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# Competition and Health Care Planning for Deregulation

Clark C. Havighurst  
Glenn M. Hackbarth

**I**T WAS inevitable that Congress's deregulatory right hand would eventually challenge what its left hand had been doing for years to the health-care industry—gradually tightening the government's regulatory grip. The first evidence of the challenge was a series of amendments, adopted last October, to the National Health Planning and Resources Development Act of 1974. These amendments significantly alter the jurisdiction and mandate of the health-care system's planners and regulators and reopen the policy debate over competition's potential for allocating resources to, and within, the health sector.

Congress did not call for immediate deregulation of the health services industry in the 1979 health planning amendments. Nor did it wholeheartedly embrace competition as the solution to the problem of steadily rising health-care costs. Nevertheless, the amendments reversed the previously implicit assumption that competition had no constructive role to play in the industry. Indeed, Congress ex-

*Clark C. Havighurst is professor of law, Duke University School of Law. Glenn M. Hackbarth is research attorney, also at Duke University School of Law.*

pressly declared its preference for allocating health services through market competition—rather than by planning and regulation—“wherever competition and consumer choice can constructively serve to advance the purposes of quality assurance, cost effectiveness, and access.” Although this statement leaves unanswered the ultimate question of when competition may be helpful, by reopening that question the amendments overturned the working premise of previous policy development and laid a statutory foundation for expanding competition's role in the future. Previously an academic pipe dream, deregulation in the health services industry has suddenly become a possibility to be reckoned with.

The shift in Congress's attitude about competition is exemplified by a single sentence that appeared first in the Senate Labor and Human Resources Committee's report on the 1974 law and once again—but with a significant revision—in the committee's report on the 1979 amendments. Whereas the earlier report stated that “the health services industry does not respond to classic marketplace forces,” the 1979 revision says that the industry “*has not to date responded*” to such forces (emphasis added).

In other words, the committee now acknowledges the possibility that the market may have untapped potential that was overlooked in 1974. This theme runs throughout the legislative history of the new amendments' procompetition language.

### The 1974 Planning Act

In order to rationalize capital investment in health-care facilities and in the development of new health services, the 1974 health planning act established a two-tier process for screening proposed new investments. On the first tier are local, usually nongovernmental, *planning* agencies run by governing boards comprised of representatives of consumers and providers of health care. These so-called health systems agencies, or HSAs, develop "health systems plans" that (1) describe the locality's need for specific institutional health services and related facilities and (2) serve as the basis for HSA review of requests for certificates-of-need filed by those who wish to offer new or expanded services. The actual certificates-of-need are granted, however, by the second or *regulatory* tier of the two-tier structure. On this tier are state certificate-of-need agencies with minimum regulatory powers mandated by federal law, including the power to prohibit unapproved investments. The local health plans and HSA recommendations are expected, of course, to inform and rationalize regulatory decision making.

Congress erected this elaborate regulatory apparatus to curb two types of "unnecessary" investment. The first involves expenditures for redundant facilities or equipment. Health-care institutions "overinvest" in this fashion be-

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cause government and private health plans (particularly Blue Cross plans) routinely reimburse those institutions for whatever costs they have incurred—often including the capital

costs of empty beds and underutilized equipment. As a result, such institutions, particularly hospitals, are unduly free to err on the high side in estimating their future needs for bricks and mortar and new technology. With third-party payers helping to keep prices from falling below costs, hospitals are not penalized for creating excess capacity to the same extent as are firms operating in a more normal market. One result of this arrangement is the nation's surplus of hospital beds, which some experts estimate at more than 100,000.

Possibly more costly to the public, however, is a second, less visible type of "unnecessary" investment—namely, investment in services or facilities that do not yield health benefits commensurate with their cost, even when they do not sit idle. Under the present financing arrangements, physicians and patients rarely have an incentive to make fine judgments about the cost-effectiveness of tests, therapies, or "new and improved" equipment. On the contrary, the prevalence of comprehensive, no-questions-asked insurance means that nearly full sway is given to the patient's urge to get the best possible care and the physician's urge to provide it. Indeed, nonprice competition, as well as a fear of malpractice claims if any stone is left unturned, drives providers to offer more and better services—more and better, that is, than the services people would rationally choose to purchase if they were spending their own money directly and were comparing benefits and costs.

### Lessons from Regulatory Experience

Congress's willingness to contemplate a more market-oriented health policy is directly attributable to the fact that the regulatory strategy is in disarray. Existing regulation, which in some states includes hospital rate regulation as well as the entry and investment controls imposed by the federal planning law, has had only minimal success. Although regulators insist that a little more time, money, and jurisdiction will allow them to turn things around, their credibility wears thinner as health-care costs continue to escalate. It is ironic that regulation could probably have carried the day if only it had succeeded in stabilizing health spending as a share of GNP and federal spending. Con-

gress's attention would then have wandered, even if the level of spending arrived at was horrendously inefficient—in the sense that many of those dollars could have been put to much better uses elsewhere in the faltering economy.

A closer look at the difficulties facing health planners and certificate-of-need regulators suggests why a strict regulatory regime for controlling health costs may be fundamentally flawed. First, "need" for a service or facility can seldom be determined with confidence. The precise benefits of particular diagnostic tools and therapies, even some that are long-established, are very often in doubt. Moreover, as evidenced by the nation's experience with the "new" health and safety regulation of the 1970s, a powerful taboo makes it difficult to undertake, or even acknowledge the existence of, trade-offs between the lives and health of citizens on the one hand and the public's finances

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on the other. Not surprisingly, then, politically exposed regulators find it hard to say "no" to even the very expensive investment that promises only marginally more effective care. They are particularly unlikely to do so if, as is usually the case, the financing system shifts much of the cost burden of the new investment to taxpayers and premium-payers outside of the regulators' local or state constituency.

To be sure, some regulators have occasionally lined up support for tough, cost-conscious decisions by forging coalitions of business, labor, and "progressive" health-care providers. (In particular, such coalitions have slowed the growth in the already bloated stock of hospital beds.) More often than not, however, regulators are fighting a losing battle with the influential proponents of more and "better" care. Even when they reject proposals by existing providers (meaning hospitals, clinics, nursing homes, and so on), total costs may not be affected. For example, a hospital rebuffed on one proposal often comes back with another—if not for beds, then for something else—and eventually suc-

ceeds in tapping into the available funds. Or a rejected applicant may invest in equipment whose item-by-item cost is below the statutory threshold of the approval requirement. And even when certificate-of-need regulation does succeed in blocking inflation in capital costs, it cannot prevent the balloon from bulging elsewhere. Thus, hospital wages and personnel-to-patient ratios have risen persistently, reflecting what may be an inefficient, regulation-induced substitution of labor for capital.

If health planners and regulators have generally been liberal in granting certificates-of-need to existing institutions seeking to upgrade and expand their services, they have been relatively stingy about investments by would-be newcomers to the market. Unable to enforce economic discipline against their regulated constituency, they have often sought to demonstrate their resolve to avoid "duplication" of services by retarding the development of efficiency-enhancing competition—for example, from health maintenance organizations (HMOs), those potentially efficient prepaid health-care plans that care for an enrolled population within a fixed budget.

Of course, the strongly political character of planning and regulation, explicitly built into the HSA structure by "consumer" and "provider" representation requirements and implicit in state-level regulation, has encouraged decisions that reflect the interests of established providers. Health planners and regulators, even if they are not "captured" by the regulated institutions, may harbor a preference for stability and cooperative problem solving over what they see as an unruly competitive marketplace. Thus, they may protect providers from competition in order to gain their cooperation and support. Planners and regulators may also prevent "cream-skimming" by new competitors so that existing providers can continue to price some services above competitive levels. The resulting extraordinary profits may then be used to subsidize unprofitable services that the regulators deem desirable. Protectionist regulation is, in short, used to perpetuate internal subsidies, a regulatory practice that Richard Posner has labeled "taxation by regulation."

These reasons for protectionism are, of course, familiar to all students of economic regulation. However, the planners and regulators in this industry have additional, unique

reasons for adopting a protectionist stance, particularly toward hospitals. Because government health programs and most private insurers now reimburse hospitals for their incurred costs, obsolete facilities all too often remain an indefinite financial burden on the public. The apparently vanquished competitor stays in the field, sustained by cost reimbursement and perhaps providing services that less hard-pressed providers would regard as "unnecessary." Indeed, it is an accepted tenet of planning dogma that excess hospital beds induce inappropriate hospital utilization, because hospitals encourage admissions and longer stays in their effort to remain viable. This belief explains why some planners and regulators have regarded competition from HMOs—as well as other competition that reduces costs by emptying existing hospital beds—as a burden rather than a benefit to the community. In a different way, it also explains why regulation alone cannot extricate us from our predicament: without substantial reform of the financing system, regulation will be overwhelmed by its own contradictions.

### Changing Views of Regulation

Disappointment with the small effect that the health planning program—indeed the entire regulatory effort—has had on the growth of health-care spending has prompted some proponents of regulation to call for new, tougher, more centralized controls. One of the best examples of such an approach is the Carter administration's much-debated proposal to put a percentage "cap" on annual increases in hospital revenues and an annual dollar "cap" on the capital projects that could be granted certificates-of-need. The effect of that scheme would be to shift the distasteful burden of rationing resources from the faltering planners and regulators to the providers themselves—who would have to decide how to employ the more limited resources placed at their disposal. While that might not be an inherently bad idea, it would obviously be difficult to establish limits that were inflexible enough to stick, low enough to pinch, but not so low and inflexible as to produce gross inequities among hospitals and regions with different characteristics. Moreover, it has never been established that providers'

methods of rationing under such resource constraints would be reliable and free from abuse. Nonmedical considerations—for example, the position of one's physician in the hospital pecking order—may have a significant effect on who gets access to an artificially scarce supply of resources.

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The Carter administration's willingness to embrace such arbitrary forms of regulation amounts to a confession that earlier regulatory efforts have failed. But Congress, which had gone along with those earlier efforts in part because they were flexible and sensitive to local needs, was unwilling to embrace the administration's "cost-containment" proposal. Indeed, by affording Congress a vision of the future under regulation, that proposal may have marked a turning point in the health policy debate, since there can be no doubt that Congress, not pleased with what it saw, began casting about for nonregulatory alternatives.

When confronted with the original control proposal, the Ninety-fifth Congress collectively blanched and then temporized by inviting doctors, hospitals, and insurers to discipline themselves. In the current Ninety-sixth Congress, the House of Representatives has decisively rejected a scaled-down proposal featuring a standby hospital-revenue cap to be imposed if the industry's cost-control program, the Voluntary Effort, fails. (The capital expenditure cap was separated from the revenue cap in the 1979 proposal and is now part of the administration's national health insurance bill.) Of course, the proposal might still be resurrected as part of an emergency response to the soaring inflation that has gripped the nation in 1980. But even if it is ultimately enacted, it seems likely that it will be viewed only as a stopgap measure, increasing rather than decreasing the urgency of implementing alternative, less heavy-handed strategies.

### **The Emergence of the Competitive Strategy**

As discouragement has deepened about the prospect for regulation that is evenhanded, flexible, and effective in holding down costs, there has been increased interest in ways to restore meaningful price competition to the health services and insurance markets. The status quo—with neither regulation nor competition enforcing adequate cost-consciousness—is widely considered to be untenable. In this view, the Voluntary Effort is a temporary palliative at best, because it does little, if anything, to redress the distortions in the underlying economic incentives of patients and physicians. In fact, that program is seen as only a reflection of the industry's current need to appear socially responsible enough to be left alone by Congress.

One likely component of any program for promoting competition is substantially in place. The U.S. Department of Justice, the Federal Trade Commission, and some state attorneys general are actively enforcing the antitrust laws against private restraints of trade in the health-care sector. Begun after a 1975 Supreme Court decision that the "learned" professions are subject to the antitrust laws, the antitrust enforcement effort, supplemented by private antitrust litigation and academic research, is revealing how important such restraints of trade have been in shaping the dysfunctional financing and delivery system. Physicians, it seems, have often acted in concert to prevent insurers and others from pursuing the consumer's interest in efficiency and lower prices. Thus, as antitrust enforcement limits the organized profession's control over the economic structure of the industry, there should be organizational and administrative innovations in the financing and delivery of medical care.

Congress itself is also entertaining measures that could hasten the onset of meaningful competition. Of particular interest are the proposals for altering the tax treatment of employer-paid health benefits, which is perhaps the single most important cause of the erosion of cost-consciousness in the industry. By making health insurance a tax-free fringe benefit for both income tax and social security tax purposes, the law encourages consumers to pay small as well as large medical bills through demand-distorting insurance instead of out-of-

pocket. Providers of care are to that additional extent relieved of the need to weigh costs against possible benefits. Moreover, because the tax law converts into taxable income any saving in employer-paid premiums that is paid out instead as wages, employees and employee unions have only a diluted incentive to choose low-cost plans. As a result, insurers have only a diluted incentive to challenge organized medicine's preferences. Insurers therefore leave unexplored many possibilities for using their bargaining power and expertise on behalf of their subscribers.

Several bills now under consideration in Congress—for example, Representative Al Ullman's H.R. 5740 and Senator David Durenberger's S. 1590—would decrease the demand for insurance and increase the demand for insurer-initiated cost control by limiting the amount of employer-paid premiums that may be excluded from income. Some of these bills would also require employers to offer their employees a choice of several different health plans and to make an equal contribution to all plans, with employees benefiting directly from choosing a lower-cost option. The hope that significant improvements in the industry's use of resources would ensue seems not entirely misplaced and certainly seems better supported by logic and experience than the hope that regulation will soon improve the industry's performance.

### **The 1979 Health Planning Amendments**

The most concrete sign of Congress's new interest in rejuvenating the market is found, however, in the 1979 health planning amendments. These amendments establish the strengthening of competitive forces as a new "national health priority," introduce legislative findings of fact concerning competition's past and future role, give health planners a new responsibility for fostering competition, and establish new decision-making criteria calling attention to competition's potential for allocating resources without the assistance of regulators. Though not a ringing endorsement of competition under all circumstances, the amendments substantially alter the concept of regulation embodied in the planning act. All things considered, Congress has made it about as clear as it could, short of immediate deregulation, that it

is no longer wedded to the conclusion that health planning-cum-regulation is an entirely adequate mechanism of social control. Planning and regulation are now viewed as imperfect, though sometimes necessary, substitutes for market forces.

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The essence of the new approach to regulation is captured in some specific findings concerning competition that were added to the law. After stating that "the effect of competition on ... the supply of health services is diminished," Congress identifies as the "primary source" of the problem "the *prevailing* methods of paying for health services by public and private health insurers" (emphasis added). Congress then directs planners and regulators to measure the need for intervention according to whether the service in question is one "for which competition does not or *will not* appropriately allocate supply. . . ." (emphasis added). Where competition can appropriately allocate supply, planners and regulators are to "give priority . . . to actions which would strengthen the effect of competition . . ."; where it "does not or *will not*" allocate supply, they are to allocate supply themselves. The clear message is that some services do not need regulation and that the need for regulation of any given service may change over time as the "prevailing" methods of financing change. Indeed, an explicit finding of a market failure would now seem to be a necessary predicate to regulatory action.

It bears emphasis that this new, more skeptical approach to regulation applies even to institutional health services—the services that regulators often argue most need their attention. Although the revised law cites institutional health services as an example of services that are now appropriately regulated, a careful reading of the full statute and the pertinent legislative history establishes that the

possibility of freer entry is contemplated even here. For example, the House Commerce Committee states in its report on the amendments that planners and regulators who are considering an institution's application for a certificate-of-need should consider whether "an innovative financing, reimbursement or service delivery arrangement . . . will . . . properly allocate the supply of those services."

### Health Planning after the 1979 Amendments

The 1979 planning amendments do not tell planners and regulators how to decide when the market works well enough to supplant regulation, but leaves them considerable leeway in this regard. The forthcoming interpretive regulations of the Department of Health and Human Services might provide some guidance, but that department's record of hostility to the market and its usual preoccupation with stop-gap cost-control measures and disinterest in more fundamental change cast doubt on its willingness to take the new mandate seriously.

Some factors that should influence the ultimate judgment about the appropriate role for competition are readily apparent. Among them are the scope of insurance coverage for a service, whether the demand for the service is significantly and inappropriately increased by that coverage, whether insurers have instituted cost controls to offset the demand-distorting effects of their coverage, and whether consumers' price sensitivity and providers' risks from the creation of excess capacity are in fact undercut by the prevailing methods of setting premiums, paying benefits, and reimbursing providers. In keeping with the amendments' emphasis on the financing system's potential for change, planners and regulators should also weigh the amenability of the service in question to as yet untried forms of private cost control. If the threat of higher costs could reasonably be expected to stimulate private insurers to take protective action against the proliferation of expensive, overutilized services, that threat could be viewed as a desirable stimulus to insurer innovation and the emergence of market forces. Thus, the planners and regulators of a market might announce that at some set date they will cease restricting new investments in a particular service, leaving insurers to control

costs for themselves. In short, planners and regulators could adopt a "market-forcing" strategy. The resulting insurer innovation would strengthen the market pressures bearing on both the providers of the service in question and on other insurers, who would also have to take steps to address the cost problem. Even the public financing programs could be regarded as capable of doing more to protect themselves against rising costs.

If one has an idealized view of government's efficacy, regulation will inevitably seem superior to the flawed marketplace, and any departure from the textbook model of competition—such as consumer ignorance about medicine—will appear to justify intervention. As described earlier, however, regulation's supposed strengths often disappear in the face of practical difficulties. Thus, if regulators could be persuaded to make a realistic assessment of the comparative advantages of an imperfect marketplace and imperfect regulation, they might defer to market forces more often. An agency might also forgo command-and-control regulation simply because it had better things to do with its limited resources. Even the HSA

that thought it might increase efficiency in the short run by limiting entry might, for example, conclude that its limited resources would be better spent on other activities with more substantial long-run benefits—perhaps encouraging local employers, insurers, and providers to participate in restructuring the financing and delivery system so as to reduce the need for regulatory controls.

Successful implementation of the new planning amendments requires that regulators be creative and farsighted and that they commit themselves to the policies of the act, even at the expense of their own bureaucratic interests or the interests of specific providers. That, of course, is a very tall order—so tall, in fact, that only a little inbred cynicism or a minimal knowledge of past regulatory behavior could lead one to conclude that it cannot be filled.

It would be a mistake, however, to assume too casually that resistance by planners and regulators will completely undermine the intent of the amendments. Would-be entrants into a market will soon learn to frame their proposals in terms that require planners and regulators to make reasoned findings on com-



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petitive impact. In addition, the courts should force the agencies to be explicit on such matters and to have substantial evidence to support their views. Most important, however, some—perhaps a significant minority—of the planners and regulators in the nation's 200-plus HSAs and more than fifty certificate-of-need agencies will recognize competition as useful in achieving their goals. Out of the creative efforts of this minority might come not only opportunities for new, efficient ways of organizing and paying for health services, but also renewed faith in the market as an institution. This, in turn, might well transform the entire regulatory climate. The decentralized nature of the planning apparatus might therefore foster a change in regulatory practice that could never occur in a single monolithic agency belatedly assigned the task of promoting competition.

It is also important to note that Congress recognized that giving regulators a statutory directive to weigh competition might not be sufficient to guarantee that competition would be accorded its due. To complement that directive, Congress exempted HMOs almost entirely from regulation on the ground that they are sufficiently disciplined by market competition that they should not be second-guessed by planners and regulators—a logical application of the basic principle that regulation is appropriate only where there is an identifiable market failure. Since the exemption from regulation itself encourages the development of more cost-sensitive plans, competitive pressures can be expected to intensify and ultimately to affect the behavior of traditional insurers and fee-for-service providers. If that occurs, competition will have obviated the need for most restrictions on new capital investment and new market entry.

### Conclusion

Twice-cursed, health planning and certificate-of-need regulation as envisioned in 1974 were doomed. Like the "old" economic regulation, they were subject to being used for protectionist ends. And like the "new" health and safety regulation, they were subject to a lifesaving imperative that made explicit trade-offs between health and economic considerations a near impossibility. Under the circumstances, it

was wishful thinking to expect that the public's interest in a more efficient health-care system would be well served.

Some, or even most, devotees of the free market will argue that it is similarly naive to hope that significant deregulation can spring from this same regulatory process. Their skepticism may be well-founded. Yet there should

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be no illusion that a rejection of this approach to deregulation will speed the outright repeal of regulation. Because regulation has such deep roots in the health-care industry, any judgment that competition cannot survive in a regulated climate is more likely to cause policy makers to abandon competition than to abandon regulation. Even if it might be the best strategy, immediate and complete deregulation is not in the political cards at the moment.

Through the 1979 health planning amendments, Congress has at least reopened the overriding question—should market competition be the preferred mechanism of social control in this industry? The result could be to allow enough play in the joints of the planning and regulatory apparatus to give competition the opportunity it deserves to prove itself in practice. ■

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