SYMPOSIUM

Preface

My first experience with a law review symposium such as this one was at the University of North Carolina in the mid-1970s. Under a grant from the Carter Administration we commissioned a series of articles around a similar theme—hospital cost containment—that were eventually published in 1980.[1] The articles reflected what was then the dominant version of health care policy: that current efforts to contain costs were the forerunners of a more elaborate and centralized system of public regulatory controls. Thus, several authors examined the legal problems that would be encountered under a scheme of expanded government control over resource allocation; another critiqued existing mechanisms to integrate consumer involvement in regulatory decisionmaking; and another analyzed the difficulty of administering efforts to police the quality of services in tandem with government programs that are primarily oriented towards cost reduction and budget control. But each of the articles, mirroring much of the academic and political debate of that time, adopted the underlying assumption that the future of cost containment would be built around government, and primarily federal government, regulatory strategies. Indeed, the purpose of the original grant from the Carter Administration was to provide some of the legal foundation for the federal hospital rate setting program, Carter's "9% Solution." That program had been proposed by the Administration as the interim holding action in anticipation of the more comprehensive cost controls that would be made part of the nationalized health financing scheme that Carter had envisioned as the centerpiece of his national health policy.

Even before that symposium was published, the Carter strategy had proven to be highly unpopular, thus making those articles auspiciously out-of-date. The proposal for a federal

1. HEALTH FACILITY REGULATION: THE NORTH CAROLINA LAW REVIEW SYMPOSIUM (K. Wing ed. 1980); *reprinted from* 57 N.C. L. REV. 1160-1479 (1979).

hospital rate setting scheme was soundly rejected by Congress. Anticipating the same fate, Carter's promise of national health insurance was quietly forgotten. The same political and academic debates that had so recently assumed government regulation as a foregone conclusion were suddenly giving considerable attention to a virtually antithetical vision of the future of health policy. Clark Havighurst, Alan Enthoveen, and other "neoconservative" theorists were arguing that government regulation was not the answer to health care cost containment but rather part of the problem. Government's role should not be to mandate cost containment resource allocation decisions but instead to promote private and decentralized decisionmaking by providers and insurers, and ultimately by private consumers of their services. What was needed in American health policy was a healthy dose of competition.

Ronald Reagan, of course, embraced this alternative vision as his answer to rising health care costs and, in fact, in the first few years of his Administration, managed to implement at least some of its dictates. Federally mandated health planning programs and many other indicia of federal health policy leadership were dismantled. Efforts were made to reduce federal spending for and, consequently, federal direction over Medicaid and other state-administered health financing programs. Some efforts were made to restructure Medicare according to neoconservative principles; much was made of experiments to encourage Medicare recipients to enroll in health maintenance organizations and other capitation schemes; and when attempts to repeal the Medicare peer review program failed, the program was recast with a somewhat more conservative patina. In the private sector, the federal government actively encouraged third party payers to develop and market alternative insurance arrangements, to integrate financing and service delivery schemes, and the like. But this was done in the name of privatization and competition, not in response to federal subsidy and mandate. At the same time hospitals, physicians, and other providers were advised that their future lay not in their commitment to the social good, but rather in their pursuit of economic self-interest. Profit maximization, proprietary strategies, and price competition, terms that were once anathematic to health care policy, were suddenly de rigeur in an environment described more often as "the market place" than as the "health care system." The states were urged to fol-

low the federal lead and to remove the regulatory barriers to these competitively-based reforms.

The major health policy reforms of the 1980s, the adoption of prospective payment of Medicare hospitals based on diagnosis rather than per diem costs, and the later development of a "relative value scale" reimbursement scheme for Medicare physicians, are harder to characterize. In one respect, these reforms moved Medicare reimbursement policy closer to a price-based scheme, rather than its traditional cost-based scheme. This was in keeping with the neoconservative strategy of making government a "smart consumer" rather than a bureaucratic regulator. In other respects, and as providers have frequently bemoaned, the PPS-DRG and RVS schemes and the resulting influence on provider behavior and autonomy certainly must "feel" like more government regulation in fact even if they represent more competition in theory. More to the point, through the mid-1980s, the Congress and, to a certain extent, the Administration cooled to the full dictates of the neoconservative agenda. Most notably, the linchpin of the competitive strategy, the removal of the government subsidy for employer-based insurance, was occasionally discussed but never seriously considered. Major competitively designed reforms of Medicaid and Medicare, such as voucher-based schemes and fixed lids on government spending, were also eschewed. The reaction at the state level was similar. Many states jumped at the opportunity to deregulate health care and unleash market forces for ideological reasons or for more basic political reasons. Other states were reluctant to dismantle their certificate of need program and other regulatory programs. A few states, in fact, attempted to fill the vacuum of federal leadership and pursue even more comprehensive regulatory controls.

There are a number of ways in which this chapter in the quixotic politics of health policy can be characterized and, more importantly, evaluated. Have we now witnessed the healthy dose of competition that neoconservative theorists originally urged and, if so, what have been the results? Or did our reluctance to abandon entirely direct government controls and the regulatory strategy of the 1970s leave us with only half a loaf of competition and deny us the full benefits that the market strategy might have ultimately provided? Is it timely to correct our course with a return to some of the regulatory

measures of the 1970s or even to more rigorous government control? If the Medicare reimbursement reforms are in fact the most significant health policy reforms of the 1980s—and I think there is little doubt that they were—what does that tell us about our willingness to cede health policy decisions to the private sector and to the dictates of competition? More to the point, given this recent history, where can we go from here in the 1990s and where should we go?

I think the answers to these questions have less to do with the theoretical debate of competition per se versus regulation per se, or even with the related arguments over the proper characterization of the programs of the past decade as properly "regulatory" or "competitive," than with the practical results of these programs. What we need to know about PPS/DRG reimbursement is not whether it is correctly described as a price mechanism or best regarded as one form of "command and control" rate setting, but rather what it has achieved and what prospects for success it holds for the future. What we need to evaluate are the existing cost containment measures in both the private and public sectors, whatever their theoretical origins, to determine what has worked and what has not and what that tells us for the next increment of change or reform.

What we hope we have done in this symposium is to further the inquiry into these questions and the development of their answers. We have asked each of our authors to consider some aspect of hospital cost containment, to assess its significance, and to evaluate the related legal and political problems that will be encountered as health policy develops in the 1990s.

Bruce Vladeck's review of the experience with PPS/DRG reimbursement focuses on some important lessons for the development of that reimbursement scheme, but, more importantly, for the development of federal health policy generally.

Tim Jost's review of the recent experience with the Peer Review Organization program examines many of these same lessons, but also the specific legal and administrative difficulties that arise in the PRO cost containment and enforcement program.

Marvis Oehm's paper reviews the experience of cost containment efforts similar to those of the publicly sponsored PROs, but in the private utilization review programs that have developed in the last decade of enhanced competition.

John Blum's paper moves from the macro level to the

micro; he examines the prospects—as well as the problems—that will be encountered as individual hospitals attempt to respond to both private and public utilization and cost containment programs by conditioning staff privileges for economic reasons.

Bruce Siegel reviews the experience of the State of New Jersey, one state that continues to pursue a regulatory-based strategy and that has attempted perhaps the most comprehensive government-mandated controls over health care in the nation.

Our final paper, written by Jim Simpson, shifts the focus back to the individual institution and reviews the underlying assumptions that have led public policy to consider hospitals as charitable and nonprofit and questions whether that assumption should not be revised given the contemporary environment within which hospitals must operate.

The UPS Law Review, faculty, and all of us who have been involved in organizing this symposium are very grateful for the efforts of these authors and hope that these papers will be given the attention that they deserve.

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