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on any state failing to have a fully designated state agency by the required date would involve any "allotment, grant, loan and loan guarantee made to and each contract entered into with an individual or entity in such State ... under this Act (Public Health Service Act), the Community Mental Health Centers Act, the Comprehensive Alcohol Abuse & Alcoholism Prevention Treatment and Rehabilitation Act of 1970 and the Drug Abuse Office & Treatment Act of 1972."

If a final designation agreement is not in effect during the first year after the applicable expiration date, the Secretary of HEW must reduce the above mentioned funds by 25 percent; in the third year by 75 percent; and all funds under these acts are to be withheld after three years have elapsed.

The penalties in the new amendments are more stringent and comprehensive than those contained in the original Health Planning Act, P.L. 93-641, Section 1521 (d). The new amendments add funds under the Drug Abuse Office & Treatment Act of 1972 to the list of sanctions. More importantly, the amendments include all funds under the stated acts, not just those for "the development, expansion and support of health resources" as stated in the original act.

NCSL requested the Bureau of Health Planning to compute for each state the total dollars involved if the penalties were imposed. They have done this based on FY 1978 figures. States should be able to obtain these dollar figures through their regional HEW office of by contacting NCSL directly.

Federal Regulations Pursuant to the New Amendments

Federal law requires HEW to promulgate rules and regulations to implement the new amendments within six months of enactment. The Bureau of Health Planning intends to publish a Notice of Proposed Rulemaking (NPRM) in the Federal Register in mid-January, 1980. The NPRM will outline the issues on which further regulatory guidance is necessary. Interested parties will be given a period of time, probably sixty days, to review and comment on these issues before the final regulations are published in April, 1980.

NCSL will insure that everyone receiving this mailing will also receive the January NPRM. Legislative response to the proposed rules can be addressed directly to DHEW or channeled through NCSL. The Human Resources Committee of NCSL's State Federal Assembly will be actively involved in the review of the regulations and would appreciate receiving at least copies of the comments or concerns of state legislators and their staffs.

SFA Resolution Supporting a Timetable Extention for States

During the NCSL seminars on the health planning amendments, it became apparent that the timetable for compliance with the new amendments presents a hardship on those states which will have to amend CON statutes in the 1980 legislative sessions. Many states have to enact legislation even before the final federal regulations are published in April.

In response to this problem, the State-Federal Assembly of NCSL, the body which gives policy guidance to the organization in areas of state-federal relations, adopted the enclosed policy resolution at its December 7, 1979 meeting. The resolution urges

passage of an amendment to the recent Congressional amendments (P.L. 96-79) which would give states until the close of the first regular session after the promulgation of the HEW regulations to enact complying CON legislation.

Because Congress was near recess at the time of passage of the SFA resolution, it was impossible to find a Congressional sponsor for such an amendment before the holiday recess. However, efforts will continue to find a sponsor as soon as Congress reconvenes in January.

For additional information regarding the status of this amendment, contact: Dick Merritt, Human Resources Staff Director, NCSL Washington, (202) 624=5413.

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Certificate-of-Need—No Panacea but Not without Merit

JOHN T. TIERNEY, WILLIAM J. WATERS, and WILLIAM H. ROSENBERG

WITH the current Administration in Washington promoting competition, the certificate-of-need (CON) program is experiencing critical scrutiny. The National Health Planning and Resources Development Act of 1974, Public Law 93–641, required all states to establish certificate-of-need programs to control major hospital and nursing home construction, renovation, and development proposals. However, many states had certificate-of-need programs long before Public Law 93–641 was enacted, and many are likely to maintain certificate-of-need programs for many years to come.

An extensive literature has developed over the past few years regarding the effectiveness of certificate-of-need (1). While the empirical evidence is mixed, the current academic perspective appears to be largely negative on certificate-of-need. Evidently, certificate-of-need has enjoyed some success in restraining the number of hospital beds, but many researchers indicate that certificate-of-need has not been greatly successful in controlling health care costs. Apparently, in those areas where beds have been controlled, hospitals have shifted investment to service-intensifying expenditures. Many analyses point out the fact that a high percentage of all certificate-of-need applications are approved. However, most certificate-of-need analyses give little attention to three of its most important features: *deterrence*, *guidance*, and *institutional planning*.

The very existence of certificate-of-need acts as a deterrent to frivolous or obviously misdirected projects. Few institutions are likely to expend the time, energy, and money to traverse the complex certificate-of-need process for a project that cannot withstand the test of public scrutiny. This is a powerful deterrent to unnecessary and inappropriate development in the health care industry.

The deterrent effect appears to be working in Rhode Island where the physician supply has been expanding more rapidly than the acute hospital bed supply. In the absence of certificate-of-need, one would have expected the hospital bed supply to expand in accordance with an expanding supply of practicing physicians. From 1956 to 1971, the number of licensed physicians in Rhode Island increased by 49%, and the number of community hospital beds during the period 1958 to 1973 (assuming a two-year lag period) increased by 31%. That is, for every new physician, .63 beds were added. After certificate-of-need was operational in Rhode Island, that is, from 1971 to 1980, the number of licensed physicians in Rhode Island increased by 13%, but during the period 1973 to 1980, the community hospital bed supply actually decreased by 2.3%. Had the trend of the previous fifteen years continued after certificate-of-need, Rhode Island would have 300 more hospital beds today (see Table 1).

TABLE 1

Hospital Bed[1] and Physician Supply[2] in Rhode Island, 1956–1980

Resource	*1956*	*1958*	*1971*[3]	*1973*	*1980*
PHYSICIAN SUPPLY					
Number	1264		1889		2100
Rate per 100,000 population	152		197		226
HOSPITAL BED SUPPLY					
Number		2707		3550	3420
Rate per 1,000 population		3.2		3.7	3.6
Beds per physician[4]		2.1		1.9	1.5

[1] Short-term, acute, community hospital beds. Source: AHA Annual Survey.
[2] Licensed physicians. Source: Division of Professional Regulation, RIDH.
[3] Rhode Island certificate-of-need program was instituted in 1968 but did not become fully operational until around 1971.
[4] Beds in year X ÷ physicians in year X–2. For 1978, the number of licensed physicians was 2238.

Further, one cannot minimize the potential of certificate-of-need in terms of guiding institutional actions. While certificate-of-need may not have had the effect of reducing overall hospital investment, it may very well have had a positive impact on the types of investments which hospitals have been making. Certainly, the desire on the part of hospitals for success-

ful certificate-of-need applications would tend to guide them into areas which are compatible with the goals and policy positions of certificate-of-need bodies and agencies. For example, the certificate-of-need program in Rhode Island has promoted a number of important policies: the utilization of tax-exempt bonds where appropriate, the pursuit of community fund drives as a source of financing capital expenditures, the employment of debt/equity ratio limitations to moderate community debt burden, the use of insolvency insurance as a substitute for large capital reserves for developing health maintenance organizations (HMOs), and the gradual and thoughtful introduction of CAT scanners. The appropriate funneling of provider activity is an obviously critical but largely unevaluated area of certificate-of-need impact.

Thirdly, certificate-of-need tends to promote better institutional planning. This is especially true in states where hospitals are required to submit annual long- and short-range plans as part of the certificate-of-need process. This is the case in Rhode Island. In Rhode Island, institutional plans serve as the notices-of-intent for certificate-of-need purposes. That is, no certificate-of-need proposals will be accepted unless they have previously appeared in the institution's documented plan for the future. Informal reports seem to indicate that hospitals themselves agree that certificate-of-need requirements have encouraged them to upgrade their institutional planning processes. In addition, the Rhode Island experience indicates that the certificate-of-need process can promote greater inter-institutional planning. In fact, over the last ten years the certificate-of-need process in Rhode Island has encouraged or required significant increases in inter-institutional planning affecting nine hospitals, almost half the hospitals in the nation's smallest state.

Thus existing empirical evaluations of certificate-of-need do not tell the whole story. There may be certain beneficial aspects of certificate-of-need which are difficult to measure. In fact, effective institutional/system planning encouraged by a credible certificate-of-need process should result in very few certificate-of-need denials. In this context, happiness in certificate-of-need is saying yes. That is, effective, upfront planning and dialogue between the institutional and systemwide levels should minimize the number of certificate-of-need denials. In any event, controlling total health expenditures is not the only policy objective of certificate-of-need. In fact, certificate-of-need by itself is not well suited to controlling total health expenditures. Nevertheless, certificate-of-need can be an effective mechanism for restraining health care costs, affecting the supply of health care resources,

and guiding health policy and planning at both the institutional and system levels. Therefore, certificate-of-need programs should not be abandoned without careful consideration of all the foreclosed opportunities which abandonment implies.

Finally, certificate-of-need would be a more effective cost-control device if there were a capital expenditure limit associated with the certificate-of-need process. As things stand now, there are no financial boundaries conditioning the number of certificate-of-need proposals which can be approved in a given time-frame. This is unrealistic and cripples the cost-control potential of the certificate-of-need process. No industry can afford to operate forever without some form of capital budget. Certificate-of-need capital limits would not only serve to restrain costs, they would also induce a healthy priority-setting process within certificate-of-need. Perhaps we should direct our energies toward improving the certificate-of-need process rather than dismantling it.

In conclusion, certificate-of-need was designed to avoid unnecessary duplication which results in underutilization and inflated costs in a largely cost-based reimbursement system. From this perspective, certificate-of-need has been successful in Rhode Island and elsewhere. Rhode Island's high overall community hospital occupancy rate (85.6%) and the absence of patently wasteful developments attest to this. At the same time, it is recognized in Rhode Island and elsewhere that effective overall cost control also requires use of a combination of other mechanisms such as prospective reimbursement, utilization review, consumer choice, and health maintenance organization (HMO) development.

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Funds: STATE HEALTH PLANNING $241,000

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THE SOCIAL CONSEQUENCES OF FREE TRADE IN HEALTH CARE: A PUBLIC HEALTH RESPONSE TO ORTHODOX ECONOMICS

Milton I. Roemer and John E. Roemer

In recent years, difficulties in U.S. health services have been ascribed to excessive government intervention and regulation; high costs and other problems would be solved, it is argued, by "return to the free market and competition." Examination of the past operations of free trade and competition in health care, however, shows that in this market not one of at least five conditions necessary for effective competition exists. Numerous adjustments made by society reflect strikingly the problems caused by these market deficiencies (such as seriously inadequate information or the presence of major social "externalities"). Furthermore, even these adjustments—such as medical ethics or health insurance—have generated serious secondary problems. Many types of waste and social inequity also persist, in spite of all the attempts to compensate for market failure. In effect, the so-called free market in health care has survived only because of the extensive regulations and other actions taken to patch it up. Abandoning these adjustments would further aggravate current problems. Only replacement of free trade by systematic social planning could hope to achieve a health care system that allocates resources and distributes services both efficiently and equitably.

In recent years it has become increasingly fashionable to attribute the many serious problems of the American health care system to "excessive government regulation." It is argued that a deliberate return to the classical entrepreneurial model of free trade and competition would solve or greatly reduce our problems of spiraling health care costs and inaccessibility of needed services. From this viewpoint, there follow many political actions to minimize the entire role of government—with respect to both regulation and planning—and to enhance the private sector in health care (1). Under the Reagan Administration, such strategies have become explicitly dominant.

INTRODUCTION: THE BASIC ISSUE

The question of whether free trade with competition, or social planning with regulation, is the most effective mechanism for governance of the health care system, has very complex ramifications. Comprehensive analysis of these issues would require a lengthy book. In this paper, we shall offer only an introductory statement of our

This paper is based on an address on "Competition in the Health Care System" presented by Dr. Milton I. Roemer to the Third Annual Michigan Statewide Health Planning Conference, held in Detroit on May 21, 1980.

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argument that a policy of greater free trade and lesser public regulation of health services would not reduce but would increase the problems of the U.S. health care system.

We contend that the current health care systems in the United States and other capitalist nations have survived to the present day only because they have been continuously modified by planning and regulation. Without those modifications, the effects of free market dynamics in the health care sector would have been so disastrous, so unacceptable politically, that these systems would have collapsed long ago, and been replaced by completely planned and regulated health care systems. In order to solve the still persistent health care problems—involving costs, accessibility, quality, and other features—America requires not greater free trade and competition, but rather much more planning and regulation.

The virtues of free trade and competition have long been acclaimed in the modern, parliamentary, and capitalist world. From early childhood, we become so deeply convinced of the wisdom of free competition as the best incentive for diligence—in the classroom, on the athletic field, everywhere—that in later life it becomes naturally accepted as the obvious path to sound social policy.

As well summarized by Anne Somers (2, p. 468), in the wind-up of a 1977 national conference of economists on Competition in the Health Care Sector:

> Competition is generally the most desirable method of quality control, price-setting, and resource allocation. In theory, at least, the consumer has the final say, while producers or providers compete for his favor in terms of quality as well as price, thus maximizing the incentive to efficiency.

Continuing with her statement of this ideal, Professor Somers states further:

> Interference by Government or any other third party in the consumer-provider relationship is non-existent or minimal. . . . Even in the health care economy, with all its idiosyncrasies, my philosophical bias is in the same direction.

Most Americans probably share this notion of the virtues of free trade and competition in all sectors of society, including the health field; the basic trouble, many think, is that the concept has not really been fairly tested. Some regard "government interference" as the major obstruction. While most would acknowledge problems caused by monopolistic producers (i.e. health care providers) and by the non-sophistication of consumers (i.e. patients), these characteristics of the health care industry are viewed as only minor disturbances that do not nullify the basic soundness of a free market policy—perhaps modified in small ways.

Examining the actual dynamics and experience of free trade and competition in the health care systems of the United States and other countries, however, one becomes increasingly skeptical of the whole idea. With respect to a goal of social justice, one finds not only the inadequacy of the free competition model for governing the complex processes of a modern health economy, but even its ultimate perversity. In countless ways, free trade and competition have operated and still operate to thwart the attainment of social justice in the health sector. Regulation, controls, and numerous other instruments of public policy have been necessary to overcome or neutralize the harmful social consequences of unbridled competition. These "interventions" have been gradually replacing free competition with a strategy that may be epitomized in the phrase "systematic social planning."

It is relevant to recall the origins of the concept of free trade and the theoretical rationale of competition as its regulatory mechanism. After this, some of the major consequences of this mechanism in the health sector can be better understood.

ORIGINS OF FREE TRADE AND COMPETITION

Theoretical formulation of the principles of free enterprise—with competition, its regulator—as the best path to a just and efficient social order, we all know, came from a Scottish economist, Adam Smith. His classic *Inquiry Into the Nature and Causes of the Wealth of Nations* was published in 1776, the same year, interestingly, that another kind of freedom was formulated by American revolutionaries in their *Declaration of Independence*. In light of the restrictions of free trade and various other vestiges of feudalism, one can well appreciate how principles of *laissez-faire* economics and unfettered competition were a great step forward at the time.

In spite of his eloquent call for a free market, Adam Smith recognized the need, even in the 18th century, for a certain amount of government regulation. He saw this as necessary to prevent monopolies, and he accepted tariffs (trade barriers) as justified to protect young industries in a nation. This was *before* the Industrial Revolution was far along, with its urban slums, sweat shops, 12-14 hour workdays, and child labor. As against monarchistic and feudal despotism, economic and political freedom seemed a far preferable general policy.

Adam Smith's 1776 model was also formulated before the great flowering of science in the 19th century. The monarchy and the church were being rejected as the guides to truth and justice, but science had not yet acquired the stature to replace them. Electricity, bacteriology, and other instruments to achieve control over nature for the sake of human welfare were to come later. Likewise, rational or scientific social planning, by which societies could be effectively controlled for the sake of human welfare, were also to come later. Labor laws, public health legislation, and social security were products of the 19th century (3).

Thus, the notion of letting each individual be free to pursue his own self-interest seemed a sounder path to social justice than royal or religious dogma. Unreasonable or improper outcomes of this freedom would be averted, or at least minimized, by the "invisible hand" of competition in a free market. The scientific method had not yet won recognition as a better strategy. It has been the development of science, and its application both to nature and to society, that makes possible the replacement of competition by systematic social planning, particularly to meet essential needs such as health care.

Before reporting some of the health consequences of free enterprise and competition in the last two centuries or so, the relationship between free trade (*laissez-faire*) and competitive market dynamics should be clarified. These considerations are, of course, not limited to the health sector.

FREE TRADE MARKET STRUCTURES

Free trade is the umbrella concept encompassing many types of market mechanisms which may arise as each individual pursues his own self-interest, unrestrained by regulation from any source, such as the state. A competitive market is one structure

which, under certain circumstances, may emerge in a *laissez-faire* environment. Other economic structures may also emerge, as often occurs in the health sector.

Thus, as schematized in Figure 1, at least four market structures may evolve under free trade capitalism. *Monopoly* or oligopoly can result if one or a few of the competing producers beat out the others in the competitive struggle. As noted later, this often occurs in the health sector when technology can yield huge economies of scale, so that many atomized producers cannot remain viable. A second possible outcome is long-term *contractual arrangements*, as when producers and consumers decide to handle their transactions through a "health maintenance organization." The third and fourth outcomes in Figure 1 require elaboration.

The process of competition under free trade may also yield a more complex dynamics. Before reaching an outcome of competitive equilibrium, the market typically passes through a stage we describe as *turbulent competitive disequilibrium*. In this stage, consumers are shopping around (usually with very limited information) and providers are offering diverse sorts and qualities of product at various prices. The idealized description of the free market assumes this period of disequilibrium to be transient, leading rapidly to *competitive equilibrium*, in which the faulty products are eliminated from the market. Due, however, to the nature of the doctor-patient relationship, seriously inadequate consumer information, and other features of the health sector discussed below, the period of turbulent competitive disequilibrium is typically protracted. Competitive equilibrium is probably the rarest outcome of free trade dynamics in the health sector. But even if such an equilibrium is attained, it may be inefficient, as well as inequitable, in the allocation of health resources (hence the representation in Figure 1 of two types of competitive equilibrium).

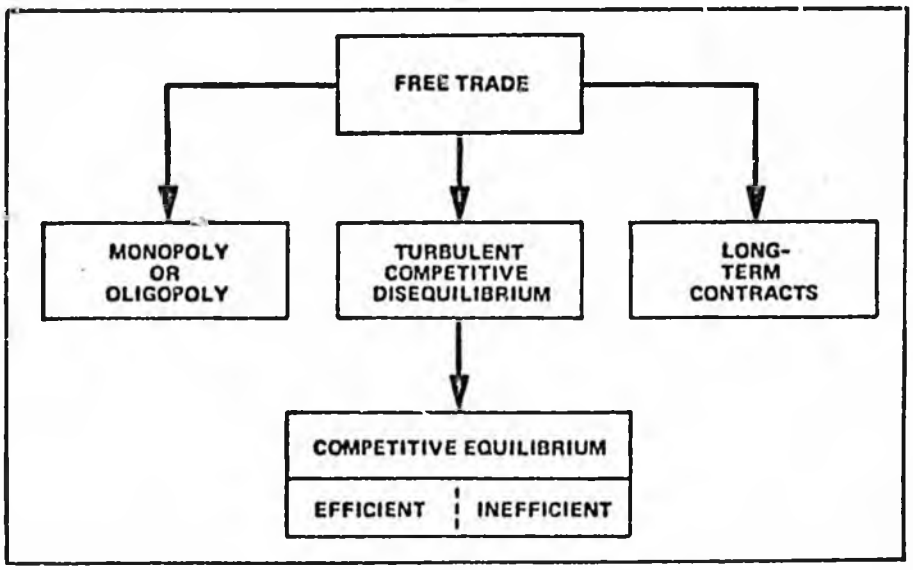

Figure 1. Free trade dynamics: some alternative outcomes.

The frequent outcomes of monopoly/oligopoly or turbulent competitive disequilibrium, unless averted by regulation, may be very deleterious to consumers. Occasionally the outcome of a free market is a long-term contract, which can be beneficial for consumers (although, as we shall see, even such contracts may require substantial regulation to protect consumers). In a sense, systematic social planning aims to extend this contracting phenomenon to a universal one, under specified conditions.

To understand why the invisible hand of Adam Smith's free trade seldom leads to a balanced market structure, with its famous property for efficient allocation of resources, one may identify at least five necessary conditions for achievement of that outcome (4):

1. *Many buyers and sellers freely interacting.* If there are few sellers, as often characterizes the health sector, competition can hardly operate.
2. *No substantial economies of scale.* If such economies are possible, a competitive solution is not efficient. It is often more efficient to have one large producer (a "natural monopoly") than many small ones. Price and quality, however, must then be regulated to protect consumers, in place of competition.
3. *Low transaction costs.* If arranging the purchase of a commodity or service is, itself, a complex transaction, then the use of the market can be very costly and inefficient. The commonest solution in industry is the firm, which avoids these costs by internal planning and authority. The hospital is an obvious analogue.
4. *Adequate information.* If buyers are to exercise reasonable choices in a market of competing sellers, they must have knowledge about the product being sold. Advertising is intended theoretically to enlighten consumers on the merits of various competing products (although it has been found necessary to regulate to reduce biased or misleading information). Without clear and reliable information, how can "consumer sovereignty" be exercised to lead to selections of the "best" product?
5. *Absence of externalities.* A transaction entails "externalities" if people beyond the buyer and seller are directly affected by it. (With significant externalities, even pure competitive markets are seldom efficient.) Immunization is an obvious example; if one person is not immunized, many others may be harmed. Even if all the other conditions necessary for a competitive equilibrium hold, with significant externalities it will not be efficient.

These five conditions are not the only ones necessary for static efficiency of a competitive market, but they are sufficient to show the inapplicability of the concept to the health sector. On the other hand, free competition is often heralded for its *dynamic* efficiency, in leading to technological innovation. Adam Smith's invisible hand, some argue, is more important in this dynamic sense—that is, competition as the mother of invention, the stimulus to technological innovations and advances. However valid this may have been in the past, how true is it today? By far, the lion's share of scientific research is funded by government and philanthropy, not by competing entrepreneurs. In 1978, private industry supported 28 percent of the cost of health-related research, compared to 72 percent from government and philanthropy (5). The contribution to *basic* scientific knowledge from entrepreneurial research is doubtless smaller than 28 percent.

Before proceeding to empirical facts on free competition in the health sector, another word is necessary on the process schematized in Figure 1. By what mechanism does laissez-faire dynamics lead to competitive market equilibrium? In theory, with many buyers and sellers, those with a poor product or too high a price lose out and disappear. Competition supposedly weeds out the inferior sellers, until only those with an optimal combination of price and quality (for the consumer) remain. No one claims any harmonious efficiency during this period of disequilibrium, but it is commonly assumed to lead rapidly to efficient competitive equilibrium.

We have noted five conditions necessary for that outcome; if any one of these is absent, an efficient market equilibrium will not be reached. Instead, the injurious instability will persist, monopoly will emerge, a long-term contract may result, or an inefficient equilibrium may occur which misallocates health resources (each with its own persistent problems, as discussed below). Even if an efficient competitive equilibrium is attained, social equity still cannot be assured.

What, in fact, are the workings of free trade and competition in the medical market? To what extent do the operations of the market result either in the long run or the short run, in "quality control, price-setting, and resource allocation" that is "desirable" or optimal for achieving the best results for the individual and for society? What is the empirical evidence on the consequences of the free trade and competition model in the health sector?

The harmful effects of a social or socioeconomic idea can be reflected in two ways: first, by identification of actions taken by society to reduce those effects, and second, by recognition of problems that persist and have not yet been fully corrected. Below we offer evidence of the first type: adjustments found necessary to compensate for the ill effects of the free market over the past century.

ADJUSTMENTS FOR THE ILL EFFECTS OF FREE TRADE AND COMPETITION

One might offer scores of examples of social programs launched to intervene in the free market, insofar as its normal operations have yielded significant social problems. Many of these problems are perceived as failures to achieve social justice, or more specifically equitable response to the personal health needs of people. Some of the problems, as we will see, relate to economic waste; still others involve explicit harm to people.

Exposition of these social adjustments may be offered in accordance with the five conditions necessary for the effective operation of a free competitive market, as explained earlier.

The Need for Many Buyers and Sellers Freely Interacting

The ordinary medical care process is hardly conducive to comparative shopping by patients among many sellers of medical care. An essential requirement for effective doctor-patient relationships is long-term continuity in the linkage of the patient with a particular doctor; the very act of consulting another physician jeopardizes this relationship. Yet the initial choice of a doctor is often based on happenstances such as geographic location or a chance recommendation.

Little has been done deliberately to assure free interaction of many buyers and sellers of primary health care. An unplanned or spontaneous social adjustment, however, has been the great expansion of hospital "emergency" services, in response to the difficulties of patient access to ordinary primary care (6). In effect, the spiraling utilization of hospital emergency departments for non-urgent primary care has been an adjustment to the lack of adequate numbers of primary care doctors in American communities.

Perhaps a more deliberate adjustment to the sparsity of sellers of primary medical care has been the U.S. movement of the 1960s and 1970s to train substitutes for the general practitioner, in the form of physician assistants and nurse practitioners. It is noteworthy that other affluent nations with adequate supplies of generalists have not employed such a strategy (7). Many types of federally subsidized community health centers in poverty areas have been another American adjustment.

With respect to secondary care, specifically surgical operations, intervention to permit comparisons between sellers has been deliberate. Health insurance plans have introduced procedures for "second surgical opinions"—not to determine the lowest price bid, but to permit the patient to decide whether the surgery is truly necessary in the first place (8). Yet even this process has been opposed by medical societies as "interference in the doctor-patient relationship."

No Substantial Economies of Scale

The social adjustments induced by the clear existence of economies of scale and the associated "natural monopolies" have been numerous.

After discovery of the Salk vaccine against poliomyelitis, the restricted licensing of a few large pharmaceutical firms to produce the vaccine was done in obvious recognition of the economies, as well as quality controls, in such restriction of competition. The same policy is pursued with respect to production of all vaccines in many capitalist countries, not to mention the socialist countries.

In organized health care settings, the irrationality of the competitive free market model has long been evident. Hospitals, for example, continue to make exclusive contracts with radiologists and pathologists, even though this bars competition in these specialties (9). Without such contracts, hospital care would be less efficient and even more expensive than it is. The same basic concept of structured "closed staff" hospitals has been found to promote efficiency and quality for *all* specialty services in general hospitals throughout most of the industrialized world (capitalist and socialist) (10).

In normal comprehensive health planning, the implementation of "certificate of need" legislation to authorize new hospital construction is an obvious recognition of the value of restricting competition due to the benefits of natural monopoly (11). Quite aside from the wastefulness of superfluous hospital beds generating unjustified utilization (see below), multiple small facilities in a community are more costly and less effective than a larger integrated facility. Similar policies govern the authorization of new pharmacies in an area, even in an entrepreneurial nation like Belgium (12).

Low Transaction Costs

The bewildering complexities of the medical care system have induced all sorts of adjustments to the high costs of the whole transaction process.

Group medical practice is one such adjustment (13). Over the last 40 years it has grown rapidly, as an adjustment to the complexities caused for the patient by specialization in medicine, and in spite of its reduction of competition. Thus, a reduced choice of specialists is traded off for the benefits of professional teamwork and greater convenience for the patient. The elaborate integrated mechanism of the general hospital is also, of course, an adjustment to the economic and logistical monstrosity that would result if each of the hospital's hundreds of services were to be sold as a separate market transaction.

The operations of virtually all programs of organized health care delivery are further demonstrations of the high cost and inefficiencies of multiple separate transactions. This may be illustrated by governmental health programs from the magnitude of the Veterans Administration 175-hospital network down to a Health Department prenatal clinic in one small town.

Consider the transaction costs involved in the rehabilitation of a patient with a serious disability. His needs for physician services, drugs, hospitalization, physical and occupational therapy, perhaps prosthetic appliances, occupational retraining, job placement, and much more are bewildering. The process is so complex that highly directive vocational rehabilitation programs have had to be organized in all states, under which "vocational rehabilitation counsellors" cut through the complexities and make decisions for the patient, rejecting the competitive process with its high transaction costs.

Adequate Information

The deficiencies of information available to the consumer are perhaps the most widespread obstacles to the efficient operation of a free health care market. A catalog of all the social adjustments stimulated to cope with this problem would be very lengthy, indeed, and only a few can be cited.

Free competition gave rise to countless numbers and types of unqualified practitioners, particularly with the growth of cities in 19th-century Europe and America. How could the average consumer be expected to distinguish the knowledgeable physician from the imposter? Licensure in medicine (and later other professions) was the solution adopted throughout the world, even though it clearly reduced competition (14). Such restriction of the free market was preferable to the tragic consequences of treatment by charlatans.

But even licensure has been an imperfect solution in the United States, as state legislatures, clinging to free market concepts, have licensed chiropractors in almost every state; this is not merely to treat vertebral disorders (for which there may be limited justification), but to handle every type of disease (15). Moreover, medical licensure laws have been widely misused, to protect the "competitive position" of existing practitioners rather than to safeguard consumers. Yet no state has been willing to risk the disasters that might follow from revoking licensure legislation. Instead, licensure boards are being reconstituted to include consumers as spokesmen for the public interest (16).

Some have looked upon professional licensure and similar forms of regulation as a strategy for prohibiting innovation that might be sound. They point to the long history of opposition to new ideas by orthodox medicine—opposition to smallpox

vaccination, to the infectious cause of "childbed fever," and even to the pasteurization of milk (17). The negative American attitudes today about the use of trained midwives for normal obstetrical deliveries or of New Zealand-type "dental nurses" for the care of children are put in the same class. But the latter types of health personnel are, in fact, productively used in dozens of countries. Their non-acceptance in the United States is not caused by regulation but by the political effectiveness of the medical and dental professions in suppressing competition. When and if public pressures are mounted to change the licensure laws, these reasonable types of health personnel will be licensed in the United States, as they are elsewhere.

The countless tragedies from misinformation—often deliberately false claims—about drugs make a long and distressing saga. In the United States at the end of the 19th century, the unfettered free market was particularly adventurist; among other things, drugs were manufactured, labelled, and sold with complete abandon. The result was enormous deception of people by grossly false claims on packaged medications, with resultant waste of millions of dollars and doubtless thousands of lives. In response, the U.S. Congress passed the first Food and Drug Control Act in 1906, greatly restricting the free market in drug production and sales. It took additional tragedies in 1939 (scores of infant deaths from a lethal "elixir" of sulfanilamide) and in 1962 (hundreds of limbless babies born to mothers taking "thalidomide") to bring further tightening of drug control legislation against the abuses of competitive free enterprise in the U.S. pharmaceutical industry (18).

The workings of hospitals have long been far too complex to be evaluated by the average patient, even by the average community physician. Many facilities lacked proper laboratories, surgical equipment, or nursing staffs, but how was the outsider to know? In response, non-governmental action was taken first in 1919; this evolved into the Joint Commission on Accreditation of Hospitals in 1952 (19). Thus, information about hospitals is provided to potential users (or buyers of hospital service) through an emblem of approval, in spite of this indirect interference with free competition for the patient's patronage. Even so, an emblem of quality may not protect the consumer, since the hospital is ordinarily chosen not by him but by the doctor—who may (and often does) have his own reasons for selecting a non-accredited facility.

Absence of Externalities

In the health sector, externalities abound with particular force. Each person's health status affects the health and welfare of everyone else. As a practical matter, therefore, nations at all stages of capitalist development have taken actions to assure the distribution of health care quite outside the mechanism of a free competitive market. One may not always appreciate the abandonment of *laissez-faire* dynamics that these actions constitute.

The rise of insurance for health care—first voluntary, later mandatory—was an early response to recognition of the societal importance of assured medical care at times of need. In the 19th century, as medical care became a market commodity (available only from charitable sources for the very poor and destitute), mutual insurance societies grew up in Europe to pay doctor bills for low-wage workers. Eventually in the 1880s, Germany enacted a law mandating "sickness insurance" for low-wage workers, and launching the concept of social security. Both the private and public forms of health

care insurance spread to many other countries (20). Not until 1965 did the United States enact any social insurance for general medical care, limiting it to the aged. Mandatory or social insurance constitutes a major adjustment to the problems of the free market ideology (21). To a lesser extent, the same is true of voluntary health insurance. By spreading sickness risks over many people and over periods of time, the constraints of price on individual demand, when sickness strikes, are greatly reduced; the degree, of course, depends on the nature of copayments, deductibles, and other "cost-sharing" requirements that may be imposed (22). Prevention of insurance "abuse" by either patient or doctor—the so-called "moral hazard" of insurance—engenders all sorts of surveillance and policing in any insurance program. With all their weaknesses and faults, which are many, both voluntary health insurance and Medicare for the aged mollify the worst effects of the classical market mechanism in the distribution of medical care (albeit through introduction of another market for insurance).

To provide medical care for the poor—for those without even the low but stable incomes adequate for insurance—other adjustments have long been made. General revenue support of the U.S. Medicaid program is only the latest in a long saga of social measures to finance needed medical care that poor people were unable to purchase in the free market (23). Parliamentary governments could ignore the brutalities of a market price for all care of the sick only at the risk of deaths in the street, mass rebellion, and social revolution. Compromising the free medical market, with tax-supported health care for the poor, was a much more prudent solution taken throughout the world, if only to maintain social order. The introduction of social security under Bismarck was not designed to extend democratic rights and liberties, but rather to weaken the rising socialist movement among European workers (24).

The entire field of preventive medicine and public health has developed out of recognition of the crucial "externality" that each person's health care affects the well-being of all others. This has long been obvious for immunizations and other measures of communicable disease control; compulsory vaccinations, isolation, and quarantine have been implemented for centuries. Although less obvious, the same principle applies to health education on behavior to reduce the risk of chronic noncommunicable disease. We need not fall into the trap of blaming the victim for his "life style" in recognizing the importance of social measures (e.g. bans on cigarette advertising) to discourage harmful habits (25). Such social measures must operate not only outside the arena of free trade, but even as a frontal assault upon it.

These specific adjustments to the ill effects of a free market in the health sector may constitute enough empirical evidence of its grave inadequacies as a means for reasonable allocation of resources in society. All five of the conditions necessary for the market to serve as an efficient distributive mechanism are seriously lacking.

But the ill effects of free trade and competition in the health sector are shown in other ways. Returning to the process modeled in Figure 1, one must recognize the development of monopoly/oligopoly on the one hand, and semi-market contractual arrangements on the other—channels of development that do not even lead theoretically to competitive market equilibrium.

OTHER OUTCOMES OF FREE TRADE IN HEALTH CARE

The obstructive and anti-social rise of monopoly in the health sector has occurred again and again. Actions taken in response to this problem have led, in turn, to injurious secondary effects.

The U.S. pharmaceutical industry has engaged repeatedly in collusive price-fixing in restraint of trade. Convictions, such as that achieved for pegging the price of antibiotics to yield superprofits to several major firms after World War II, were widely publicized (26). But such exposure of monopolistic practices is probably only the iceberg seen above the water. Is it not significant that the U.S. pharmaceutical industry has long had the highest rate of profit of any type of enterprise (27)—higher than the steel industry or the manufacture of computers?

Medical societies have long used "ethics" as a constraint against development of innovative patterns of medical care delivery. Their strategy has been essentially monopolistic. Agreements among producers to stifle innovation sabotaged the ability of competition to regulate the whole free enterprise system.

There were other more subtle ways, however, that private physicans could block the development of competitive new patterns of health care delivery, designed to give consumers a better deal. Consumer cooperatives getting their medical care through group practice clinics constituted one such pattern; doctors in these clinics could be barred from admitting their patients to community hospitals, dominated by private solo practitioners. Exactly such a tactic was used by the Medical Society of the District of Columbia, along with the American Medical Association, in an attempt to destroy the Group Health Association of Washington, D.C., in the 1930s. It took legal action in the courts to stop this assault on competition from new health care ideas, resulting in the 1943 conviction of the AMA for "criminal conspiracy in restraint of trade." (28) In spite of this watershed decision, medical societies continue to apply social ostracism and other subtle strategies against physicians who would deviate from the status quo of private fee-for-service medical practice.

The development of long-term contractual arrangements under free trade in the health sector has taken several forms. While constituting partial departures from conventional market arrangements, each of these mechanisms has generated secondary problems, which in turn require regulatory controls.

Recognition of broadly accessible health care as sound social policy led to the rise of health insurance—first voluntary and then mandatory—as discussed earlier. Insurance overcame the obstacles to accessibility erected by market prices for medical care; but, in the absence of regulation, it generated much unnecessary service to enhance the earnings of doctors and hospitals.

In reaction to this abuse—that is, a serious flaw in the very mechanism (health insurance) designed to adjust for the inequities caused by the free market—numerous corrective adjustments have become necessary. In most countries official fee-schedules for medical services have been established, freezing price competition, and in the U.S. Medicare program various constraints have been put on the determination of "reasonable, customary, and prevailing" doctor fees. Under 1972 law, PSROs (professional standards review organizations) were set up throughout the nation to monitor the propriety of all services in hospitals financed by both Medicare and Medicaid (29).

It has also been found necessary to establish a federal Office of Fraud and Abuse, to cope with professional misconduct. Thus, socially planned insurance, organized to assure accessibility to health care, generates secondary problems, unless the economic freedom of vendors is regulated.

Health maintenance organizations (HMOs) are the most recent striking expression of a diversion to long-term contractual arrangements, in response to free market problems. The HMO is basically a strategy for complete removal from the orbit of the market of a population of patients and health care providers. Buyers and sellers make an agreement, a fixed-price contract, for future delivery (usually for one year) of needed medical care. This mechanism has been found to be so effective in controlling the cost escalations of the free medical market, that in 1973 federal legislation was enacted to promote it (30). The growth of HMOs has been slower than some had hoped; the reasons are many, but a major one is doubtless the opposition of private medical entrepreneurs precisely because the HMO constitutes such a departure from free market dynamics. It greatly modifies the profit incentives to maximize sales. Moreover, the HMO is regarded as an incursion on physician freedom and a first step in a broader assault on the medical market.

At the same time, HMOs have not been an unmixed blessing; they have given rise to new forms of abuse. In the early 1970s, to reduce medical care expenditures for the poor, California and certain other states actively encouraged the establishment of HMOs for Medicaid-eligibles. But these "prepaid health plans" (PHPs) were allowed to operate without any official standards; as a result dozens of unscrupulous organizations were formed, giving seriously deficient services (31). With fixed monthly payments from the state government assured, the PHPs gave grossly inadequate ambulatory as well as hospital care; an indigent patient would have to be at death's door before he was admitted to a hospital. It took widely publicized evidence of scandalous medical neglect or fiscal abuses to lead to new state regulation of these Medicaid HMOs. Only after this corrective action were the corrupt HMOs eliminated (32).

Others have spoken glowingly of the HMO as the crucial strategy for achieving the benefits of free competition in the U.S. health care system (33). The fundamental merit of the HMO concept is, in fact, its modification of the usual profit motive of maximizing the sale of medical services, toward an opposite motive of minimizing services—presumably through "maintenance of health." But the dynamic is far more complicated than this, and the potential for abuse is enormous, as shown in the California experience.

The allegedly effective competition among several HMOs in one midwest metropolitan area has been widely acclaimed (34). Its replication elsewhere or, indeed, its continued integrity in Minneapolis may be reasonably expected only if cautious state regulation and painstaking consumer education prevent the abuses experienced in California in the 1970s. (It is relevant that Minnesota's current statutory regulation of HMOs is especially rigorous.) Regulatory safeguards would be needed against still other potential abuses in "selection of risks" or "preferential pricing," which have long caused inequities in the commercial insurance industry (35). Whether the burden of public regulation necessary to assure equity and efficiency—under a system of HMOs competing with each other and also with other health insurance programs—would be less than under a wholly planned health care system, is very doubtful.

UNSOLVED PROBLEMS OF THE FREE MARKET

Beyond all the evidence of free market failure, reflected by the many adjustments stimulated in response, there are a host of persistent problems on which little action has been taken or the attempted corrections have been ineffective. Only some of the most prominent of these unsolved problems need be briefly noted:

High and endlessly rising costs of medical care are probably the most prominent unsolved problem in the whole contemporary health sector (36). Several of the adjustments just reviewed have been directed to cost controls, but expenditures continue to mount. Some traditional economists argue that the regulatory constraints on competition are the *cause* of cost escalations–as though the many inherent obstacles to a free competitive market in health services, reviewed above, did not exist. The numerous imperfections of the competitive process in the health sector have not been sufficiently corrected by regulation, on the one hand, nor replaced by systematic planning, on the other. Prospective global budgeting of hospital operation, for example (not to be confused with prospective *per diem* reimbursement), is not implementable in the current pluralistic American health economy. It is these realities of halfway regulation, combined with halfway competition, that yield inflation of health care costs.

While professional licensure has eliminated the worst chicanery from the medical care market, it has not gone far enough. Disciplinary actions taken against even grossly incompetent doctors are notoriously weak. The beginnings of mandatory continuing education, enforced by requirements for periodic relicensure of pharmacists, physicians, nurses, and others in a few states, point up the need for great extension of such policies (37).

Excessive medical, and particularly surgical, specialization in America has led to many difficulties, most prominently a serious shortage of primary care doctors. Under the Health Professions Educational Assistance Act of 1976, training grants have been designed to favor residencies in primary fields of medicine. Much more is needed, however, to assure the appropriate access of everyone to a continuing and reliable source of primary health care (38).

Geographic maldistribution of physicians and other health personnel–causing serious handicaps for rural populations–is a problem plaguing the health care system of every capitalist nation. While many factors account for this problem, the operation of the free market is important among them; most rural people are relatively poor and lack the purchasing power for proper medical care. Many countries have coped with this by scrapping market mechanisms, and requiring a period of rural service from all new medical graduates. Norway has its highly developed "district doctor" system, and the United States has its modest "National Health Service Corps." (39) Far more powerful measures are needed, if this major inequity of the free medical market is to be corrected.

Permeating the American free market in health services is the paradoxical problem of "supply creating demand"–fundamentally because the seller (doctor) rather than the buyer (patient) makes most of the decisions on the health services to be obtained and paid for (40). The problem has been most conspicuous with respect to hospitalization and its spiraling costs, and yet one wonders why it took until the late 1950s to recognize the dynamics.

As the rise of U.S. hospital costs accelerated in the 1950s, attention became focused on possible "overutilization." It was charged that, because insurance had eliminated the constraints of price, patients were "abusing" it and consuming more hospital days than needed. One would have thought patients could check into a hospital, as into a hotel. Studies at Cornell's Institute of Hospital Administration, however, showed that—with almost any ratio of hospital beds in a community, high or low—doctors managed to keep those beds filled at about the same occupancy level (41). As a result, New York State enacted in 1964 the first "certificate of need" law to control hospital bed supply. Soon many other states did the same, and federal law in 1974 made such regulation virtually nationwide (11). What a strange commentary on the operations of the free market model of supply, demand, competition, and price! Excess supply did not bring down the price, but caused greater overall expenditures.

Indeed, excess hospital beds have resulted not only in higher rates of patient-day utilization, but even higher costs per day, as competing hospitals acquire superfluous technology in order to attract doctors. How can more CT (computerized tomography) scanners be justified in Los Angeles County (some 65 units for a population of 7,000,000) than in all of Great Britain (population of 55,000,000) where the machine was invented? (42). The low point in hospital enticements to doctors may have been reached in May 1980, when evidence was disclosed that a supposedly prestigious institution, with low bed occupancy, was operating a "call girl service" for doctors, to induce them to admit patients (43). Legal prosecution, of course, was necessary. With respect to CT scanners or excess hospital beds, planning agency decisions—hardly distinguishable from regulation—are necessary to control the extravagances of the free market in hospital care. Not many states, however, have been as forthright as Michigan, in passing legislation to deliberately reduce excess hospital capacity (44).

Evidence that supply creates demand has now accumulated for every component of the health care industry, not only for the use of hospital beds (45). Surgeons create "demand" for surgical operations, the benefits of which are far from established (46). In Canada, the in-migration of foreign medical graduates was stopped a few years ago when it was learned that each new physician meant an expenditure of some $300,000 —about 40 percent for his own gross income and 60 percent for the hospital and other secondary services that he generated. Similarly, a steady increase in the U.S. doctor-population ratio has led not to any decline in prices, but to a rise in aggregate expenditures.

Partial or half-way planning leaves many problems unsolved. Thus collectivized financing along with entrepreneurial delivery of service creates enormous problems in surveillance of quality and expenditures. For reasons explored earlier, insurance, taxation, and other third-party sources of finance have been mobilized everywhere to help achieve health care equity. At the same time, everyone agrees that third-party payment inevitably dulls or eliminates both the doctor's and the patient's sensitivity to price. Such social financing, nevertheless, is quite properly designed to facilitate the seeking of health service in the first place. Thus, for the lion's share of total health care costs now supported by third parties, the free market has already been largely abandoned (47). Yet, monitoring medical care fee claims under third-party financing programs is enormously difficult and seldom effective.

Within the field of health insurance, insofar as competition operates among carriers,

its effects have promoted inequity. The commercial insurance practice of "experience-rating"–decreasing premiums for the young and healthy, and increasing them for the aged and disabled–has forced the non-profit insurance plans to follow suit or lose their enrollment (48). The only solution to this perverse dynamics would be a system of universal social financing, within a framework of either enormously regulated competition or systematic social planning.

Zealous devotion to concepts of the free market and competition has led to the rejection of "ethical" bans on medical advertising (49). The importance of consumer accessibility to complete objective information is one thing; freedom of advertising is another. Even with the utmost scientific effort, evaluation of either the "process" or "outcome" of health services is extremely difficult to carry out, let alone to report lucidly. Take note of the limited impact of the U.S. Federal Trade Commission on the advertising of so-called "ethical drugs"–as revealed each month in the highly authoritative *Medical Letter on Drugs and Therapeutics*–in spite of the relatively broad powers vested in government by the Food, Drug, and Cosmetic Act. Objective information should be broadcast by government or some neutral body, not by parties obviously trying to sell their own particular products. Are we to welcome to the health care industry the skillful distortions with which advertising has glamorized cigarette smoking, liquor consumption, and other garden paths to disease and death?

Inadequate consumer information persists in plaguing a free market health care model, despite the most earnest efforts to ameliorate it through education. To the extent that a patient may have an impact on the doctor's decisions, he must be inordinately knowledgeable. Even if he or she is, it is rare for the patient to prevail over the judgment of the doctor. Not many patients are as sophisticated as Norman Cousins who, aided by a physician of exceptional humility, cured himself of an incurable disease (50). For every Mr. Cousins, there are thousands of other patients whose non-compliance with their doctor's prescription of anti-hypertensive drugs, for example, leads to fatal strokes.

The problems arising from the complexity of medical information, beyond the understanding of the vast majority of consumers, can be tragic. The choice of a faulty product (e.g. an incompetent doctor) may be prolonged disability or death. Rapid technological change creates new information requirements almost daily. If new drugs could freely enter the market each week, there could be endless human tragedy and waste as consumers tested each product. (Regulation, of course, has been necessary to bar this.) Even after a product has been purchased and consumed, how can the consumer judge its value? Health outcomes depend on many environmental, genetic, and other factors outside of medical care.

Market mechanisms may achieve reasonable distribution of some luxury goods and services, such as fancy clothing or night-club entertainment, but they cannot be expected to work soundly for health care. Regarding services accounting for 80-90 percent of health care costs, decisions in the last analysis are made by the doctor, not the patient. How can one expect *consumer* preferences to govern the flow of products in the medical market (51)?

Finally, one need only take note of the magnitude of "unfinished business" faced by the nation's 212 local health planning agencies, to recognize the enormity of health deficiencies remaining in the free market of health care. It has not been excessive regulation, but the consequences of the free market that led to establishment of Health Systems Agencies as mechanisms to cope with excess general hospital beds,

health care cost-containment, emergency medical services, environmental health protection, perinatal intensive care, and rehabilitation services—to name only some of the problems recently identified in the planning of one local HSA (52).

Health planning (national and local) constitutes, after all, a series of interventions in the free market of health care, designed to correct its many failures.

IN CONCLUSION—SYSTEMATIC SOCIAL PLANNING OF THE HEALTH SECTOR

We trust this is enough of a recitation of the failures, distortions, wastages, and human inequities of the free market in health care to clarify our reasons for rejecting it, and preferring a strategy of *systematic social planning.* The failures of a free market in health care to achieve effective allocation of resources for meeting the needs of populations have been gigantic. Some entrepreneurial voices even reject as "naive" the very concept of *needs*, and wish only to consider "effective demand" in a market. Yet, the market has not been completely abandoned in capitalist nations, only because countless corrective measures have kept patching it up.

Entitlement to health care, unlike most other goods and services, has come to be recognized throughout the world as a "universal human right." (53) The rationale is both humane and pragmatic. To implement its distribution, one cannot be satisfied with a free market mechanism that treats health care fundamentally as a commodity to be produced for profit and sold. A pig trough philosophy of access has been rejected. The incompatibilities between these two concepts of health care—as a commodity for sale versus a basic right—are overwhelming.

In broad terms, an agenda for a systematically planned health care system is not difficult to summarize: (a) universal population coverage; (b) comprehensive services, based solely on need; (c) emphasis on prevention through integration with treatment; (d) health personnel trained at public expense to serve in coordinated teams; (e) health facilities public and regionalized; (f) quality regulated through built-in organizational structure (rather than external surveillance); and (g) fully collectivized financing (54). In a word, a planned social system would replace the vagaries of the competitive medical market. Consumer choice would not disappear (e.g. for Doctor A rather than Doctor B), but it would be constrained by conditions under which one person's choice does not thwart reasonable response to another person's need.

The way of science, which matured only after the days of Adam Smith, has far more effective strategies to offer, both along the biological and the social dimensions of health care. Health services can be effectively distributed not by the tools of price or non-price competition, not on the basis of personal affluence, geographical location, social position, educational sophistication, or any other of the features on which free market dynamics depend. The production and distribution of health services can be based on their scientifically demonstrated value and on the differential needs of each human being (55).

The strategies required to construct a soundly planned health care system are not simple, nor free from the possibilities of error. Each of the above seven attributes of such a system requires vast information and sophisticated judgment in the arena of

both economics and politics. If one prefers an option of modifying the free market, however, the requirements for regulatory intervention are no less—if efficiency and social justice are to be attained. Programs of this sort, formulated by Alain Enthoven (33) and others, would require elaborate administration and constant regulation. These complex issues and options must be discussed, but the issue before us is the past and present medical markets. We believe it can be demonstrated that deliberate and systematic social planning of the health services can be more effective, less subject to the evils of corruption and inequity, than the most judiciously regulated model of the free competitive market. The lessons of history on the perverse social consequences of the pursuit of individual self-interest in the health sector are abundant. The human and social benefits of rational scientific health planning are demonstrable throughout the modern world.

In this paper, we have addressed the ascending wave of opinion in the United States that current difficulties in the health sector arise from "too much" regulation, and that the path to efficiency and justice lies in uninhibited competition and free trade. An objective assessment of past experience, we believe, points to a path in exactly the opposite direction.

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February 1, 1983

Dave Palmer
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Office of Representative Tischer
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Dear Mr. Palmer:

Enclosed, per your request, are several publications on the topic of certificate of need. These include:

- A Study of Intermediate Outcomes of the CON Review Process - a final report by the Arthud D. Little Co.
- "Certificate-of-Need - No Panacea but Not Without Merit" by William H. Rosenberg
- "The Social Consequences of Free Trade in Health Care: A Public Response to Orthodox Economics" by Milton I. Roemer and John E. Roemer
- Regulating Hospital Capital Investment: The Experience in Massachusetts - an NCHSR publication

Our library and files contain many other materials and reports which you are welcome to review at your convenience.

When I receive a final copy of the "Briefing Paper on Certificate of Need" which is being prepared by the ALPHA Center, I will be happy to send you a copy.

Please let me know if we can be of further assistance.

Sincerely,

Phoebe A Lindsey

Phoebe A. Lindsey
Director

Enclosures (4)

Regulating Hospital Capital Investment: The Experience in Massachusetts

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Office of Health Research, Statistics, and Technology
National Center for Health Services Research

NCHSR

RESEARCH SUMMARY SERIES

Regulating Hospital Capital Investment: The Experience in Massachusetts

Julianne R. Howell, Ph.D.
University of California, San Diego

March 1981

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Office of Health Research, Statistics, and Technology
National Center for Health Services Research

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Abstract

This study examines hospital capital investment among Massachusetts short-term general voluntary hospitals between 1967 and 1976, and assesses the impact of Certificate of Need (CON) regulation. A profile of capital expenditures for fiscal years 1967-1976 was developed from Massachusetts Rate Setting Commission data for 26 sample hospitals, stratified by teaching status and Boston versus non-Boston location. Case studies were conducted in nine sample hospitals to explore the determinants and consequences of major capital projects undertaken by the institution. Enormous capital expansion took place from 1967-76. Hospitals in areas of rapid population growth significantly increased their bed size; other hospitals replaced or modernized inpatient facilities, and expanded ambulatory care capacity. All hospitals significantly expanded their ancillary service capacity. With respect to the impact of CON regulation, the evidence revealed that by 1976 and beyond, CON review had reduced all dimensions of project scale and cost by as much as two-thirds of that originally proposed

This *NCHSR Research Summary* was written by Julianne R. Howell, Ph.D., Assistant Professor, Department of Community Medicine, University of California, San Diego, School of Medicine, La Jolla, California. The project was supported by the National Center for Health Services Research through grant HS 02862. The full report is for sale to the public by the National Technical Information Service, Springfield, VA 22161 (703/487-4650), order number PB 81-136551. This report is also available from University Microfilm, 300 North Zeet Road, Ann Arbor, MI 48106, order number 80-23791.

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Broadly speaking, certificate of need laws are grounded on the assumption that a primary reason for spiralling health care costs lies in the existence of duplicative and inappropriate facilities and services. To avoid perpetuating this problem, it is necessary to curtail the construction of new facilities and the provision of new services unless they can be shown to be needed. The rationale for certificate of need is compelling. However, there are many who doubt that the substitution of a regulatory mechanism for an admittedly imperfect market mechanism will improve the situation. On the other hand, it is the failure of the market system, embodied in the so-called "Roemer effect" which posits that the existence of hospital beds creates a demand for them, that certificate of need programs are designed to correct. How well these programs work is still an open question.

This report presents a summary of Ph.D. dissertation research supported by the National Center for Health Services Research. The study examines in detail hospital capital investment undertaken by Massachusetts short term general hospitals between 1967 and 1976. Patterns of capital expansion are compared for teaching versus nonteaching, and for Boston versus nonBoston hospitals, and special emphasis is placed upon assessing the impact of certificate of need legislation. It is hoped that this report will contribute to our understanding of the regulatory process and the reactions of those who are involved.

Gerald Rosenthal, Ph.D.

March 1981

During the past decade the rapid and continuing increase in the costs of medical care has emerged as a major health policy issue at all levels of government. Leading the health care cost spiral has been the acute care hospital sector; expenditures for hospital services constitute the largest portion of total health care spending, 40 percent in recent years, account for more than half of the government share, and since the enactment of Medicare and Medicaid in 1965 have risen almost twice as fast as outlays for other categories of medical care.[1] Most efforts to curb the increase in health care costs have therefore been focused on acute care hospitals.

Analyses by several different investigators have now established that approximately half of the total increase in hospital costs since 1960 has been attributable simply to inflation – that is, to the increase in the wages and prices in the hospital sector that would have been required simply to produce the same level of service over time. The remainder of the increase, however, stems from the inexorable growth in the sophistication of labor and non-labor inputs required to produce the ever more complex services that now comprise a hospital admission or "patient day".[2,3] Capital expansion – the construction of new facilities, the addition of new beds and services, and the investment in new "equipment-embodied technology" – has long been recognized as one of the major vehicles through which the intensity of hospital care is increased. As a result, the creation of mechanisms to limit capital investment by hospitals, and particularly the enactment of Certificate of Need (CON) regulation, have received early and continuing prominence in state and federal government strategies to contain rising health care costs.[4]

Despite the importance of hospital capital expansion and of Certificate of Need, neither the factors influencing hospital capital investment nor the impacts of CON upon them have been examined in detail. Not even the actual composition and patterns of hospital capital expenditures over time have been de-

termined because the sources of readily available data are too aggregated to reveal any but the most obvious changes in total beds and total investment. Yet an understanding of the nature and determinants of hospital capital expansion is essential to the evaluation of the impacts of current regulatory mechanisms and to the design of more effective strategies to shape future investment.

This study was conducted to fill some of the gaps in current knowledge about hospital investment behavior and its response to regulation. Previous investigations either examined hospital capital expansion or attempted to evaluate the process and outcome of Certificate of Need. By contrast, this study employed a design that combined an in-depth analysis of the amount and composition of capital investment across the whole voluntary hospital industry in one state, both before and after the introduction of CON regulation, with an examination of the implementation of the CON program itself and of the changes in the nature of hospital investment resulting from the presence of CON. Study findings, therefore, offer insights into the dynamics of hospital capital expansion and the impacts of CON that previous work could not provide.

The study focused on short-term general non-government nonprofit (i.e. voluntary) hospitals in Massachusetts over the period Fiscal Years 1967-76, five years prior to the enactment of CON regulation in the Commonwealth on November 15, 1971, and five years following CON implementation, and addressed the following major sets of questions:

- Is there a basic pattern of investment followed by all hospitals or by certain categories of hospitals, such as teaching versus nonteaching institutions? In particular, how frequently does investment in beds occur and is there a relationship between investment in beds and investment in ancillary services?

- What are the incentives, opportunities, and constraints that have governed a hospital's choice of investment projects? Have these determinants varied by type of hospital and/or time period?

- How much of hospital capital expenditure falls under the aegis of CON review and what, therefore, is the potential of this mechanism to limit future capital expenditure?

- What is the lag between the introduction of CON regulation and the time that capital expenditures reviewed by CON first appear in a hospital's asset base? When, therefore, can CON impacts be appropriately examined using "ultimate" outcome

measures focused on the amount and composition of hospital investment? What measures of more "intermediate" outcomes can be used to evaluate CON performance in the interim?

- How have the Certificate of Need program, the prospective reimbursement programs of the Rate Setting Commission, and the broader planning efforts under P.L. 93-641 affected hospital investment behavior in Massachusetts? What changes in current regulatory policies and procedures might establish more binding constraints on hospital capital expansion?

TABLE 1: Sample composition and its determination using optimal allocation

Stratum	Stratum size (N_h)	Stratum standard deviation [1] (in Thousands) (s_h)	Sample size (n_h)
Major teaching	10		5
Boston	7	$7,100	3
Non Boston	3	6,200	2
Lesser teaching	7		4
Boston	5	8,900	3
Non Boston	2	6,700	1
Limited teaching	5		2
Non Boston	5	6,800	2
Nonteaching	73		15
Boston	18		4
≤ 100 Beds	6	130	2
> 100 Beds	12	1,240	2
Non Boston	55		11
≤ 100 Beds	14	1,600	2
101-200 Beds	18	1,900	2
> 200 Beds	23	5,900	7
Total	95		26

[1] Standard deviation of Certificate-of-Need approved capital expenditures 1972-76 as estimated from Massachusetts Determination of Need Program Information System

Optimal Allocation Formula (with equal cost of sampling for each stratum):

$$n_h = \frac{n N_h s_h}{\sum_{l=1}^{L} N_h s_h}$$

n = total sample size
n_h = sample size in the hth stratum
N_h = population in the hth stratum
s_h = standard deviation in the hth stratum

From public information available in the files of the Commonwealth of Massachusetts Rate Setting Commission, data were collected on the annual capital expenditures over the period FY 1967-76 made by each sample hospital in total and in the following categories: land, "plant" (including building, building improvements, and fixed equipment), and major movable equipment (MME). Data on asset values at historical cost and accumulated depreciation were also collected for Fiscal Years 1966, 1971 and 1976.

For all "projects" that involved total expenditures of $100 thousand or more (current dollars), the introduction of a major new ancillary service, or the addition of 4 or more beds, information was then obtained on the specific changes in hospital facilities and services that resulted from these investments: number and types of beds added or renovated, number of square feet added or renovated, ancillary service changes, etc. Data from the Rate Setting Commission, the Massachusetts Department of Public Health, the Massachusetts Determination of Need Program (as Certificate of Need is officially known in Massachusetts), and the sample hospital itself were combined to provide the necessary

Methodology

This study was designed to combine a statistically valid quantitative examination of capital investment among Massachusetts voluntary hospitals with a more qualitative case-study investigation of the factors that shaped the amount and composition of this investment. The design was developed because the combination of quantitative and qualitative analyses could yield complementary insights into hospital capital investment and the impact of Certificate of Need upon it that neither approach alone could provide. The quantitative analyses could offer a basic profile on the amount and composition of capital expenditure over time and on variations in the pattern of investment among hospitals of different teaching status and geographic location. Against this background, case-study analysis of selected institutions and specific investment projects could then offer information on the motivations underlying a hospital's capital program, the decision-making process surrounding capital expansion, and the consequences resulting from it. The conduct of case studies could also provide an opportunity to explore perceptions of CON and its effects held by individuals involved with hospitals in a variety of different capacities.

Development of the capital expenditure profile

The 95 short-term general voluntary hospitals in Massachusetts were stratified by Boston versus non-Boston location (with "Boston" defined by the boundaries of Health Services Area 4) and by teaching status: major teaching, lesser teaching, limited teaching, and nonteaching. Nonteaching hospitals were further stratified by bed size into those with 100 or fewer beds, 101 to 200 beds, and more than 200 beds. All teaching hospitals had at least 200 beds and therefore did not have to be further classified according to total bed complement. A random sample of 26 hospitals was then selected, using the technique of optimal allocation to determine the number of institutions to be drawn from each cell (Table 1).

detail. For projects approved by the Determination of Need Program, information was also obtained on changes in design, scope, and estimated cost that resulted from the process of CON review.

Data on the amount of capital expenditures, in total and for "plant" and MME considered separately, were used to examine general differences in capital investment by teaching status, geographic location, and time period. Because hospital accounting conventions recognize a capital expenditure only at the time the asset is first put into service, a hospital's capital expenditure profile is quite "lumpy" if examined on an annual basis. Therefore, total and average annual expenditures over the "pre-CON" period of 1967-71 versus the "post-CON" period 1972-76 were analyzed instead. In order to eliminate the effects of the considerable inflation in capital costs that occurred during the study period, all expenditures were converted to constant 1967 dollars using deflators derived from two indices employed by the Rate Setting Commission (RSC) to determine price-level depreciation: the Marshall and Stevens Class B Eastern Index for plant and an index for major movable equipment developed specifically for Massachusetts hospitals by American Appraisal Company at the request of the RSC.

Within the basic "picture" of hospital capital investment established by the expenditure data, "project" data were then used to determine more specifically the nature and composition of investment. Eight project categories were defined, and particular attention was focused on exploring variations across time and hospital type for "major bed projects" (i.e. new buildings or wings constructed by hospitals that included at least 20 inpatient beds), projects devoted to ancillary services and/or ambulatory care, and projects devoted to research. These project categories proved most important in institutional development strategy over the study period for all types of hospitals examined.

Conduct of case studies

Case studies were designed to elicit information on the course of institutional development among different types of Massachusetts voluntary hospitals by using a specific capital project or group of projects completed by an institution to focus discussion. This approach was chosen to assure that the same set of decisions and outcomes would be discussed with different "actors" in a hospital and to allow interviews to probe concrete details surrounding an actual capital investment as well as more general issues of

institutional development. All but 3 of the 26 sample institutions had either completed major capital projects during the study period or had submitted applications for such projects for CON review during this time and, therefore, were considered candidates for case-study. Ultimately, 9 institutions were selected representing the range of teaching status both in Boston and the rest of Massachusetts. In each case-study hospital, extensive interviews were conducted with the director or associate director, the chief financial officer or one of his principal assistants, a senior member of the board of trustees, the current or past president of the medical staff, and either the Chief of Radiology or Chief of Pathology. Selected other members of a hospital's administration, board, and medical staff who had played particularly important roles in the institution's development and who were identified during the course of discussion with the hospital director were interviewed as well. In order to gain some insight into the development of the three sample institutions that had made only limited capital investments during the study period, the director or associate director of two of these hospitals was interviewed as well.

Extensive interviews were also conducted with various members of the staff of the Massachusetts Department of Public Health to obtain information on the structure, function, and evolution over time of the Determination of Need Program and with staff of the Rate Setting Commission to clarify details of the prospective reimbursement system the Commission is developing for Massachusetts hospitals.

Findings

Both the capital expenditure analyses and case study findings revealed that Massachusetts voluntary hospitals experienced dramatic changes in the scale and scope of their operations during the period under study. Further, an appreciation of these changes and the forces underlying them proved essential to correctly interpreting the effects of Certificate of Need regulation upon hospital expansion. Therefore, the basic patterns of investment that have been characteristic of different types of Massachusetts hospitals are first summarized before the presentation of findings on the potential and actual impacts of CON.

Capital investment among Massachusetts voluntary hospitals

The period 1967-76 was one of enormous capital expansion among voluntary hospitals in Massachusetts. Net total capital asset values per bed of total complement at least doubled for all categories of institutions. Yet, average total bed complements increased by no more than 20 percent among any type of hospital (except nonteaching institutions with less than 100 beds) and actually declined slightly among nonBoston major teaching hospitals and among limited teaching hospitals. Major teaching hospitals in Boston led all other types of institutions in total capital investment, spending on average $23 million per hospital (constant 1967 dollars), $60 thousand per bed of total complement. Lesser teaching hospitals, both in Boston and elsewhere in the Commonwealth, showed the greatest change in asset values over the study period, increasing their net total capital assets almost 400 percent through average capital expenditures per hospital of $14 million (constant 1967 dollars), $44 thousand per bed. Nonteaching hospitals, on average, spent $4 million per institution, $25 thousand per bed.

Despite this universal expansionary behavior, the pattern of capital expenditures during the "pre-Certificate of Need" period 1967-71 versus the "post-CON" period 1972-76 proved distinctly

different as a function of hospital teaching status and bed size (Table 2). Among major, lesser, and limited teaching hospitals and hospitals with greater than 200 beds in general, total capital expenditures during 1972-76 in constant 1967 dollars were, on average, almost twice those during 1967-71; among nonteaching institutions, particularly those with fewer than 200 beds located outside of Boston, these patterns were reversed and expenditures "pre-CON" exceeded those "post-CON" by at least two-fold. When expenditures for physical plant versus major movable equipment were examined separately, those for plant exhibited the same patterns across time found for total expenditures. By contrast, expenditures for major movable equipment, the category most readily identified with hospital investment in "technology", were essentially constant across time, except among lesser teaching hospitals which showed a two-fold increase during 1972-76.

These patterns in total and plant expenditures, apparently associated with the presence of CON regulation, proved instead to be a function primarily of the completion dates of "major bed projects" and the synchrony in the construction of such facilities among similar hospitals (Table 3). Thus, the higher expenditures in 1972-76 among various categories of teaching hospitals largely resulted from the fact that these hospitals completed their major bed projects in 1972 or later. The higher expenditures in the "pre-CON" era among nonteaching hospitals arose because most of these institutions completed their major bed projects during 1967-71.

Differences in the completion dates of major bed projects reflected during the study period were found to have been present throughout the years since the conclusion of World War II. On average, Massachusetts voluntary hospitals constructed new inpatient facilities once every 14 years during this time. In general, construction peaked at different times for different types of institutions, largely as a function of particular environmental influences such as the ready availability of Hill-Burton funding to community hospitals during the early 1950's and the impact on teaching hospitals of the Medicare regulations requiring the replacement of ward care with semi-private accommodations.

Among virtually all types of Massachusetts hospitals, almost half of total capital expenditures during the entire study period was devoted to major bed projects, and case studies revealed that the 25 such projects completed by sample institutions played the pivotal roles in hospital development strategy and response to

TABLE 2: Average capital expenditures per hospital 1967-71 and 1972-76 by teaching status and geographic location—5-year sums, constant 1967 dollars in thousands

	Total		Total/Bed		Plant		Plant/Bed		MME		MME/Bed	
	1967-71	1972-76	1967-71	1972-76	1967-71	1972-76	1967-71	1972-76	1967-71	1972-76	1967-71	1972-76
Major teaching	$6,624	$11,833	$18.2	$28.8	$3,898	$8,006	$10.6	$19.2	$2,558	$3,231	$7.0	$8.1
Boston	8,425	14,766	24.1	37.3	5,048	9,856	14.4	24.7	3,203	4,140	9.2	10.6
Non Boston	2,420	4,987	4.6	9.0	1,215	3,687	2.3	6.3	1,053	1,110	2.0	2.3
Lesser teaching	4,831	9,448	14.7	28.9	3,553	6,788	10.7	20.8	987	1,721	3.0	5.2
Boston	4,024	9,834	13.4	30.9	2,756	6,770	9.2	21.4	885	1,789	2.9	5.5
Non Boston	6,847	8,484	18.2	23.9	5,546	6,835	14.7	19.3	1,209	1,552	3.3	4.3
Limited teaching	2,758	3,383	9.2	10.8	1,991	1,799	6.7	5.7	730	960	2.4	3.1
Nonteaching	2,513	1,688	15.8	9.4	2,068	1,078	13.0	5.8	416	455	2.6	2.5
Boston	2,236	1,314	13.8	10.4	1,758	824	11.1	7.6	437	442	2.5	2.5
≤ 100 Beds	747	1,493	11.6	19.0	662	1,334	10.2	16.9	86	143	1.4	1.9
> 100 Beds	2,980	1,224	14.9	6.1	2,306	568	11.5	3.0	612	593	3.1	2.9
Non Boston	2,604	1,810	16.5	9.1	2,170	1,161	13.6	5.2	410	460	2.7	2.5
≤ 100 Beds	1,229	357	15.5	3.9	1,029	62	12.6	0.7	200	144	2.9	1.7
101-200 Beds	3,980	1,551	26.1	9.8	3,522	814	22.7	4.5	419	516	3.0	3.2
> 200 Beds	2,364	2,897	9.5	11.8	1,807	2,099	7.1	8.6	530	609	2.3	2.5
All hospitals	$3,129	$3,273	$15.6	$13.0	$2,366	$2,266	$12.2	$ 8.3	$ 700	$ 867	$3.1	$3.3
Statistically Significant Differences [1]	p < .01	TEACH	None		None		None		TEACH TEACH × LOCATION		TEACH TEACH × LOCATION	
	p < .05	None	TIME × LOCATION × BED SIZE		TEACH		TIME × LOCATION × BED SIZE		LOCATION BED SIZE		LOCATION	

[1] Four Way Analysis of Variance by Time Period (TIME), Teaching Status (TEACH), Geographic Location (LOCATION), and BED SIZE.

TABLE 3: Total capital expenditures (in constant 1967 dollars) "Pre-CON" 1967–71 versus "Post-CON" 1972–76 among sample hospitals and fraction of total attributable to major bed projects

Hospital category	Total capital expenditures (in millions) "Pre-CON" 1967–71	"Post-CON" 1972–76	Fraction of total attributable to major bed projects 1967–71	1972–76
Major teaching	$18.1	$32.4	0	.50
Lesser teaching	9.3	18.1	.57	.49
Limited teaching	3.8	4.6	0	.29
Nonteaching	50.2	33.7	.76	.38
All hospitals	$81.4	$88.8	.54	.44

changing market conditions. For all categories of voluntary hospitals, both before and after the introduction of CON, these projects provided the opportunity to greatly expand ancillary service "capacity" necessitated by rapid technological change and growing numbers of physicians entering practice with specialty and subspecialty training. Among nonteaching hospitals, in particular, the increase in the sophistication of the institution's product that resulted from the ancillary service expansion accompanying major bed project completion in the late 1960's represented a significant change in the hospital's capability to diagnose and manage complicated medical problems. Such projects provided the opportunity to introduce intensive care units, to inaugurate high-technology ancillary services, such as radiation therapy, and to greatly expand the scope of basic ancillary services such as radiology and laboratory. As a result, the necessity for community hospitals to transfer difficult cases to teaching centers was considerably diminished and a marked change in the structure of the hospital services market occurred.

With the decrease in referrals from community hospitals, teaching centers had to turn increasingly to their surrounding neighborhoods as a source of patients and redefined their mission to include provision of the full range of medical services as well as tertiary care. The major bed projects completed by major and lesser teaching hospitals were, therefore, largely motivated by the necessity to create the commanding institutional presence and to expand the primary care services considered essential to competing successfully for patients. The implementation of Medicare and Medicaid contributed greatly to the success of these efforts by providing third-party coverage to potential patient populations that previously had lacked the financial means to seek care in the private sector. While teaching hospitals also used such projects to marginally increase total bed complement, only non-

teaching hospitals in areas of rapid population growth significantly increased their bed size during the study period. The 25 major bed projects completed by sample hospitals resulted in the construction of more than 2200 new beds, but almost two-thirds of these beds replaced existing old ones. Hence, total bed complement increased by less than 800 beds.

Because most hospitals experienced only minimal increases in their total bed complements but greatly expanded the size and value of their physical plant, their resource "intensity" per bed increased considerably. The increased intensity, however, was found both prior to and following the introduction of Certificate of Need and simply reflected that fact that by the late 1960's and beyond, the provision of "state of the art" ancillary services and ambulatory care had become as necessary a part of a hospital's basic "capacity" as the hospital bed itself. A hospital lacking such services could not fill its beds because it could attract neither the necessary medical staff nor the requisite patient population.

During the study period, all types of voluntary hospitals constructed new inpatient facilities. Major and lesser teaching hospitals in addition significantly expanded their facilities devoted exclusively to ancillary services and research as these institutions enlarged their teaching and research commitments in response to greatly increased medical school enrollments and federal support for medical education and research.

While much of hospital capital investment during the study period was motivated by the desire of hospital decisionmakers to be responsive to the increased technological sophistication of current and potential staff physicians, decisions on the timing and scope of major investments were still primarily the province of hospital administrators and trustees. Except in teaching hospitals where major chiefs of service, such as the Chief of Medicine, played particularly influential roles in shaping institutional development, staff physicians were not the primary influences determining the amount or composition of a hospital's capital investment.

During the late 1960's and early 1970's, because third-party reimbursement assumed most of both the capital and operating costs associated with such investment, hospitals were largely unconstrained in their ability to expand. Some limited constraint on the overall scale and cost of major construction, however, was imposed for most hospitals by concerns over maintaining per-diem rates roughly comparable to those of other institutions in their market. Hospitals, therefore, had to exercise some caution

in the amount of debt they assumed. By the mid-1970's, the presence of the Determination of Need Program and charge control policies of the Rate Setting Commission, coupled with more restrictive reimbursement policies introduced by Medicare, began to introduce some further constraints, though not before most hospitals in Massachusetts had at least inaugurated if not completed capital expansion on a truly massive scale.

The extent of Certificate of Need coverage

During the period 1967 - 76, on average three-fourths or more of a hospital's total capital expenditures either were or would have been subject to CON review (Table 4). Of the expenditures devoted specifically to an institution's inpatient facilities, 80 percent or more would have or did require CON approval; by contrast, only 37 percent of hospital expenditures for major movable equipment either did or would have come under the aegis of CON.

Basically, all construction of new facilities and all projects involving the introduction or modernization of high-technology

TABLE 4: Average fraction of capital expenditures per hospital that either was or would have been subject to Certificate-of-Need review 1967–1976

	Total	*Plant*	*Major movable equipment*
Major teaching	.60	.73	.28
Boston	.66	.81	.28
	(.21)	(.10)	(.24)
Non Boston	.48	.54	.27
	(.39)	(.45)	(.06)
Lesser teaching	.83	.91	.46
Boston	.81	.88	.35
	(.04)	(.08)	(.31)
Non Boston	.89	.98	.46
Limited Teaching	.67	.86	.15
	(.14)	(.03)	(.13)
Nonteaching	.76	.85	.40
Boston	.73	.84	.44
≤200 Beds	.80	.85	.55
	(.17)	(.07)	(.24)
>200 Beds	.70	.87	.35
Non Boston	.76	.85	.39
≤200 Beds	.84	.93	.42
	(.06)	(.05)	(.19)
>200 Beds	.66	.74	.34
	(.33)	(.35)	(.22)
All hospitals	.74	.84	.37

( ) = standard deviation

specialized ancillary services fell under the authority of CON. Thus, all of the investments that have served as key elements in a hospital's strategy to make major changes in institutional image and/or product are subject to regulatory control, and Certificate of Need, therefore, has at least the theoretical potential to have a considerable influence on the direction of a hospital's future development. The minor renovations to existing facilities and purchase of major movable equipment associated with hospital investment in basic ancillary services, however, for the most part fall outside of the boundaries of CON authority, and whenever possible, at least in recent years, many hospitals have "packaged" even those few investments that should have been submitted for review in ways that avoided the CON ceiling. Thus, CON regulation has not been an effective mechanism for controlling this component of hospital capital investment and other approaches have more potential for limiting the amount of routine "technological investment".

The accomplishments and limitations of Certificate of Need regulation in Massachusetts

Previous investigators have commonly used "ultimate" outcome measures, such as the change in total hospital capital investment or investment per bed, to evaluate the effects of CON.[5,6,7] The patterns of hospital investment revealed by this study suggest, however, that such measures are not appropriate at least for several years following the introduction of regulation. The majority of hospital capital expenditures are attributable to infrequent large-scale "major bed projects" that have been built in different periods by hospitals of similar size and teaching status. At least in Massachusetts, the introduction of Certificate of Need regulation coincided with the conclusion of the peak of construction among small nonteaching hospitals and the beginning of the construction peak among teaching hospitals and large hospitals in general. Hence, differences in total capital expenditures across time display a spurious association with the introduction of CON that, in fact, was not related to the presence of regulation. Further, because all projects actually under construction when CON regulation began were exempt from review and because the construction of a major new facility takes several years, less than one-[illegible] of the expenditures actually made by sample hospitals during the "post-CON" period had in fact been reviewed by the program (Table 5). During the first two years "post-CON", virtually

TABLE 5: Average fraction of total capital expenditures per hospital falling under aegis of CON in 1972-76, 1972-73 and 1974-76 compared with average fraction actually approved by CON during each period

	*Fraction of expenditures falling under aegis of CON 1972-76**	*Fraction actually CON-approved 1972-76*	*Fraction of expenditures falling under aegis of CON 1972-73*	*Fraction actually CON-approved 1972-73*	*Fraction of expenditures falling under aegis of CON 1974-7**	*Fraction actually CON-approved 1974-76*
Major teaching.....	.66	.27	.70	.01	.56	.44
Boston	.71	.28	.75	.01	.57	.37
	(.21)	(.45)	(.24)	(.02)	(.27)	(.44)
Non Boston	.56	.25	.57	0	.54	.54
	(.46)	(.15)	(.46)		(.44)	(.44)
Lesser teaching.....	.81	.40	.78	.11	.57	.53
Boston	.78	.26	.77	.14	.41	.41
	(.14)	(.61)	(.30)	(.25)	(.32)	(.32)
Non Boston	.87	.74	.80	0	.89	.89
Limited teaching....	.52	.42	.02	.02	.61	.50
	(.38)	(.24)	(.02)	(.02)	(.38)	(.23)
Nonteaching	.53	.29	.32	.01	.43	.31
Boston	.52	.27	.39	0	.50	.24
≤200 Beds...	.72	.22	.58	0	.61	.24
	(.15)	(.37)	(.52)	0	(.13)	(.40)
> 200 Beds...	.15	.15	0	0	.23	.23
Non Boston . ..	.53	.30	.30	.01	.41	.34
≤200 Beds...	.51	.34	.22	0	.47	.38
	(.35)	(.40)	(.44)		(.37)	(.07)
>200 Beds ...	.53	.24	.40	.01	.33	.31
	(.40)	(.38)	(.50)	(.03)	(.43)	(.44)
All Hospitals	.57	.31	.38	.02	.46	.38

*Fraction of Expenditures that according to CON Regulations would be subject to review, including both expenditures that actually were reviewed and those that would have been if they had not been initiated prior to enactment of the CON statute in November, 1971.
( ) = Standard deviation

none of the capital expenditures made by hospitals had been subjected to review. By 1974 and beyond, almost all expenditures that fell under the aegis of CON had in fact been reviewed and approved by the program. Nonetheless, during the 1974 - 76 period, the great majority of the expenditures that had been reviewed were attributable to projects approved during the first year of CON operation when the program lacked the rigorous review procedures and standards that characterized the function of the "mature" Certificate of Need process in 1976 and beyond (Table 6).

For these reasons, an ultimate outcome assessment was concluded to be inappropriate during the 1972 - 76 interval for which relevant data were available. Instead, this study evaluated CON effects using two measures of "intermediate" outcome: first, changes in project scope and design that resulted from the process of review, differentiating those achieved during the Program's "early" phase 1972 - 74 versus its "mature" period post-

TABLE 6: Amount and fraction of CON-approved expenditures in millions (current dollars) made during 1974-76 attributable to projects approved during 1972, by hospital teaching status

	Total expenditures 1974-76 that had been CON-approved	Amount of 1974-76 CON-approved total approved in 1972	Fraction of 1974-76 total approved in 1972
Major teaching	$31.3	$26.7	.85
Lesser teaching	17.5	13.4	.77
Limited teaching	6.5	2.2	.33
Nonteaching	23.5	16.8	.72
All hospitals	$76.8	$59.0	.75

1975, and second, changes in internal hospital investment strategy and interhospital relationships attributable to the presence of Certificate of Need.

Over the period 1972 to 76, only 9 percent of projects submitted to CON review by sample hospitals were denied certificates of need, and even many of these projects were eventually approved in modified form. However, as other investigators have also noted, a program's denial rate merely reflects the degree to which the review process permits negotiation over project details before a final decision is rendered.[8] The CON process in Massachusetts involves considerable interaction between program staff and applicant hospitals in the course of project evaluation. Consequently, despite the low project denial rate, one fourth of all projects ultimately approved by the CON program were either significantly modified as a result of CON review or were approved only with attached conditions that required some change in existing hospital operations. The projects of all types of hospitals, including those of the major teaching institutions in Boston, experienced such modifications.

Throughout its existence, the CON program devoted its most careful analysis to projects involving acute care beds. During the early years of regulation, CON review concentrated on reducing the increase in a hospital's total bed complement that would result from the construction of a major bed project. The final CON-approved form of a project virtually always either included fewer new beds than an applicant had proposed or required that existing underutilized inpatient services, such as obstetrics or pediatrics, be closed as a condition of approval for the proposed project. During this phase of CON program operation, however, projects were usually approved at the total cost proposed by the applicant hospital, and the final costs of many completed facili-

ties often exceeded even these generous budgets by several million dollars before the Rate Setting Commission in 1975 became aware of the problem and helped to institute more rigorous financial analysis and control in the CON review process.

By late 1975, the scope of CON review had been expanded beyond a consideration of the number of beds proposed to include a critical analysis of every aspect of a project. Over the next three years, the CON Program began to develop the detailed standards and criteria required to evaluate "need" for various ancillary services and ambulatory care components as well as for acute care beds and established a basis for examining many dimensions of a project's scale and cost. During this mature phase of CON analysis, the final approved form of some projects was reduced by as much as two-thirds of that originally proposed, and in several instances the process of CON review and approval was able to eliminate several million dollars in proposed expenditures. Case-study interviews revealed that hospitals had not specifically "padded" proposed projects in order to provide opportunities for cuts by the CON Program, and these reductions therefore represent true savings attributable to the presence of regulation. No group of hospitals has been immune to such careful scrutiny, and even cherished projects of influential teaching hospitals were considerably diminished in scope and cost.

During both its early and mature stages, the Certificate of Need Program in Massachusetts also achieved considerable success in preventing the duplication of high-technology specialized ancillary services. In particular, for several years CON severely restricted the diffusion of CT scanners by approving only one scanner per HSA region outside of Boston until criteria for the appropriate use of CT scanning had been established and the technological development of the necessary equipment sufficiently stabilized to limit the high cost of rapid obsolescence. The CON Program was also able to reduce already existing redundancy in services such as radiation therapy by denying applications for new equipment submitted by hospitals lacking sufficient utilization to justify continuation and modernization of the service. In its mature form, the Massachusetts Determination of Need Program has also markedly changed the whole hospital investment "environment", in the view of all hospital decisionmakers. The construction of new facilities and the introduction or modernization of specialized ancillary services that have played so prominent a role in institutional development strategy are no longer the sole province of the individual hospital. Instead, the details of such projects must now be carefully negotiated with

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other institutions in the hospital's market area and with the Health Systems Agency and the CON staff. As a result, internally hospitals have been forced to evaluate their appropriate roles and mission much more carefully and to develop more systematic and precise plans for capital expansion and replacement. Externally, interactions and interrelationships among hospitals have been greatly increased; hospital councils in many areas of Massachusetts have now become the arenas in which hospitals are attempting to develop the cooperative relationships that will diminish some of the pressures for product competition by allowing one institution to become the center for renal dialysis, another for obstetrics, a third for CT scanning, and so forth. These are negotiations of considerable delicacy because each hospital views its services as highly interdependent. Therefore, only the presence of external constraints imposed by CON, planning in general, and the emerging prospective reimbursement systems of the Rate Setting Commission has forced hospitals to alter the natural tendencies to maintain or acquire specialized services and facilities evidenced by hospital investment during the early years of the study period.

Nonetheless, Certificate of Need has not established a binding constraint on hospital capital expenditure. The CON process achieves only limited control over the acquisition of major movable equipment because the majority of such expenditures fall below CON review limits and hospitals have been successful in "unbundling" even some projects that should have been reviewed to circumvent the CON process. While CON reduced the scale of new construction, it has not prevented the addition of new physical capacity because the program now has no overall basis upon which to evaluate "need" for new replacement construction. Further, while CON has developed standards for acute-care beds that now permit precise calculation of the number of beds a hospital requires, the guidelines for the ancillary services and ambulatory care that now comprise such a major component of hospital capital expansion are much less specific. Finally, even mature CON analysis is based upon standards that define optimal efficient hospital practice on a service-by-service basis. Certificate of Need regulation provides no means of establishing an overall limit to the amount of resources an individual hospital or hospitals in general "should" commit to capital investment. Even the presence of a mature CON program, therefore, does not force an institution to choose among "necessary" projects for which expenditures can be justified on the basis of current or projected demand.

Implications and recommendations

These findings have significant implications for the conduct of future evaluations of regulatory impacts, for the ongoing operation of the Massachusetts Determination of Need Program and the prospective reimbursement system of the Rate Setting Commission, and for the use of "competitive" versus regulatory strategies in the effort to contain rising medical care costs.

Implications for the design of future evaluations of regulation

From the perspective of future evaluations of regulatory impacts, three particularly important lessons emerge from this study. First, regulation is imposed upon already existing patterns of behavior that in a realm such as capital investment with its long lags in planning and implementation are not likely to show an instantaneous response to a changed environment. Unless an effort is first made to understand these underlying patterns, one risks serious misinterpretation of the results generated by evaluation. Second, the implementation of regulation is an extremely complex process. The mobilization of requisite staff and the development of defensible procedures necessary to establish a rigorous and effective program take *years*, not months, even in the presence of strong political commitment to the importance of the effort. Therefore, it is simply unrealistic to expect that the effects of program action will begin to appear immediately after its enactment, especially if measures of ultimate outcome are used to determine these effects. Essential as it is to evaluate the impacts of the numerous government interventions that have been introduced in recent years, it is also important to be realistic in establishing a time frame within which results can be expected. Otherwise, one risks concluding that a program has been ineffective or worse, has been counterproductive when, in fact, it is simply too early to determine what its actual effects have been. Finally, much as measures of ultimate impact are eventually the ones that provide the true test of regulatory accomplishments, it is important to develop and use more intermediate measures of program

performance until final outcomes do begin to appear. Intermediate outcome measures are currently held in lower esteem than measures of ultimate outcome and usually require more detailed and costly data collection. Nonetheless, measures of intermediate outcome, such as those employed in this study, are the only ones that can provide the kind of interim assessment of program strengths and weaknesses necessary to improve regulatory performance.

Proposed modifications in current regulatory procedures

As judged on these intermediate outcome measures, the Determination of Need Program in Massachusetts has clearly been successful in creating an external mechanism that can assure the "necessity" of the investments being pursued by hospitals and limit the wasteful duplication of some facilities and services that previously accompanied each hospital's pursuit of its own individual interests. At present, however, the CON process in Massachusetts (and elsewhere in the country as well) is based on standards of absolute need and does not provide a means for allocating limited resources. Under present procedures, tradeoffs are not required, either among the worthy projects of a single institution or among those of the various hospitals serving a particular population. Hence, Certificate of Need does not now constrain capital investment in total and can therefore make only a limited contribution to the ultimate objective of restraining further increases in the consumption of real resources by the hospital sector.

The principal strategy now being advocated to impose a binding constraint on hospital capital expenditure is the introduction of a total expenditure "cap", either at the national level as Title II of President Carter's 1977 Hospital Cost Containment legislation proposed or in selected states, as New York for example, has considered. The crucial issues of how a fixed expenditure ceiling should be allocated across health services areas and how criteria could be developed to permit the approval of specific hospital capital projects within this "budget", however, have not been addressed in any detail. Given the difficult and time-consuming process that the development of defensible standards even for the review of individual projects proved to be in Massachusetts, it is hard to imagine how the necessary criteria for allocation of a fixed budget could be generated.

The patterns of hospital investment revealed by this study suggest, however, that a less comprehensive and therefore potential-

ly more feasible approach directed at the level of the individual hospital might be taken to more effectively constrain hospital capital expenditure in total. Such an approach would combine the development of a specific capital budget for each hospital to limit routine annual investment in major movable equipment and minor plant renovation with the establishment of more stringent criteria to guide evaluation for less frequent capacity and service expansion projects. The following specific modifications in current Certificate of Need and rate setting procedures are proposed as the first steps toward establishing more stringent limits on the amount of capital expenditure by Massachusetts hospitals:

- An annual budget for major movable equipment should be developed for each hospital on the basis of size, teaching status, and other relevant characteristics and not tied simply to the institution's own current MME asset value. The budget should be established through the Rate Setting Commission's prospective reimbursement system and once full payer participation in this system is secured, hospitals should be permitted to spend their budgets as they wish, submitting only projects involving high-technology ancillary services or new construction for CON review. Such a change would free the CON staff from reviewing projects that rarely have been modified significantly by the CON process, eliminate current incentives for hospitals to try to subvert CON review for these types of expenditures, and provide more time for the analysis of the types of projects that are the major vehicles used by hospitals to achieve significant changes in product and image.

- As part of the development of Health Systems Plans and the State Health Plan, criteria should be formulated to specify the grounds justifying replacement of existing facilities. In addition, more precise guidelines must be developed regarding expansion of facilities for ancillary services and ambulatory care. Such criteria and guidelines are essential to support more rigorous review of proposals for future major construction and hopefully would better enable Certificate of Need to counteract the environmental factors that stimulated and facilitated the enormous expansion in hospital physical plant since the mid-1960's.

- The Rate Setting Commission should reinstate its efforts to replace the current provision of historical cost depreciation with a "capital allowance" for each hospital that would include the costs of principal on current indebtedness and provide funding for future capital replacement and, if necessary, expansion. The de-

velopment of such an allowance was initially intended to be one important component of the prospective reimbursement system being established for Massachusetts hospitals. Recently, the Commission has retrenched from this position, feeling that it lacks sufficient information on capital formation to make a compelling argument for changing current reimbursement policies. The vital role that this and earlier studies have shown such policies to play in contributing to hospital capital expansion suggests that a capital allowance is an important component of an effective prospective reimbursement system and should be developed as initially planned.

The role of "competition" versus regulation in limiting increasing medical costs.

In recent years, numerous voices have been raised against the failings of "command and control" regulation, and more "market-oriented" solutions have been advocated as a better means of overcoming the problems to which regulation has been addressed.[9] In the health care sector, the development of health maintenance organizations (HMO's) is the most prominent of the "competitive" strategies now being promoted.[10] Because the financial viability of an HMO depends upon careful control of the costs of hospital care rendered its enrollees, HMO's are sensitive to the price of hospital services in a way that individuals with comprehensive insurance coverage are not. Hence, if HMO's gain wide acceptance, hospitals may be forced to compete on the basis of price as well as product.

Nonetheless, it must be appreciated that at present HMO's still cover a small fraction of the population, that most physicians still are in fee-for-service private practice, and that the number of physicians is still increasing. It is widely recognized that physician utilization of hospital services is a major contributor to the total level of hospital costs and that the increasing number of physicians therefore has ominous implications for future increases in the cost of hospital care and indeed of medical care in general. The findings of this study have demonstrated, however, that while hospitals have expanded service and facility "capacity" in response to the "needs" of current and potential medical staff, the major decisions involving the timing and scale of expansion reside with hospital administrators and trustees. Therefore, capital expenditure and rate regulation designed to constrain the future options of hospital decisionmakers has the potential to exert considerable influence on physician behavior as well. Hence, the

continuation and indeed strengthening of existing hospital regulation offers an important instrument for limiting the future cost impacts of the growth in the supply of physicians.

Given the nature of the health services "market", therefore, the fostering of "competition" and the further refinement of regulation should be viewed not as alternative strategies but rather as complementary mechanisms to introduce some economic discipline into a sector that has largely operated without it.

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15. Supplementary Notes			

16. Abstracts

This study examines hospital capital investment among Massachusetts short-term general voluntary hospitals between 1967 and 1976, and assesses the impact of Certificate of Need (CON) regulation. A profile of capital expenditures for fiscal years 1967 - 1976 was developed from Massachusetts Rate Setting Commission data for 26 sample hospitals, stratified by teaching status and Boston versus non-Boston location. Case studies were conducted in nine sample hospitals to explore the determinants and consequences of major capital projects undertaken by the institution. Enormous capital expansion took place from 1967-76. Hospitals in areas of rapid population growth significantly increased their bed size; other hospitals replaced or modernized inpatient facilities, and expanded ambulatory care capacity. All hospitals significantly expanded their ancillary service capacity. With respect to the impact of CON regulation, the evidence revealed that by 1976 and beyond, CON review had reduced all dimensions of project scale and cost by as much as two-thirds of that originally proposed.

17. Key Words and Document Analysis. 17a. Descriptors

NCHSR publication of research findings does not necessarily represent approval or official endorsement by the National Center for Health Services Research or the U.S. Department of Health and Human Services.

Marianne Miller, NCHSR Project Officer, 301/436-8943

17b. Identifiers/Open-Ended Terms

Health services research
Regulating hospital capital investment
Impact of certificate of need regulation

17c. COSATI Field Group

18. Availability Statement	19. Security Class (This Report)	21. No. of Pages
Releasable to the public. Available from National Technical Information Service, Springfield, VA 22161 (Tel.: AC 703/487-4650)	UNCLASSIFIED	30
	20. Security Class (This Page) UNCLASSIFIED	22. Price

FORM NTIS-35 (REV. 10-73) ENDORSED BY ANSI AND UNESCO THIS FORM MAY BE REPRODUCED BECOMES OBSOLETE

U S GOVERNMENT PRINTING OFFICE 1981 – 341-787:105

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE
FY84 BRIEFING PAPER

I. GENERAL INTRODUCTION

The Division of Public Assistance (DPA) is responsible for administration of ten programs:

- Aid to Families With Dependent Children (AFDC)
- Old Age Assistance (OAA)
- Aid to the Disabled (APD)
- Aid to the Blind (ABL)
- Food Stamps
- General Relief
- General Relief Medical
- Catastrophic Illness
- Medicaid
- Energy Assistance

Several of these programs are funded wholly or in part with federal funds. These programs include AFDC (50% Federal), Food Stamps (95% Federal), Medicaid (48% Federal) and Energy Assistance (100% Federal). Food Stamp funding is not contained in the State budget. The remaining programs are funded entirely from state general funds. Along with the presence of federal money in these four programs comes a complete set of federal rules and procedures governing conditions of eligibility for benefits as well as rules for overall program operation.

The Division conducts business through a mixture of private vendor contracts and state staffed facilities. Most activities still administered by state staff are prohibited by federal law from transfer to the private sector. At present the Division has state staffed client service offices in (21) locations:

SOUTHEAST	SOUTHCENTRAL	NORTHERN	SOUTHWEST
Juneau	Anchorage	Fairbanks	Nome
Sitka	Valdez	Galena	Unalakleet
Ketchikan	Dillingham	Ft. Yukon	Bethel
Wrangell	Kodiak	Kotzebue	Aniak
Petersburg	Kenai		
	Wasilla		
	Palmer		
	Homer		

The Division also contracts for application-taking assistance in Barrow with the North Slope Borough and in Kotzebue through a similar arrangement with Maniilaq Association. Total Division staff authorized for FY83 is 299 positions.

In addition to these state and contractor operated client service offices, the Division has paid agents in approximately 165 additional communities around the State, bringing the total number of communities having local Division representation to approximately 185 locations.

The Division will serve approximately 25,000 families monthly during FY84. Since a large number of these families will access more than one of the Division's programs, the above numbers do not represent an unduplicated count of families to be served. A conservative estimate would place the unduplicated count of families who will receive aid during FY83 at 20,000 families consisting of approximately 45,000 persons, or roughly 11% of the State's population. One out of ten Alaskans will, by these estimates, seek some type of cash, food, medical, or energy assistance from the Division in FY84.

II. ADVISORY COMMITTEES

The Division also does business with four advisory committees. These include the Medical Care Advisory Committee, the Catastrophic Illness Committee, the Corrective Action Committee, and the Energy Assistance Committee.

1. The Medical Care Advisory Committee: Comprised of persons appointed by the Commissioner who provide policy and program guidance for the administration of the Medicaid and General Relief Medical programs.

2. The Catastrophic Illness Committee: A three member body appointed by the Governor who provide the Commissioner with policy guidance in the operation of the Catastrophic Illness Program, which is a sub-program of General Relief Medical.

3. The Corrective Action Committee: Comprised entirely of Division employees and is chaired by the Division Director. The Corrective Action Committee meets to review error data compiled by the Quality Control Section as well as from other surveillance sources, and develops appropriate corrective action to reduce the occurrence of these errors.

4. The Energy Assistance Committee: Appointed by the Commissioner to evaluate the Division's energy assistance plan.

III. DIVISION BUDGET OVERVIEW

The Division's FY84 total budget request is $164.6 million plus $24.0 million in Food Stamps benefits for a total of $188.7 million ($89.9 million SGF).$15.2 million or 8% finances the administrative activities of the Division. The remaining $173.0 million flows directly to needy Alaskans as cash ($60.9 million), food stamps ($24.0 million), medical care ($81.7 million), or energy assistance ($6.7 million). A comparison of Division administrative and program budgets between FY83 and FY84 is as follows:

Budget Category	FY83	FY84 Request
Human Services N.W.	$ 179.3	$ 179.3
Administration	14173.5	15183.1
Cash Assistance	56384.8	60851.5
Food Stamps	26500.0	24000.0
Medical Assistance	74355.9	81720.0
Energy Assistance	7208.6	6747.5
PFD Hold Harmless	12866.5	-0-
TOTALS	$191668.6	$188681.4

IV. QUALIFYING LEVELS FOR ALASKA'S PUBLIC ASSISTANCE PROGRAMS

The following table displays the FY83 income qualifying limits for the Division's programs compared to the poverty level. AFDC and APA benefits for FY84 will be approximately 6% higher.

Programs	1 Person	2 Persons	3 Persons	4 Persons	Based On Gross Or Net Income
FOODSTAMPS	636	844	1052	1260	Gross
AFDC	-	546	614	682	Net
AGED, BLIND AND DISABLED	546	802			Net
GENERAL RELIEF	300	400	500	600	Gross
ENERGY PROGRAM	851	1113	1375	1637	Gross
OMB POVERTY LEVEL	489	649	809	969	Gross

V. DIVISION PROGRESS REPORT

The Division was faced with serious problems from a number of quarters. These included:

- The AFDC payment error rate was at 30%.
- Decision timeframes for new applicants exceeded the federal standard of 30 days routinely, and in some offices reached 60 days or longer.
- The computer system which supported the client service offices and authorized monthly benefits was developed in 1968 and was near collapse.
- The state run medical payment system was taking up to 6 months to pay medical providers for medical services received by public assistance recipients.
- Recipient failure to report information to the agency was contributing to a mushrooming overpayment problem with inadequate field staff to impose tighter surveillance of recipients' financial circumstances.

The Division set out in 1979 to remedy these problems. The goals were:

- to reduce the level of overpayments to recipients and concurrently the high error rates,
- to place the agency on a solid legal footing through introduction of regulations and statute revisions,
- to upgrade the data processing capabilities supporting client service offices,
- to reimburse the medical community in a more timely and cost efficient manner by transferring the medical payment system to the private sector, and
- to accomplish this with as little harm to truly needy Alaskans as possible.

The Division accomplished these goals as evidenced by the following milestones:

- The Division successfully transferred the processing of medical claims to the private sector. Complete transfer was completed in August 1982. The present five year contract provides for processing of medical claims through 1987. The contract calls for a 20 day processing standard at one third the cost of the previous Department operated system.

- The Division is nearing implementation of its new data processing support for client service offices. This new eligibility system will integrate all ten of the Division's programs into a single data base. The system will permit on-line eligibility determination and benefit issuance from the central computer from any Division office by late 1983 and further improve client service.

- State regulations and policy manuals for each program have been adopted.

- Decision timeframes on new applications of 30 days or less have been maintained in all programs.

- AFDC, Medicaid and Foodstamp error rates are much improved.

- Major program reforms were implemented in AFDC and Food Stamps during 1982. Monthly reporting of financial circumstances, introduction of prior month budgeting, and requiring home visits have reduced error rates and caseloads.

VI. DIVISION CONCERNS FOR 1983

1. Error Rates

Improved quality in AFDC, Medicaid and Foodstamp eligibility determinations remains a top priority of the Division. To date federal expectations in each of these programs have been met or corrective action plans (CAP) been negotiated to achieve reductions. The Division entered a new penalty period in October 1982 that brings with it the following payment error rate expectations for the next 12 months:

Program	Current Error Rate	Required Error Rate
AFDC	11%	4%
Food Stamps	23%	21%
Medicaid	1%	5%

An important factor in the error rate calculation is that all client caused errors, such as failure to report information, are counted against the State when assessing its error rate.

2. AMPS Performance Improvement

The new Alaska Medical Payments System (AMPS) must continue to be improved to foster a better relationship between the medical community and low income Alaskans needing medical care.

3. Eligibility Information System (EIS)

The detailed design of this new automated eligibility system has been completed. This new system will reduce much of the risk of agency caused error in the eligibility determination process, and greatly improve service timeframes to Alaskans around the State.

4. Food Stamp Mail Issuance Losses

A new federal rule has been established setting a mail loss limit of .5%.

Pay $1.52 per mailout. FBks has lots of mail loss

Under federal rules Alaska has the option of sending households an Authorization To Purchase (ATP) card which can be exchanged for food stamps at a client-service office or U.S. Post Office, or the State can mail households their food stamps directly.

The Division currently mails food stamps directly to all recipients monthly except those residing in Anchorage. Anchorage residents are issued an ATP which is exchanged for food stamps at the Post Office. Alaska has periodically experienced a high loss level with the direct mailing of food stamps. Fairbanks residents were removed from direct mail for a period of time for this reason but are now back on direct mail. Because of the rural nature of many addresses, mail losses have at times exceeded 1%. This loss rate must be watched routinely to avoid State repayment of any loss amounts that exceed .5%. Backup delivery methods have been designed in the event that direct mail creates losses above the .5% level. These backup measures should be deployed if needed.

5. Food Stamp Rural Allotment

Alaska must push for implementation of a rural Food Stamp allotment. Since 1973 the State has been lobbying the U.S. Department of Agriculture (USDA) and the U.S. Congress for a higher food stamp allotment for rural Alaska. The State has demonstrated repeatedly that rural food costs exceed urban costs by 40% or better. Congress gave USDA the authority to create the 2nd standard in Alaska in 1981. USDA has failed to implement this law thus far even though the State defined the geographic areas to be affected.

6. HB174 Implementation

During the 1982 Session the Legislature passed HB174 which provided for an increase of approximately $50 monthly to most AFDC families but no funds were appropriated. This increase was to be in addition to the 7.4% annual cost-of-living increase also given AFDC families on July 1. The purpose of HB174 was to close the gap between the payment levels for two adults receiving APA and two individuals on AFDC. In view of this, Governor Hammond advised the legislative leadership that HB174 would be implemented within available funds. The Division has concluded that funds are available to implement HB174 safely effective January 1, 1983. The Division has published regulations proposing to do this. In excess of $2 million has been included in the FY84 AFDC request in anticipation of this increase in AFDC grant levels. A final decision is pending whether to effect this increase in FY83, or to wait until FY84, or to forego the increase altogether if funds for FY84 are determined not available in view of the constitutional spending limit.

7. Medical Budget Projections

The Department has perpetually had problems predicting spending levels in this category. While projection models for administrative and cash assistance budgets generally were reliable, prediction of medical costs were not. Most states have a problem similar to Alaska's. Several changes will improve the Division's ability to predict the medical costs for a fiscal year and to remain solvent in times of trouble:

(A) Shift Medicaid and GR Medical expenditure accrual from "month of service" to "month of billing". Under the present system a fiscal year is nearly over before the Division can safely predict its outcome.

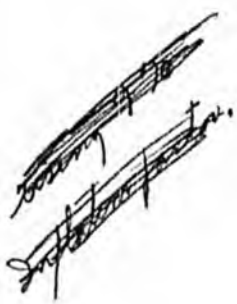
(B) Consider adoption of uniform cost reporting and prospective reimbursement for hospitals and nursing homes. Hospital and nursing home expenditures comprise 54% of the medical budget.

(C) Consider new Medicaid regulation requiring all non-emergency hospital admissions be reported to the Department in advance. In its simplest form this requirement would generate needed information to permit total program liabilities to be more closely watched.

8. Strategy to Contain Escalating Medical Costs

In any period, total spending is always a function of the number of recipients, the volume of services used, and the unit price of service. With an automatic cost-of-living increase that expands Alaska's eligible population, coupled with no unit price control or volume limits, Alaska currently has no ability to effectively control growth in medical costs.

According to a recent study by THE URBAN INSTITUTE, Medicaid payments rose at an annual rate of 15.5 percent from FY73 to FY79 nationally. Alaska had the highest annual rate of increase at 41.8 percent during this same period. Since, FY79 costs have increased in excess of 20% annually in Alaska.



This situation will be further complicated in FY84 and later years in light of Congress' actions to reduce Medicaid funding to all States (TEFRA changes). Alaska is facing a 4 to 5 million dollar shortfall in FY84 because of these federal changes. Absent additional funding to replace these lost federal/State revenues, critical decisions need to be made to bring program spending in line with available federal/State resources.

This decision process must arrive at an equitable balance between persons eligible, covered services and unit price for services received, particularly hospitals and nursing homes. All of these choices are largely controlled by the Alaska Legislature. This decision process will also cause the State to more precisely define its health care policy for all areas of Alaska, particularly in rural areas where the delivery of health care cannot be accomplished as competitively in large urban areas with more than one hospital.

9. General Relief Program Review

This state funded program is not meeting the emergency subsistence needs of employable Alaskans. Strict income requirements and a demonstrated need (such as an eviction notice) must be met. If eligible, a maximum monthly payment of $80 per person is allowed by state statute. The Division makes these payments to landlords and utility companies to ensure only critical subsistence needs are met. Participation in this program has declined, even though the BIA General Assistance program was terminated. An analysis of this program is critically needed to determine if changes in qualifying conditions and benefit levels are appropriate. No changes have been made in the qualifying limits since 1978, and the $80 payment limit since 1957.

10. Catastrophic Illness Program

This program was funded at $2.1 million for FY83 but has requests totalling $8-10 million. Any individual with unpaid medical bills of $1000 may apply. The Catastrophic Illness Committee determines the eligibility formula and may adjust it as frequently as necessary to stay within available funding. Under the current formula, the FY83 program is already out of funds. A complete review of this program is also in order.

11. Work Programs

Considerable debate continues as to the type of work programs that should be imposed on Alaska public assistance recipients, if any. Options range from merely registering for employment to requiring every able-bodied recipient to perform some type of public service employment. Because of Alaska's conservative set of public assistance programs, and the lack of two parent, unemployed households on assistance in this State, the Division has recommended that a mandatory public service program not be adopted in Alaska. Rather, the Division has recommended an emphasis towards job search and job training with built-in program disincentives for recipients who refuse to cooperate. The following elements are essential to a meaningful program in Alaska within an acceptable administrative cost:

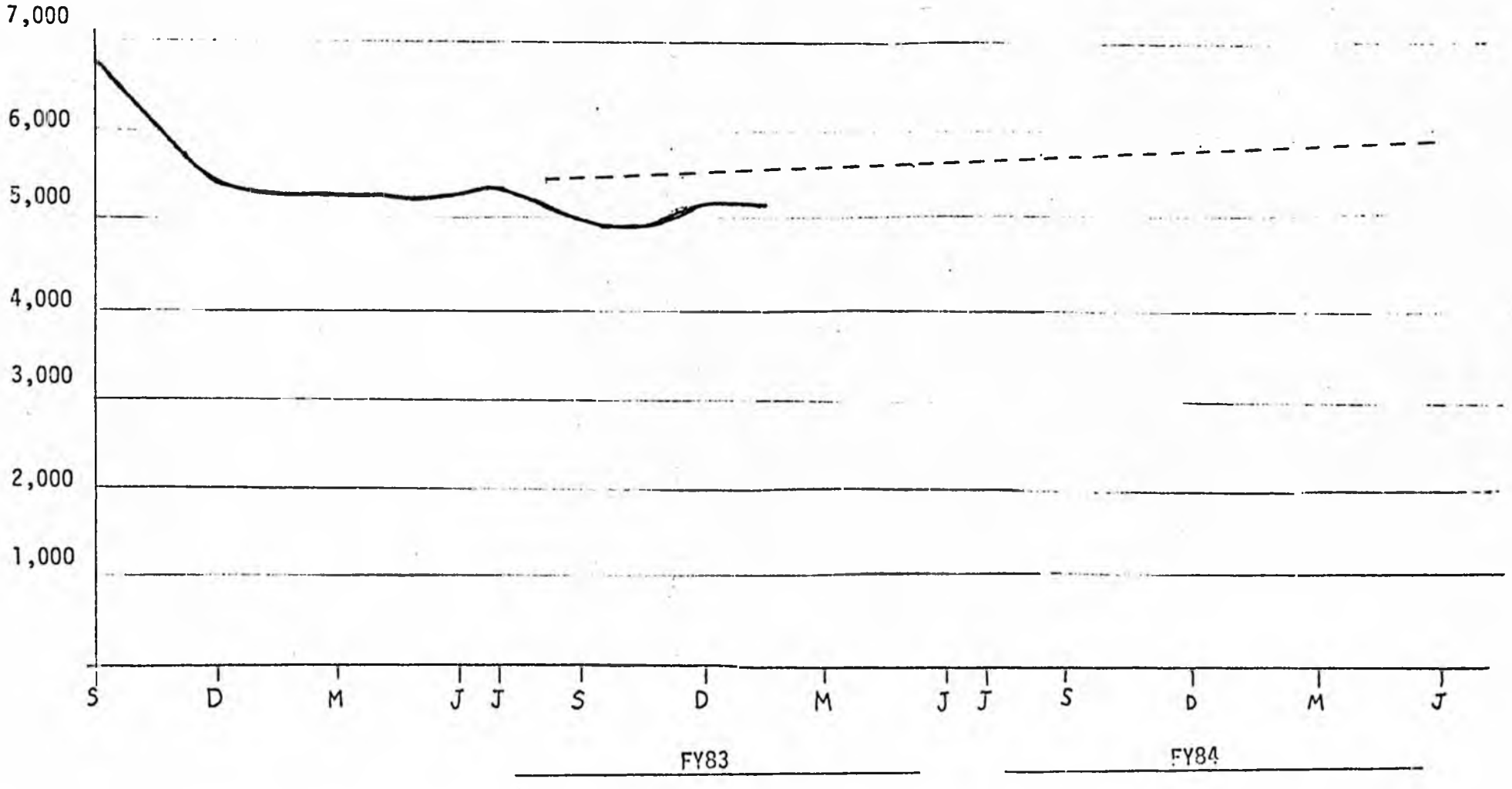
(a) Focus on high availability jobs
(b) Constructive not punitive in nature (Rules out CWEP)
(c) Establish client motivation through AFDC program disincentives for those who do not cooperate
(d) Prepare client to compete with non-welfare job applicants
    - Resume preparation
    - Effective job search skills
    - Develop a marketable skill through training or education
        ** typing
        ** key punching
        ** general clerical
        ** day care
    - Effective job interview skills
    - Agency follow-up on unsuccessful interviews to determine why
    - Client preparation to leave AFDC/Medicaid once employed
(e) Coordination with State and private job placement agencies
(f) Contracts for OJT leading to permanent position with private agencies

(g) Minimal surveillance burdens on agency - low state staff needs
(h) Coordination with day care agencies/homes for school age kids
(i) Recipient workshops - allow successful recipients to enlighten and encourage others
(j) Fair good cause system for clients who do not cooperate
(k) Pilot project experience

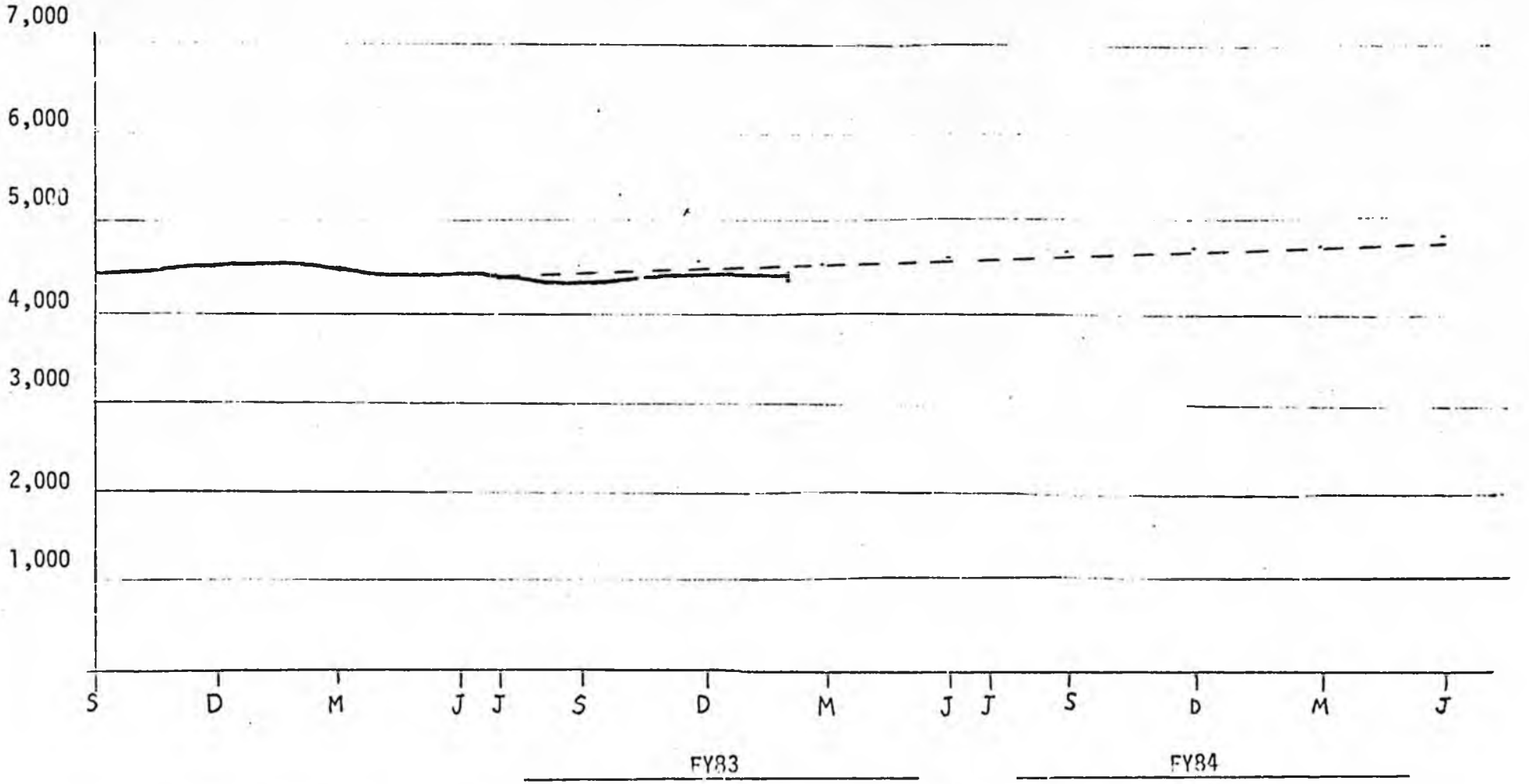
12. APA Federalization

The State is in a position to consider federal administration of its aged, blind and disabled programs. Although these three programs were federalized in 1974, Alaska and a number of other states continued to operate their programs because the uniform national payment was below that previously received by recipients in these states. As a result, there is a great deal of duplicate administrative effort, conflicting information and other problems which could be avoided if the State part of the program were federalized as well. The Division commissioned an analysis of this issue. The final report will be available by March 1, 1983 at which time the Department will consider the merits of complete federalization from both an administrative and program perspective and then make a recommendation to the Governor.

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)
Caseload analysis Sept. 1981 thru June 1984



ADULT PUBLIC ASSISTANCE PROGRAMS
Caseload analysis Sept. 1981 thru June 1984



ADULT PUBLIC ASSISTANCE (APA) :

OLD AGE ASSISTANCE (OAA)
AID to the BLIND (ABL)
AID to the DISABLED(APD)

——— APA ACTUAL CASELOAD Sept. 1981 thru Feb. 1983

----- APA PROJECTED CASELOAD FY83 and FY84

Division of Public Assistance

FY84 Contracts/RSA

BRU	Component	Contract	FY84 Amount
PA Admin	Admin	Dept. of Law	$ 51.4
PA Admin	Admin	AMPS	736.2
PA Admin	Admin	AMPS Reports	43.4
PA Admin	Admin	TPL Collections	40.0
PA Admin	Elig Det	Fee Agents	149.7
PA Admin	Elig Det	Loomis	207.7
PA Admin	Elig Det	North Slope	81.7
PA Admin	Elig Det	U.S. Post Office	139.0

	FY83 Projected Without SB817	FY83 FCC With SB 817	FY83 Base Revised 10/1/82	FY84 Factor	FY84 Request	% Increase FY84 vs FY83 FCC
Medicaid	$48,923.5	$64,924.5	$61,933.4	12.7%	$69,809.8	7.5%
GR Medical	$14,625.8	$7,931.4	$10,392.8	14.6%	$11,910.2	50.2%
Total	$63,549.3	$72,855.9	$72,326.2	13.0%	$81,720.2	12.2%
(State)	(37,232.0)	(36,413.8)	(37,320.1)	14.2%	(42,604.8)	17.0%
(Federal)	(26,317.3)	(36,442.1)	(35,006.5)	11.7%	(39,115.2)	7.3%

Comments

Estimated costs of medical care for FY83 if SB 817 had not been passed by the 1982 Alaska Legislature. SB 817 moved all low-income children into the Medicaid Program out of GR Medical, among other changes.

Revised FY83 estimate taking SB 817 into account. Several key assumptions made:
1. $1.5 million would be later added to $7.9 million GRM from Federal Budget Impact Fund.
2. Prescription drugs would be paid out of Medicaid, not GRM.
3. SB 817 would be implemented on 7/1/82 for 12 month cost savings.
4. Adult medical care would be provided under GRM for persons not eligible for AFDC, OAA, AB& or EPD. If funding fell short, services would be reduced.

Latest FY83 estimate showing full costs of Medicaid and GRM. Assumptions include:
1. $1.5 Federal impact money assumed part of $10.3 GRM base.
2. Drugs moved back into GRM ($1 million).
3. SB 817 implemented 10/1/82 not 7/1/82.
Based on these assumptions the total FY83 medical cost expected exceed authorized State funding by $906.3 if the federal impact funds are not made available.

Factors vary by type of medical service in Medicaid and GRM. These factors are a composite for Medicaid and GRM.

Estimate of medical costs for FY84 with following assumptions:
1. Medical care costs will increase at 9%.
2. Caseloads and therefore persons covered will increase at 6%.
3. No limits will be applied to rate of increase in hospital or long term care rates.

The Department seriously questions the forecast of a 9% increase in medical costs for FY84. Preliminary information from the hospital association indicates their facilities are expecting increases in costs ranging from 12% to 16%.

23 CONTINUED 2

AGENCY Health and Social Services

PROGRAM Public Health

BRU Medical Assistance BRU

COMPONENT

Revised Date

FY 84

001305

01 11543(7.021-23

FDIJ

- State Revenue Sharing
  25% capital construction
  $250,000 operations

- Medicaid

- 3rd party payments

- Blue Cross Joan Gaumer, Martin Tirador

- Aetna

CURRENT BUDGET

MENTAL HEALTH ADVISORY COUNCIL AND LAND BOARD

ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
16,200			

SPECIAL PROJECTS AND GRANTS (3 POSITIONS)

ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
427,300			

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
	711,700	461,300	250,400

HEALTH PLANNING & DEVELOPMENT (10 POSITIONS)

ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
	525,300	260,900	264,400

CERTIFICATION & LICENSING (6 POSITIONS)

ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
327,800			

ADMINISTRATION (4 POSITIONS)

ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
169,700			

HEALTH PLANNING COMMITTEE (1 POSITION)

ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
64,200			

HEALTH SYSTEMS AGENCY GRANTS

ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
150,000			

COMMISSIONER'S OFFICE

ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
	860,300	860,300	

COMMISSIONER'S OFFICE (11 POSITIONS)

ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
860,300			

GAO STUDY - competitive strategy

CON - Restricts competition

MEDICAL MARKETPLACE

with KEY ELEMENTS. MARKETPLACE will OPERATE EFFECTIVELY. KEY ELEMENTS ARE:

1. A LARGE Number of buyers and sellers
2. CONSUMERS must bear CONSEQUENCES of bad DECISIONS
3. SELLER MUST be able to leave or enter to MARKET FREELY

Differences from ECONOMIC model in MEDICAL MARKETPLACE

1) THIRD PARTY PAYMENTS REMOVE CONSUMER'S RESPONSIBILITY for fiscal effect of their ACTIONS. IN 1981 only 32.1% of health CARE USERS paid for their own treatment

2) BECAUSE of COMPLEXITY of health CARE, CONSUMERS are NOT AWARE of CONSEQUENCES OR OPTIONS re: health CARE. 70% of health CARE EXPENDITURES are INFLUENCED by PHYSICIANS.

3) # of PROVIDERS is SMALL in SOME MARKETPLACES i.e. RURAL AREAS - ALASKA IN GENERAL

4) RESTRICTIONS to entry into MKTplace - licensing of NURSES; PHYSICIANS, FACILITIES VIA CON, possibly by STATE FUNDING.

TABLE 1 - good on competition.

JAN 31 1983

PROVIDENCE HOSPITAL

SISTERS OF PROVIDENCE

SERVING IN THE WEST SINCE 1856

3200 PROVIDENCE DRIVE - POUCH 6604
ANCHORAGE, ALASKA 99502
PHONE: (907) 276-4511

January 26, 1983

The Honorable Bette Cato
Alaska State House of Representatives
State Capitol
Pouch V
Juneau, Alaska 99811

Position Paper on HB 19 and a companion bill being submitted to the Senate -- pertaining to an "Act repealing the certificate of need program."

Dear Representative Cato:

Providence Hospital joins the rest of the hospitals in this state in requesting the repeal of the certificate of need law and endorsing House Bill 19 (Fritz and Hayes) and the companion bill about to be submitted to the Senate. The process which this law sets in place is cumbersome and wasteful and totally inappropriate for Alaska.

The major impetus for the law was to control excess hospital beds in many large cities and to help control rising health care costs. The belief was that by controlling the number of beds, capital expenditures and new services, costs would be contained. The results have been much less than desirable throughout the country, and, in Alaska, have been needless, wasteful, cumbersome and costly.

The lack of success in Alaska is better termed overkill. Designed for areas of heavy population, excess hospital beds and competition, the law does not work and is inappropriate for our small state for several reasons:

- The law only covers private facilities, and does not cover public health, military or state owned institutions.

- Alaska has only one city with more than one hospital, and there are only three hospitals in the whole state (eligible for review) of over 100 beds.

- The law is reactive to existing decision making processes. Hospitals in Alaska already have local public review and approval designed in their own budget review processes. Many hospitals are owned by

municipalities, and all have governing boards or advisory boards of local citizens. These citizens and municipalities should have control of the expansion and budgetary decisions of their own institutions. Several other layers of bureaucracy and review are cumbersome, costly and inefficient. For our Certificate of Need, the following is an actual review cycle showing the different bureaucratic levels we had to go through just to have a decision made on one project.

Letter of intent to file certificate of need

Pre-application conference (HSA, Municipal Health Commission, State)

Public Hearing on Certificate of Need Application (State)

Joint Project Review (HSA and Municipal Health Commission)

Concurrent Review (HSA and Municipal Health Commission)

Board Review (Municipal Health Commission)

Board Review (HSA and Southcentral Health Planning & Development Agency)

Commissioner's Review (State)

From the time of holding the application conference to the ultimate decision by the Commissioner, the process has taken over a year.

- The law places a costly burden on all institutions who have to prepare and submit Certificates of Need. The documents which need to be prepared are massive, require hundreds of hours of preparation and at least 35 each need to be produced for the review boards and other parties. The 110 day minimum time period for a review is unrealistic, and often times, the institutional cost of delaying implementation means an eventual increase in price of the piece of equipment or construction project due to inflation.

- The law also passes on a cost to the public in that state, regional and local staff are needed to coordinate the program, prepare staff analyses and hold public meetings. We are estimating that the cost of state, regional and local staffs have increased the cost of health care by at least $8,000,000 in the last six years.

- The dollar limit for what must be reviewed is absurdly low. In 1982 alone, Providence spent hundreds of man hours and other monies preparing six CON applications for such things as a $167,000 replacement incinerator (the old one being 25 years old was required to be replaced by both State and EPA codes!); a CT scanner and Cath lab replacement; and a $250,000 computer enhancement for an x-ray machine. Believe it or not, the STATE did not give approval on the incinerator until the 90th and final day for a decision to be made.

The Alaska State Hospital Association is unanimous in endorsing the repeal of the CON law. We have also received indications from several legislators and the Alaska Medical Association that repeal of the CON law would be best for a growing state such as Alaska.

We are supportive of local planning for Alaska's health care needs. The process, however, should be positive and proactive -- encouraging institutions to respond to needs in the community -- not negative, reactive and cumbersome.

Your support in repealing the certificate of need law in Alaska would be appreciated. With an early response and passage of HB 19 or the companion bill in the Senate, a tremendous and costly burden will be lifted from Alaska's hospitals.

Thank you for your consideration.

Sincerely,

Al M. Camosso
Administrator

1982-CURRENT

145.83 [Repealed, 1979 c 323 s 16]

145.831 [Repealed, 1979 c 323 s 16]

NOT REPEALED - DAVE

MINNESOTA CERTIFICATE OF NEED ACT

145.832 PURPOSE; CITATION.

Subdivision 1. The legislature finds that the 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. The purposes of sections 145.832 to 145.845 are to promote comprehensive health planning; to assist in providing the highest quality of health care at the lowest possible cost; to avoid unnecessary duplication by ensuring that only those health care facilities and services which are needed will be developed; and to provide an orderly method of resolving questions concerning the necessity of construction or modification of health care facilities.

It is the policy of sections 145.832 to 145.845 that decisions regarding the construction or modification of health care facilities should be based on the maximum possible participation on the local level by consumers of health care and elected officials, as well as the providers directly concerned.

Subd. 2. Sections 145.832 to 145.845 may be cited as "The Minnesota Certificate of Need Act."

History: *1979 c 323 s 1*

NOTE: This section is repealed by Laws 1982, Chapter 614, Section 12 effective March 15, 1984. See Laws 1982, Chapter 614, Section 13.

145.833 DEFINITIONS.

Subdivision 1. As used in sections 145.832 to 145.845, unless the context otherwise requires, the terms defined in this section have the meaning ascribed to them.

Subd. 2. "Health care facility" means any facility licensed under sections 144.50 to 144.56, or any nursing home licensed under sections 144A.02 to 144A.11; but does not include any facility licensed under sections 245.781 to 245.813 or 252.28, unless the facility is a vendor of medical care under section 256B.02, subdivision 7, and is certified as any type of intermediate care facility or skilled nursing facility or is operated by the commissioner of public welfare as a state hospital. "Health care facility" also includes any facility in which services are provided primarily for the treatment of kidney diseases.

Subd. 3. "Health services" means all clinically related services, diagnostic, treatment or rehabilitative, that are cost centers utilized by a health care facility for its accounting purposes. The cost center shall conform to definitions of cost centers recognized by generally accepted accounting principles and shall conform to the cost center definitions utilized in reports of the facility, or organization to any other state agency or program. The cost centers include alcohol, drug abuse and mental health services.

Subd. 4. "Predevelopment activity" means any activity by or on behalf of a health care facility or any person which occurs in preparation for the offering or development of a new institutional health service if the predevelopment activity would require an expenditure in excess of $150,000 or if the predevelopment activity involves any arrangement or commitment for financing the offering or development of a new institutional health service.

Subd. 5. "Construction or modification" means:

(a) Any erection, building, alteration, reconstruction, modernization, improvement, extension, lease or other acquisition, or any purchase, lease or other

COMMITTEE REPORT

HOUSE

FURTHER:

Date: _____

Mr. Speaker:

The Committee on _____ has had _____

An Act repealing the certificate of need program; and providing for an effective date.

under consideration and reports it back as follows:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[ ] replace with CS for _____ [ ] same title [ ] new title

and recommends _____

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note [ ] Zero Fiscal Note Attached

[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING DO PASS

MEMBERS HAVING OTHER RECOMMENDATIONS:

Mike Davis Do not Pass

CHAIRMAN

H 60

SOURCES OF HOSPITAL FUNDING

Ak statue: 25% construction cost reimbursement AS 29.90.010

$250,000 or $2500 per bed operating grant

Capital budget process through legislature funds major construction.

Tax free bonding capability via Alaska Medical Facility Authority provides access to lower rates on bonds.

Approximately 30 to 42% of hospital revenues are from state and federal funds.

State medicaid has risen from a 2 million dollar program in 1972 to 70 million dollar program today.

2-25-83 9:40 AM

MAE-MICO:

ENTITLEMENTS OUTSTANDING AS of JULY 1, 1983
(FY84) 25% Hospital REIMBURSEMENT

FAIRBANKS MEMORIAL	1,215,281	1 YR REMAINING
JUNEAU DETOX FACILITY	75,059	3 YRS REMAINING
KENAI - CENTRAL PEN. HOSPITAL	2,167,338	4 YRS REMAINING
#	3,457,678	

Proposed Amendment to SSAB 19

By Dem. H

Section 4 AS 29.90.010 - 29.90.030 is Repealed

Section 5. Those hospitals or health facilities which are currently receiving funds pursuant to ~~sections~~ AS 29.90.010-29.90.030 shall continue To receive construction AID AS Though AS 29.90 were not repealed until its entitlement is satisfied. No new applications shall be received a processed after the effective date of this legislation

Dorothy Curran - FBks citizen
Speaks against repeal:

Dennis DeWitt - Pres Ak St. Hosp. Assn
Supports the repeal:
will reduce consumer costs
Medicaid
Cost of care containment has not occurred

Susan Callan - Health System Agency
Speaks for repeal: raise thresh. to Fed. Regs.
+ tie it to inflation

Peggy Wilson - Staff to Health Resources System Agency.
Speaks against repeal:
Ak av. cost $409
St of Wash. - 262

John (Penn) Puah / Phoebe Lindsay - D.H.S.S.
Supports Repeal: must look at the following in relationship
1. Medicaid
2. C.O.N.
3. Health Care Cost
4. Capital Budget - tighter review process.
5. Revenue Sharing - Capital projects
all requests for funding goes thru C+RA.
repeal should be in conjunction with
review capital process.

1. No competition
2.

Elaine Sitka - Art Wilman

Bonnie Observer - Ketchikan - John Manning (SE. AK Health agency)

Barbara - Anch - Susan Callan (Health Systems agency)
Peggy Wilson

Tom Minger - FBks Memorial Hospital Administrator
speaks for repeal: expensive, cumbersome, delays construction which is expensive daily, short building season, public input by Hospital dayboards. State has not saved $. Medicaid population # havent increased, the # of requests + services have increased

Question: Banker-
60% State $

Dr Bierne:
Speaks against Repeal:
Wants modification (major) upward of $4 thru amendment, to $1 mil

Art Wilman - SE. AK. Health Systems agency
Speaks against Repeal: agrees w/ Bierne
The law + regs are to cumbersome but gives some control by citizens. threshhold to $1.5 mil.

Al Tirador - Blue Cross
Speaks against repeal: will increase care costs, recommends capital thresh to $1 mil. Remove some juris. by State agencies.
streamline process, use of local health committees, one agency to make recommendat. to Senator ie Planning & Develop.

Rep Clarkson – Speaks against

no cost controls { not a free market
Consumer indifference
high cost of Technology.
Lack of info in the consumer info

no state has repealed – only sunset Provisions

Cost to State – $250,000 FY84

Lack for documentation from witnesses on "Costs" of CON.

Studies show 2/3's in savings w/ CON.

Anch – projected need Bed capacity 575 beds to 606 beds

692 total if CON approved w/ Humana + Providence

Waste of Taxpay $

Humana – " will build w/out taxpay funds

but 30% revenue rec'd from Bed occupancy.

Medicare etc

Per bed
$196 mil Providence – 250 added Beds 186 mil $206

$150 thou Humana – 200 ad. beds 50 mil $161

$ Medical Care in State – $ 15B mil paid under CON

22 mil = 25% Construction re-imburse

7.5 mil – Operating

Medicaid, Corrections, etc

Proposed Substitute:

Increase Threshold to Fed law or above

$ 400 thou – Equip

$ 600 thou – Construction

Exempt – any replacement of Equipment

Non-Medical Equip + Construction

Any purchase or expense to meet fire + other codes

1. Simplify + streamline CON
2. Impose deadline Commissioner decision
3. Do the health care input adequate

Establish a rate review Council - Tough
to tie appropriate w/ approval.

Dennis DeWitt -

719 Beds established

~~Consultant~~

Mr Davis - Providence occupancy 80% overall

Consultant -
beds filled

HOUSE HESS
COMMITTEE MEETING
AGENDA

DATE: February 25, 1983

TIME: 1:00 pm

I. Call Meeting to Order

A. Note Committee Members Present

B. Welcome Those Observing

C. Remind those wishing to testify to sign up, and those giving testimony to speak up and state their names.

II. Announce Legislation Under Consideration:

SSHB 19 An act repealing the certificate of need program.

Other notes or reminders:
Announce / ask committee about Confirmation Hearings

Monday, February 28, 1983

HCR 17	Relating to the state medal for heroism.
HJR 27/ SJR 11am	Relating to health care delivery to non-Native dependents by the U.S. Public Health Service.
HB 117	An act relating to sexual abuse of a minor.
HB 127	An act to increase punishment for sexual assault in the first degree.
HB 128	An act raising penalties for promoting child prostitution.

MAE —

FEB 16 1983

CERTIFICATE OF NEED:

REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

Alaska Health Coalition

529 5th Avenue, Suite 8
Fairbanks, Alaska 99701
(907) 456-2553

February 11, 1983

FEB 16 1983

TO: Members of the Alaska Legislature

Proposed legislation (HB 19 and SB 85) would repeal Alaska Statute 18.07.031-18.07.111, better known as the Alaska Certificate of Need (CON) law. These bills reflect the position of the Alaska Hospital Association, whose member institutions are subject to the provisions of the CON process. The attached paper, developed by the Alaska Health Coalition, was written to provide legislators and the public with a series of alternatives to consider during discussion of these important bills. The paper summarizes the provisions of the CON law, discusses several of the problems which have been identified with the current process, and reviews the effectiveness of the CON program, both nationally and within Alaska. In addition, a list of recommendations is provided for consideration in revising the current CON law.

The Alaska Health Coalition is a group of interested citizens with memberships from the three Alaska Health Systems Agencies and the Statewide Health Coordinating Council. The primary purposes of the Coalition are to review the need for health planning, development, and promotion activities and to develop goals, describe functions, and recommend structures to achieve optimal health for the citizens of the state. Therefore, we believe that the subject of public review of capital expenditures as currently provided for in the Certificate of Need law is an important issue which deserves a reasonable, objective discussion. We present this paper for the purpose of initiating this discussion.

For additional information, please contact any of the following organizations: Northern Alaska Health Resources Association, Fairbanks (456-2553); South Central Health Planning and Development, Anchorage (278-3631); or, Southeast Alaska Health Systems Agency, Ketchikan (225-9681).

Best regards,

Chas M. Kaltenbach

Charles M. Kaltenbach, Dr. P.H.
Chairman

CMK:sem

Enclosure

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