. *Id.* § 300m-2(a)(4)(A).

192. 42 C.F.R. §§ 122.304(a)(1), 123.404(a)(1) (1978).

193. *Id.* §§ 122.304(a)(2), (b)(1), 123.404(a)(2), (b)(1).

194. *Id.* §§ 122.304(a)(3), 123.404(a)(3).

195. *Id.* §§ 122.308, 123.409.

196. 42 U.S.C. § 300m-1(b)(13) (1976). *See also* 42 C.F.R. § 123.407(a)(9) (1978).

197. 42 U.S.C. § 300f-2(g) (1976). For a useful analysis of the legal issues surrounding appropriateness review, see Cole, *Issues and Strategies in Appropriateness Review: A Legal Analysis*, in PRELIMINARY APPROACHES TO APPROPRIATENESS REVIEW UNDER P.L. 93-641, at 89 (M. Mandel ed. 1978). *See also* Weiner, *Appropriateness Review and Rate Setting*, in *id.* at 39.

198. The Senate version of the bill would have granted this authority. *See* Kopit, *supra* note 182, at 182.

the Act provides funding to support rate review experiments in six selected states.¹⁹⁹ Only a few states have initiated rate review programs, but federal financial support may encourage others to do so.²⁰⁰

Opposition by providers may be sufficiently strong to resist further extensions of government control. Nevertheless, it is worth noting those regulatory proposals that are likely to be given serious consideration.

If certificate of need programs prove to be ineffective, more drastic measures may be adopted to limit capital expenditures. The Carter Administration's hospital cost containment proposal²⁰¹ included provisions that would have established an annual capital expenditure limitation of \$2.5 billion. The limit would be apportioned among the states, and no state program could grant certificates of need in excess of its allotment.²⁰²

It has been proposed that certificate of need programs be supplemented by regulatory authority to decertify institutions when there is existing excess capacity.²⁰³ In fact, the Senate version of the National Health Planning Act would have required participating states to include decertification authority in their certificate of need program²⁰⁴; this provision was amended, however, to become the more timid "appropriateness review" authority ultimately enacted.²⁰⁵ One state has enacted comprehensive decertification authority, although it has never been used.²⁰⁶

Whether these or other, more serious measures²⁰⁷ will be adopted depends in large part on whether the cost problem can be reduced to a politically tolerable level. Carter's cost containment proposal was defeated under peculiar circumstances: hospital representatives made commitments to the Congress that the industry, through its own orga-

199. 42 U.S.C. § 300m-5 (1976).

200. See Weiner, *Participatory Procedure and Political Support for Hospital Cost Containment Programs: Limits of Open Administrative Process*, this Symposium.

201. See Wing & Siltan, this Symposium, at text accompanying notes 39-57.

202. H.R. 6575, 95th Cong., 1st Sess. (1977) (Title II). See Wing & Siltan, this Symposium, at note 50.

203. Kopit, *supra* note 182.

204. S. 2994, 93d Cong., 2d Sess. (1974). See S. REP. NO. 1285, 93d Cong., 2d Sess. 53, reprinted in [1974] U.S. CODE CONG. & AD. NEWS 7842, 7892.

205. 42 U.S.C. § 300f-2(g) (1976). See Kopit, *supra* note 182, at 182.

206. N.Y. MENTAL HYG. LAW § 13.15 (McKinney 1978); N.Y. PUB. HEALTH LAW § 2806-a (McKinney 1977); see Kopit, *supra* note 182, at 186.

207. A temporary moratorium on hospital construction has been proposed. B. ENSMINGER, *supra* note 86, at 71-72; FUCHS, *supra* note 53, at 151; GOVERNMENT RESEARCH CORPORATION, A FRAMEWORK FOR CAPITAL CONTROLS IN HEALTH CARE 3-4 (1978).

nized "Voluntary Effort," would bring about at least a 2% annual reduction in hospital inflation.²⁰⁸ Whether this effort will be successful and, if successful, sufficient, remains to be seen. Its success may forestall further governmental regulation; its failure may provide the political justification for more serious controls.

III. CONCLUSION

The preceding summary of the American health care delivery system as it exists today reflects a basic and growing conflict: the consumer, with growing expectations of health services frustrated by the inflating cost of those services, is confronted with a system of health care providers with little willingness or economic incentive to reduce costs. Government attempts to resolve this conflict have thus far been ineffective. Tentative regulatory initiatives, fashioned more by political considerations than by any notion of sound, coordinated public policy, have had little measureable success; yet this lack of success has only increased the pressures to do "something" and created a climate in which more drastic measures, once thought to be unnecessary or inappropriate, are now being considered.²⁰⁹

At the heart of the conflict lies the problem of cost—an aggregate total of \$180 billion in 1978, predicted to exceed \$200 billion by 1980.²¹⁰ Health care costs consume 10% of the federal budget and as much as 8% of the budget of some state governments.²¹¹ The cost of health care is not just one of many examples of inflation in an inflationary economy; it is a significant cause of inflation in the economy in general. A few economists argue that the seriousness of the cost problem has been overblown. The cost of health care may be 8.6% of the GNP, but we are, apparently, tolerating that level of spending; and there is no reason to believe that a nation as wealthy as ours cannot spend 10% or even 15% of its resources on its health care. That may be the price we must pay for what we want.

Such rationalizations can, however, only temporarily ease the tension. If \$180 billion is an acceptable level of spending, \$200 billion or \$240 billion or whatever lies ahead will not be so easily tolerated. The problem is not just the absolute level of spending; it is the inflation and the inflation of inflation. At some point, if the costs of health care con-

208. See Wing & Sifton, this Symposium, at note 41.

209. *Id.* at text accompanying notes 39-71.

210. See note 4 *supra*.

211. See note 5 *supra*.

tinue to rise, the problem will grow to the point at which it cannot be avoided or muted by marginal adjustments or by shifting the economic impact of that cost. Cutbacks in state Medicaid budgets or closures of public hospitals may lessen that impact on state or local government and shift the burden to consumers; we may even go through the motions of enacting some sort of nationalized health insurance scheme, achieving a more equitable distribution of costs at the expense of more aggregate inflation. But simply shifting the burden from one level of government to another, or from the consumer to the taxpayer—or vice versa—can at best provide only temporary relief. Unless cost is controlled, the conflict has to escalate to a confrontation. We are not simply making an allocation of resources; we are trying to achieve both economy and efficiency. We want at least the level of services we now receive, but we no longer are satisfied with the resulting cost. Thus, we are increasingly willing to mandate government intervention into the decisionmaking of health care providers. Today, political considerations may have forestalled cost containment, decertification or even the procompetition strategies preferred by the free market theorists, but we have not avoided the problem. We may at the moment prefer "Voluntary Effort" to an increase of government control, but unless the problem of cost can be resolved, the political reality of tomorrow may be quite different.

The likely response is predictable: incremental increases in regulatory controls and more serious efforts under existing programs. Yet it is possible that this too will be unsuccessful. The regulatory strategy may be unworkable in practice, or it may be theoretically unsound. No amount of coercion, regulation, or financial incentives may be sufficient to reorient the existing system of ostensibly private providers in a direction acceptable to the public. At that point, a major restructuring may be the only alternative. This could be in the form of the more elaborate systemic revisions suggested by Havighurst and others—literally creating more competition by creating more competitors—or it could mean public ownership of health care resources, either in the form of a nationalized health service or by creation of a publicly owned alternative competitor. Already we have reached the point at which such previously heretical alternatives can be seriously discussed.

But these are the alternatives of last resort and the choices of circumstances that have not yet materialized. Rather, in the short run, we are likely to take a series of incremental steps towards increased government control, a more serious testing of the regulatory strategy, but

not a major departure from the basic structure of our system. Our focus, therefore, can be appropriately directed toward existing regulatory efforts and the lessons they demonstrate for both the near and distant future.

