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POLITICAL EVOLUTION OF FEDERAL HEALTH CARE REGULATION

by Lawrence D. Brown

Prologue: In battles over ideology, each side stands ready to accuse the other of a preoccupation with health system regulation—either too much or too little of it. During the 1992 presidential campaign, a Bush spokesperson accused Clinton of forwarding a plan that “would involve massive new government intervention in the medical marketplace and... would enhance the role of a heavy-handed... bureaucracy.” For his part, Clinton rejected the ‘polarizing rhetoric’ that insists on a choice between regulatory and private extremes. To sort out the rhetoric from the reality, it is useful to define exactly what is meant by “health care regulation” and to trace its evolution in the health care marketplace. “Paradoxically,” writes Lawrence Brown in this paper, “health care has become steadily more regulated at all Levels of government and in the private sector, too, at the same time as other economic sectors—such as transportation, telecommunications, and banking—have moved the opposite way.” The “intellectual puzzle” raised by this paradox is this: “How did a society with sizable ideological and political obstacles to regulation and a heartfelt allegiance to free markets come to adopt us much regulation as it has in the health system?” Given the outcome of the presidential election, it remains to be seen whether health care regulation continues on its current course, or whether a radical change is in the works.

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Abstract: Although federal regulation of health care faces cultural obstacles and skepticism among policymakers, it has grown markedly over the past two decades. Beginning in the 1970s with decentralized programs aimed at regulating provider behavior (Health Systems Agencies and certificate of need) and budgets (state rate setting), health care regulation grew more centralized in the 1980s as federal policymakers expanded their influence on behavior (peer review organizations and medical practice guidelines) and budgets (Medicare prospective payment and the resource-based relative value scale). Behavioral regulation has increased the heavy micromanagement that providers face in the United States, while budgetary regulation falls well short of the fiscal macromanagement (global budgets, for example) that other Western nations use. As cost increases intensify, the coalitions that supported limited regulation as a compromise designed to forestall more threatening intrusions may yield to political pressure for firmer central budget controls.

All Western nations regulate their health care systems. All (save the United States) accept the need for a clear, firm policy framework, promulgated by the central government, to set the rules of the game for purchasers, payers, providers, and consumers. They recognize that the combination of third-party payments and extensive benefit entitlements makes it practically impossible to do otherwise. The notion that health care regulation is a wrongheaded strategy appealing solely to those who resist the allure of markets is distinctly American.

For a little over twenty years the U.S. federal government has expressed official anguish over rising health care costs and has responded mainly by hosting a great debate between competitive and regulatory solutions. Competitive theorists would have government stimulate or reorganize the system to give freer or better play to market forces. Regulatory proponents urge government to issue direct prescriptions and proscriptions that constrain the behavior or the budgets (or both) of the system’s players. Both schools have attracted ardent adherents, but neither has been strong enough to vanquish the other. The 1990s find a health care system that is both increasingly competitive and more heavily regulated but that obeys no broad conceptual blueprint on either front. This blend of halfway competition and limited regulation has not achieved the goal that animated the debate — costs that rise more slowly — and the choice between or the right mix of these approaches has again come under the strategic microscope. Throughout the 1992 presidential campaign, the Bush administration proposed that government leverage be used to unleash the energies of the health care marketplace. The Clinton campaign talked (guardedly) of more direct interventions, including global budgets.

As the nation faces the distinct possibility of new regulatory departures, it is pertinent to ask, What is this thing called regulation that inspires such controversy in health affairs; how has it evolved politically over these two decades; and what are its likely future political prospects?
For the past two decades the White House has remained largely in the hands of moderate or conservative Republicans who pledged to reduce the scope of federal control over health and other sectors of the economy. Paradoxically, health care has become steadily more regulated at all levels of government and in the private sector, too, at the same time that other economic sectors—such as transportation, telecommunications, and banking—have moved the opposite way.

These regulatory trends are doubly paradoxical because health costs have risen steadily even as policymakers have adopted more regulation. Explanations for this uncomfortable coincidence tend to lie in the ideological eye of the beholder. Market-minded analysts treat regulatory “failures” as evidence that the strategy has been a mistake all along. Those who favor stronger public intervention contend that the regulatory initiatives of the 1970s and 1980s were too timid and too often focused on the behavior of providers, not their budgets.

The United States not only views regulation through peculiar conceptual lenses but also goes about it differently than comparable nations do. Most Western societies put the strategic accent on budgetary regulation—negotiated fee schedules for physicians, global budgets for hospitals, caps and ceilings on spending for the health sector or for elements within it, or public budgets for most of the system. These nations depend relatively little on behavioral regulation—detailed case-by-case scrutiny of what providers do clinically. (Obviously, the distinction is not airtight. Behavioral regulation affects economic activities and therewith budgets, and budgetary regulation can be effective only if it influences behavior. The difference lies in the direct object of strategic intervention.) The United States has, at least until recently, reversed these emphases, scrutinizing providers’ behavior while avoiding constraints on their aggregate spending. In the 1980s, however, the mix of behavioral strategies changed while major additions to the federal budgetary arsenal were adopted. Some contend that the system is now poised for a dramatic shift toward budgetary regulation; others predict that such a move would trigger unmanageable political conflict.

Health regulatory politics present a formidable intellectual puzzle: How did a society with sizable ideological and political obstacles to regulation and a heartfelt allegiance to free markets come to adopt as much regulation as it has in the health care system, and, having moved this far with limited success, why has it not adopted more of it? Solving the puzzle requires dealing with three pieces. First, given that the United States spends far more on health services than its Western peers spend,
why has it been slower to install a regulatory framework that might slow the epic growth of costs? Second, although the heavy U.S. commitment to behavioral regulation is odd by cross-national standards, not especially effective, and annoying to providers, why has the nation been so slow to exchange it for larger doses of more powerful and plausible budgetary regulation? Third, do federal efforts in the 1980s to sort out strategies of behavioral regulation and extend the reach of budgetary regulation suggest an open frontier for regulation in the 1990s and beyond?

This paper seeks to illuminate these questions by tracing the evolution of federal regulatory interventions and by exploring the political dynamics behind that evolution. The argument is that the peculiarities of health regulatory strategies derive from distinctive patterns of coalition and conflict among purchasers and providers. Purchasers stand split between a public sector that finds regulation distasteful but is driven by fiscal necessity to embrace it anyway, and a private sector unwilling (at least to date) to overcome its allegiance to markets and small government. Providers have watched uneasily the public sector’s growing regulatory resolve and have responded both by working to shape emerging budget-centered programs and by accepting larger measures of behavioral regulation that are at once less threatening to their incomes than is budgetary regulation and more palatable to private purchasers (who often acknowledge a need for regulation but prefer that it be minimally intrusive). All of this ambivalence invites cost shifting and circumvention of regulatory goals, however, and cannot achieve stability, which enhances the sense that firmer public/private purchaser cooperation and tougher regulatory controls on providers must be in prospect.

Four Types Of Regulation

Because this brief paper offers neither a theory of regulation nor a comprehensive survey of all health policy developments that are in some sense regulatory, it may be useful to make explicit its focus at the start. In the health sphere, regulation takes four main forms. First, laws regulate. For example, statutory language authorizing payment of hospitals’ actual costs in Medicare regulated reimbursement in one way, and legislation adopting a prospective payment system regulates it in another.

Second, regulatory provisions clarify and guide implementation. Issued under the authority of law (the Administrative Procedure Act) and published in the Federal Register, regulations accompany most federal health care programs, be they project grants (such as health mainte-
nance organization [HMO] development), formula grants (Hill-Burton), or entitlements (Medicare and Medicaid). The United States is hardly antiregulatory in these two realms, as the formidable scale and complexity of health care laws and regulations show. This national taste for fine print derives from many sources, including the temptation of a government of laws, not people, to nail down everything in statute; the weighty representation of lawyers among the ranks of lawmakers; the determination of all coalition-building parties in a weakly disciplined system to work favorable language into the law; the adroitness of legislative and group combatants looking to administrative regulations for victories denied them in the legislative process; and the bureaucratic duty to make sense of strange laws for those who must implement and otherwise live with them.

Third, regulatory programs are more or less freestanding legislative enactments aimed to achieve specific objectives. (The line between a regulatory provision and program can be fuzzy, as in Section 1122 of the Social Security Amendments of 1972.) Regulatory programs have long been familiar and relatively uncontroversial in such state and local forms as fire, safety, building, and sanitation codes in hospitals and other institutions; and accreditation and licensing rules. More recent and more contentious cases are the programs this paper mainly addresses: federal regulatory programs designed mainly to slow the growth of costs.

Fourth, regulatory policies are broad “macro” decisions that shape the health care system by constraining the flow of resources into it and setting limits on key players’ freedom of action. A global budget is a case in point; so is the succinct package of principles in Canada that limits the provinces’ discretion in designing their health plans. These macro or meta measures are the highest form of regulation. Because they necessarily entail a big role for big government, they are intensely controversial in the United States. European and Canadian experience suggests that such policy decisions can be a strategic substitute for more detailed regulatory programs and provisions. This paper focuses largely on the recent federal subset of regulatory programs and on the prospect that these may be enfolded into—perhaps traded off for—a larger framework of federal regulatory policy.

Regulatory Controls: Loci And Foci

Until about 1970, the notion that the federal government might impose its heavy regulatory hand on the health care system was heretical. Indeed, the Medicare and Regional Medical Program statutes explicitly promised organized medicine that these new legislative depa-
tures would not be used to justify federal interventions in organization and delivery patterns. Reality quickly broke in, however, as Medicare and Medicaid spending rose beyond expectation and the great debate on the relative merits of competition and regulation as cost containment strategies heated up. The Nixon administration bet its chips on HMOs, which would supposedly slow the growth of costs by means of their own internal efficiencies and the competition they would trigger between themselves and traditional insurers. Some members of Congress, however, believed that this speculative strategy should be supplemented by more immediate measures, and debate turned to the federal government’s regulatory options. In sifting among these, legislators had to choose not only between behavioral and budgetary interventions but also between decentralized (state and local) and centralized (federal) loci of control (Exhibit 1). In essence, Congress began moving among the four approaches, starting with the least controversial and intrusive options and implanting “teeth” as the failures of weak measures helped to make the political case for stronger ones.

The challenge facing policymakers in the early 1970s was how to fashion health regulatory programs when each element in “federal regulation of health care” was politically problematic. Did federal regulation mean that bureaucrats in Washington would start telling doctors and hospitals what to do? Did it mean that the feds would cope with costs by cutting providers’ incomes and revenues? Would Washington start re-arranging the supply side of the system, perhaps with “rationing” in mind? In the climate of the early 1970s the answers to all of the above had to be, “Of course not.” Regulation would be more palatable if the federal government delegated it to state and local entities; putting it in the hands of the medical profession itself would assuage fears about arbitrary dictates from the federal bureaucracy. Less than a decade after policymakers, with nary a word of discussion about fee schedules, had declared that Medicare would retrospectively pay physicians and hospitals their usual and customary charges and actual costs, there was little

Exhibit 1
Matrix Of Regulatory Models

<table>
<thead>
<tr>
<th>Type of regulation</th>
<th>Decentralized behavioral</th>
<th>Decentralized budgetary</th>
<th>Centralized behavioral</th>
<th>Centralized budgetary</th>
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<tr>
<td>Professional Standards Review Organizations (PSROs)</td>
<td>Rate setting</td>
<td>Peer Review Organizations (PROS)</td>
<td>Prospective payment system (PPS)</td>
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<tr>
<td>Health Systems Agencies (HSAs)</td>
<td></td>
<td>Practice guidelines</td>
<td>Resource-based relative value scale (RBRVS)</td>
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<td>Certificate of need (CON)</td>
<td></td>
<td>Outcomes research</td>
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taste for direct intervention in payment mechanisms. Nor did the regulatory designers view their programs as leverage for broad changes in the larger system. Rather, the premise was that inappropriate and unnecessary utilization by physicians, and unjustified expansion and acquisition by hospitals, produced waste (and thereby raised costs) in an otherwise sound—indeed admirable—health care system. Regulation meant determining and dispelling waste at the system’s margins.

**Decentralized behavioral regulation.** The early ventures in decentralized behavioral regulation reflected these political constraints. The Professional Standards Review Organizations (PSROs) countered the angry charges of organized medicine that the feds were concocting “cookbooks” by authorizing funds to sustain about 200 community- or state-based organizations run by local doctors (usually meaning state or local medical societies) themselves. The organizations’ work posed little or no threat to physicians’ incomes. The PSROs established norms and standards for various diagnostic categories and applied them to individual cases of hospital use (mainly lengths-of-stay under Medicare and Medicaid) in hopes of identifying and deterring outlying physicians. In effect the program enshrined usual- and customary practices as norms. Sanctions (seldom applied) fell mainly on patients for whose continued hospital days Medicare’s fiscal intermediaries might refuse to pay if the physician’s recommended length-of-stay failed to pass muster; The program was in no sense an assault on the larger system. Its main purpose was simultaneously to contain costs and to enhance quality by disallowing decisions that physicians could not justify when queried by a reviewer (usually a nurse employed by the hospital on whose medical staff physicians served).

The Health Planning and Resources Development Act of 1974 set similarly modest regulatory goals for the Health Systems Agency (HSA) network it established and for the certificate-of-need (CON) programs it required of the states. The HSAs were regional bodies subject to federal rules and guidelines but were governed by large, multi-interest boards of consumers and other groups from the community and were accountable to statewide planning bodies and coordinating councils. The act expanded provisions of Section 1122 of the Social Security Amendments of 1972, which authorized state planning agencies to review hospitals’ expansion and modernization plans. (If these plans were insufficiently justified, they could be deemed ineligible for capital reimbursement in Medicare and other programs.) The CON requirement instructed those states (about half of them in 1974) that had not yet enacted a CON program to do so or face federal penalties. The HSAs were assigned to forge a more rational link between needs and resources in their commu-
nines, but (despite the hopes of some that they would become vehicles of budget allocation in a national health insurance scheme) they controlled no resources. The CON program reviewed hospitals’ plans to expand, modernize, and buy equipment; it issued approvals based on the merits of each case, inquiring whether each proposed project was in fact “needed” by the community. Although the HSAs were health “systems” agencies, they had little leverage on the system’s components, let alone over the system as a whole, and the CON programs were not intended to rationalize the hospital system, only to reject the occasional wasteful proposal by individual players within it. By raising questions or withholding endorsement, community and consumer forces sometimes used the leverage of the HSA and CON processes to force providers to bargain over new priorities—new preventive or primary care programs, for example—but these were generally incremental victories at the system’s margins.5

The decentralized behavioral regulatory programs, in short, let the federal government “do something,” but something that kept political conflicts well removed from Washington, upset the system (and its providers) as little as possible, and wore a halo of professional and community self-regulation and (therefore) of scientific and democratic decision making. Providers (especially physicians) denounced these federal regulatory intrusions, but the programs’ design offered effective insulation. Who could object to modest federal efforts that merely empowered state and local providers and consumers to attack wasteful use of resources in a system that had undeniably grown too expensive?

Decentralized budgetary regulation. Behavioral regulation was the federal government’s earliest preferred strategy in part because it posed little threat to the system’s economic interests. It is thus hardly surprising that such budgetary regulation as emerged in the early 1970s was restrained indeed. With the minor exception of hospital payment limits initiated in Section 223 of the Social Security Amendments of 1972, Washington established no budgetary regulation programs at all. In Section 222 of those amendments, it simply authorized the Department of Health, Education, and Welfare to waive Medicare payment rules for states that wanted to experiment with new hospital payment systems (among other innovations) that promised to cost the federal government less than did the standard arrangements.

The states’ responses were decidedly limited. Comprehensive systems of hospital rate setting emerged mainly in northeastern states (Connecticut, Massachusetts, New Jersey, and New York), plus one semi-southern state (Maryland) and one west of the Mississippi (Washington). In these states, political entrepreneurs, troubled by rapidly rising
health spending, saw in the prospective setting of hospital rates and revenues a plausible corrective. Slower growth of hospital spending did, of course, threaten hospitals, and political leaders found it necessary to ease their fears. In Maryland and Washington State, for example, industry leaders worked with state officials to fashion rate-setting legislation. Hospital association heads believed, and persuaded their constituents, that federal rate regulation was on its way and that they might claim exemption for their homegrown systems when that unhappy day arrived. New Jersey rate setting was, among other things, a device to redistribute resources to faltering urban hospitals in Newark, Trenton, and Jersey City. In Washington State, rate setters viewed themselves more as management consultants assisting clients than as public taskmasters controlling public utilities. Most rate-setting states agreed that the program would not be a weapon to promote downsizing of the hospital sector; only New York used rate setting to force closures. The political logic of the coalition that supported decentralized budgetary regulation was essentially the same as that behind its behavioral counterpart. Political leaders (in this case, state based) could claim credit for savings realized by eliminating “waste and inefficiency;” reform-minded providers (in this case, in the hospital industry) could assure indignant constituents that a modest regulatory encumbrance would forestall measures that might assault incomes and revenues more aggressively.

Budgetary regulation began its political life as largely nonfederal (feds approved the waivers and offered advice but did not impose detailed blueprints), nontime-threatening, and nonnational. The feds could overcome their timidity when properly motivated—for example, in the Nixon administration’s Economic Stabilization Program (ESP), which imposed wage and price controls on much of the economy, including hospitals, as a temporary check on inflation. When controls came off, however, hospital spending rose rapidly in a race to recoup, proving, Karen Davis and colleagues write, that “long term measures were required to control health care cost inflation.”

The fate of President Jimmy Carter’s call for extensive centralized budgetary regulation demonstrated, however, that the system was unprepared to embrace such measures. In April 1977 the Carter administration proposed legislation that would impose national limits on the annual revenue increases hospitals could accrue and on the volume of capital spending the industry could undertake. Hospitals and organized medicine fought the plan vigorously, and many legislators decried this great leap forward into federal regulation. In November 1979 the plan breathed its last as about 100 House Democrats defected from the president’s position to vote against it. The 1970s closed with a limping,
lingering legacy of state and local behavioral regulatory programs, a half-dozen cautious state rate-setting programs, and a resounding legislative rejection of tougher federal measures.

Centralized behavioral regulation. Decentralized regulation, mainly behavioral, was a plausible compromise throughout the 1970s for a society whose health care purchasers distrusted government and regulation but faced rising costs they did not know how to contain otherwise. The defeat of Carter’s centralized budgetary plan at the end of the decade showed that uncontrolled spending was not a sufficient motive to make public (or private) purchasers rethink their antiregulatory animus, but the problem remained: The decentralized programs were not doing enough to curb costs.

Policymakers responded in four main ways in the 1980s: They abandoned some decentralized initiatives, centralized others, added new centralized schemes to regulate provider behavior, and began to embrace centralized budgetary regulation. First, the commitments to planning and capital expenditure review embodied in the planning act of 1974 came under sharp attack in Ronald Reagan’s first term (1981-1985) and finally lost their legislative authorization in 1986. The aim of planning was to bring community resources better into line with needs, but without budgetary leverage it often proved to be an exercise in frustration for its myriad participants. The CON requirement for capital expenditure review was dismissed as an unjustified federal imposition on the states, a barrier to supposedly salutary competitive dynamics, and a strategy with few cost savings to show for its cumbersome bureaucratic demands. The states were free to retain HSAs and CON programs with their own funds (that a majority kept CON suggests that it had become a comfortable part of the political furniture), but federal regulation of hospital behavior (as distinct from budgets) diminished.9

The PSROs were no more stellar performers than were the HSAs and CON programs, but Congress was unwilling to drop this approach to utilization review from its regulatory portfolio. One reason may be that planning and CON emerged from the House Commerce and Senate Human Resources committees and had no direct connection to Medicare use and spending, whereas the PSROs were the progeny of the House Ways and Means and Senate Finance committees and had at least the potential to register immediate savings in Medicare. Potential was one thing, practice another; and most observers agreed that the implementation of the PSRO program had not been a pretty sight. Many of the local organizations had foundered amidst organizational complexities, including the quest for strong medical leadership and staff; they were never clear how to balance quality assurance with cost con-
tainment and had moved slowly, often in the face of hostility, to implement review procedures in local hospitals. Evaluations in the late 1970s suggested that the program had, on balance, probably cost about as much as it had saved, and the Reagan administration was eager to end it.

Congress could retreat from behavioral regulation of hospitals because it had (in 1983) adopted a new system of budgetary regulation, the prospective payment system (PPS), which it expected to work better. It was not prepared to ax behavioral regulation of physicians because it had (then) no promising substitute. (Despite growing talk of tightened fee schedules, the resource-based relative value scale [RBRVS] did not make its way into policy until 1989.) Dissatisfied with the PSROs but unwilling to scrap utilization review by physicians’ peers, Congress imposed stronger central control over the effort. The Peer Review Organizations (PROs) that replaced the PSROs were made statewide in scope; the grants awarded to the PSROs were supplanted by competitive contracts let by the feds to PROs; and Washington’s determination to see savings was made clear. The central government was beginning to lay a firmer guiding hand on the micromanagement of physicians.

The PROs, like the PSROs before them, drew support from a coalition that included fiscal conservatives who believed that physicians should dutifully stand watch over Medicare spending, political liberals who wanted to establish and extend the principle that the federal government should regulate physician behavior (even if that meant, initially, that the foxes would guard the hens), and a small subset of physicians who argued that behavioral regulation by peers could head off worse intrusions—behavioral regulation by bureaucrats, budget regulation, or both. The strategy, however, proceeded from a conceptual premise that grew more problematic over the 1980s. The PROs, like most utilization review schemes, proceeded as if standards distilled from prevailing practice norms, used to catch overutilizers, constituted a coherent regulatory technology. But John Wennberg and others showed that medical practice norms were highly erratic and often inexplicable, and others were insisting that cost problems should be attributed not (only) to high rollers but (also) to excesses imbedded in the norms themselves. Effective behavioral regulation of physicians, it seemed, would require a new conceptual foundation as well as stronger central direction.

Pressing these arguments, health services researchers urged the federal government to take the next logical step, namely, to support development of medical practice guidelines and outcomes research. These arguments appealed to the key coalition elements that sustained the PSROs and PROs. Conservatives thought it wise to help physicians heal themselves for the fiscal benefit of Medicare. Some liberals assumed that
outcomes research and guideline development would document and dramatize massive irrationalities in the system and, by discrediting it, build a case for stronger public regulation. Physician reformers liked the notion that professional self-education and reform could head off tougher reforms. In 1989 Congress transformed the National Center for Health Services Research (NCHSR) into the Agency for Health Care Policy and Research (AHCPR) and instructed it to launch the development of medical practice guidelines and to make awards to Patient Outcomes Research Teams. As the 1980s ended, the federal government had left decentralized behavioral regulation largely to state Medicaid programs and the private sector (which, unable or unwilling to constrain price, sought to win savings by means of volume controls such as utilization review); had shifted its main regulatory encounters with hospitals onto budgetary terrain; and had centralized and expanded its efforts to regulate the practices of those captains of the medical team, physicians.

Centralized budgetary regulation. Policymakers show an understandable ambivalence about the proper focus of regulation. In budgetary terms, hospitals are the biggest spenders, which argues for regulating them—but what happens in hospitals largely reflects the decisions of physicians. This ambivalence is easily resolved: Policymakers have fashioned programs to regulate both hospitals and physicians. Choosing suitable modes of regulation introduces further complexities, however. Although regulation of both physicians and hospitals evolved toward greater centralization as costs failed to respond sufficiently to federal efforts, the two sectors were regulated differently. Physicians faced increasingly centralized behavioral regulation (and an important new form of budget regulation since 1989, the Medicare fee schedule using the RBRVS), whereas in the 1980s hospitals traded off some behavioral regulation for a new central budgetary system (PPS).

In 1980 federal health regulation was mainly decentralized in locus and behavioral in focus. Policymakers’ distaste for centralized budgetary regulation had been proved in 1979 by the defeat of the Carter plan. But before the 1980s ended, Washington had embraced centralized budgetary controls for both hospitals and physicians in Medicare. Why?

One explanation for this change in policy course is that central budgetary regulation seemed to be the sole feasible antidote to cost problems in Medicare that steadily grew worse during the 1980s. First, it answered a clear call to arms, a sense that an urgent problem demanded a forceful federal response. (Congress had earlier adjusted payment rules to brake Medicare hospital spending in Section 223 of the 1972 Social Security Amendments. The section subjected actual cost payments to
efficiency tests that compared the cost patterns of hospitals with those of their peers, to identify excesses. The Section 223 limits encouraged the federal government to develop and refine its data and methods for paying hospitals, but they “never generated significant savings.”

In the early 1980s Medicare costs were shooting up, and increases in hospital spending (nearly 18 percent in 1981) were the most conspicuous element in a health budgetary picture that aggravated a growing federal deficit. In the late 1980s Medicare costs still rose unacceptably, but PPS had slowed the growth of the hospital component; spending on physician services stood out like the proverbial sore thumb. In both cases policymakers agreed that these trends could not continue, and this agreement prompted them to take a fresh look at the uses of budget regulation.

Second, the programs drew strength from a growing consensus that the central government had to be part of an effective solution. Responding to President Carter’s cost cap plan, the hospital industry declared a Voluntary Effort (VE) to prove that it could slow the rise of costs without federal regulation. The effort failed, and it did not help the industry’s cause that the beginning of the end of the VE coincided closely with the political demise of the Carter proposal. The Reagan administration then promised to introduce comprehensive market-based reforms that would avert the need for regulation, but it too failed to deliver. By 1982 most Washington notables agreed that if hospital costs in Medicare were to be checked, the federal government must take the regulatory lead. Likewise, in the mid-1980s some analysts predicted that the physician surplus would, by expanding the supply of providers, bring cost increases down and that the spread of alternative delivery systems would discipline physician costs. By 1989 neither market-based theorem looked plausible, clearing away important ideological obstacles to an expansion of the federal regulatory agenda.

Third, a potent body of research suggested that if regulation were the most plausible strategy at hand and the central government an indispensable player, budgetary models would best repay its efforts. In the 1970s HEW had launched research on the results of the state rate-setting experiments it had encouraged. Even as the evaluative literature challenged the cost-effectiveness of the leading forms of behavioral regulation (PSROs, HSAs, and CON), researchers contended that hospital rate setting in the half-dozen states with mature, strong programs had held the annual rate of increase in hospital spending to 3 percent or so below the national average. In the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, Congress set the foundations for a new prospective payment system. Then, coupled with an appealing analytical model
proposing diagnosis-related groups (DRGs) as a basis for payment, the evidence spurred policymakers to approve PPS for Medicare in 1983. Similarly, the RBRVS reform of 1989 drew on a decade of work by researchers at the Harvard School of Public Health and promised both to save money and to improve equity in Medicare physician payment.

Conclusions And Prospects

Past patterns. Several patterns emerge from this survey of the past twenty years of federal health care regulation. First, although the proclaimed ideology of the (non-Carter) executive branch and much of Congress over the decades has scorned regulation in favor of competitive strategies, the reach of regulation in the health care system has grown steadily larger and shows no signs of shrinking. Second, over these years federal policymakers have declined to choose decisively between behavioral and budgetary strategies and have adopted increasingly stringent measures of both. Third, notwithstanding this superficial parity between approaches, behavioral regulation has waxed for physicians and waned for hospitals, while the big news in both sectors was the arrival of new budgetary schemes in the 1980s. Fourth, although devolution of federal activities to the states has been an article of faith in Washington for most of these years, health care regulation has grown steadily more centralized over time. (The pattern is clearer for Medicare than for Medicaid, in which states’ discretion has increased considerably since 1981. On the other hand, the arduous process of winning federal waivers to use this discretion has been a powerful brake on devolution.) Fifth, a constant political dynamic appears to guide this process. The federal government, leery of regulation but seeing no practical alternative to it in the face of soaring Medicare and Medicaid expenses, enacts modest regulatory programs over the protests of indignant providers. The programs prove too feeble to curb spending, however, and so policymakers both expand and centralize regulation, now with the grudging acquiescence of (many) provider groups, who fear that the fiscal meter is running too fast to forestall more threatening plans—including assaults on incomes—if the current crop of programs do not deliver savings.

The decentralization programs, in short, contributed impressively to political evolution if not to economic efficiency. They taught providers that federal interventions did not mean the end of their professional world and that they must and could learn to play in a new policy game. Likewise, they showed policymakers the limits of regulatory endeavors that deferred heavily to state and local forces, building new-albeit grudging-legitimacy for firmer central measures. By promoting educa-
tion, cooperation, and—not least important—resignation, these programs eased the transition to a larger governmental role, which might not have won acceptance without these trials and errors in the laboratories of federalism and localism.

**Current trends.** Considering that health care regulation was approached with fear and trembling twenty years ago, federal policymakers deserve credit for compressing a remarkable body of innovation into a notably brief political interval. Nevertheless, the glass remains at least half empty. Physicians face substantial behavioral regulation, but all of the micromanagement may be more cumbersome than effective and may not justify its addition to the nation’s sizable administrative costs. Utilization review varies in rigor and results from site to site, and the efficacy of medical practice guidelines and outcomes research is as yet unknown. Although the adoption of the RBRVS fee schedules in 1989 is surely a regulatory landmark, the scheme addresses only the Medicare program, leaving abundant openings for variation in physician practices and charges and making little fundamental dent in incomes. Likewise, Medicare’s hospital PPS was a regulatory departure of the first importance and has registered some significant savings. But PPS remains a relatively small first step down the road of budgetary regulation, for it retains per case payments unconstrained by any type of global budget and, like the RBRVS, applies mainly to Medicare.

Despite all the innovation, few analysts or budgetmakers are content with the results of this delimited federal health regulation, and few regard it as stable. The controls imposed by these programs, although strengthened over time, are too weak to prevent unacceptable increases in federal spending on Medicare and Medicaid. And the federal government’s alacrity in devising regulatory programs that promise savings to itself while letting the devil take the hindmost among other payers spurs cost shifting and growing consternation among the private payers afflicted by it. Notwithstanding the myriad competitive and regulatory innovations of the past twenty years, the U.S. health care system remains astonishingly laissez-faire. Providers, payers, and purchasers (including levels of government) continue to play largely by “rules” they set themselves. The central policy question is, Will these and other stakeholders recognize the need for an end to laissez-faire and cooperate in the transition to a new political order?

The United States arguably has gone about as far as it can with partial, segmented regulation and will need to move to a centrally constrained health budget coupled to policies that frame the health care “game” with a clear, firm set of rules that are binding on all payers and players. Foreign systems offer a rich menu of options for doing so.
aside, most such systems incorporate two basic elements. First, they set a framework for structured negotiations between purchasers ("sickness funds," government, or both) and providers (physician and hospital associations or individual hospitals) to establish fee schedules and payment rates. Second, in part because such negotiations are a necessary but insufficient means of holding costs in line, they discipline negotiations by imposing on them some form of global cap on health care spending— for example, the public budget itself (Britain, Canada, and Italy), a "global envelope" that links growth of health spending to growth of the economy (France), or rules that tie allowable health cost increases to increases in employee income (Germany). With these potent (although not foolproof) budgetary controls in place, these societies largely eschew clinical micromanagement and behavioral regulation. Indeed, the United States is probably the most heavily regulated system in the world, from a clinical standpoint.

What are the prospects that the United States will soon take the next steps toward "real" budgetary regulation? The three variables that helped to explain the adoption of limited central budgetary regulation in the 1980s may illuminate whether it will be expanded in the 1990s.15

Demand for change. First, the call to arms—the sense that a pressing problem demands an imminent policy response—has spread well beyond the confines of federal budgetmakers to the electorate. In 1992 the old story of rapidly rising health care costs has been coupled with fresh bad news, namely, the apparent "unraveling" of the health insurance market and growing fear among middle-class voters that they and their families will not be able to retain affordable, acceptable coverage. As the cost of health care occupies a higher position on the national political agenda, some observers sense the impending arrival of "real" budgetary regulation in a larger policy package designed to achieve affordable universal coverage. The failures of twenty years of cost containment policy may have come home to roost. The political pressures for relief will mount along with rising costs, as reflected in the insurance premiums and packages of millions of voters. Relief cannot be delivered without tough measures. The 1990s may well mark the beginning of the end of the laissez-faire indulgences that still pervade much of the system.

Agreement on federal role. The second ingredient in health policy change—broad agreement that a strong federal hand in problem solving is inevitable—is more problematic. Above all, the continuing absence of strategic unity between public and private purchasers impedes forward motion. The federal government has regulated on its own behalf and has permitted unconstrained cost shifting to private purchasers. But the idea of working with the federal government to enlarge the scope of regula-
tion and give it new teeth remains ideologically distasteful to many corporate payers, so this crucial latent source of support for budgetary regulation is seldom manifested politically. Unwilling (or thinking themselves unable) to do much about the price they pay for health services, corporations have largely concentrated on controlling volume by cost sharing and behavioral regulation, which they view as both more directly under their influence and somehow more “American” than global budgets and such.

Business (and, for that matter, many in government) also shrinks from embracing stronger federal regulation, not only from an innate ideological aversion but also because many executives continue to believe that a competitive alternative would work better. So long as key public and private purchasers want to learn all they can about the potential of HMOs, managed care, managed competition, and purchaser networks that “buy right” before they swallow bitter regulatory medicine, they will not lobby for firm systemwide budgetary controls. The learning process may be glacial. The past two decades have shown that market-inspired hope springs eternal and that the variations on procompetitive themes are endless.

It is also far from clear that providers will welcome a federal assumption of broad budgetary controls or constraints. Providers have accepted some of today’s partial, limited regulatory programs in good part because they pose relatively little threat to physicians’ incomes and institutional revenues. A comprehensive system of structured negotiations within global budgets no doubt would strike at the growth (and perhaps the levels) of provider payments and would end cost shifting as a safety valve. Perhaps providers (especially physicians) would find systemwide budgetary regulation a good deal overall if it were linked to a major reduction in behavioral regulation and the nit-picking that goes with it. This seems to be the position of the American College of Physicians, which in September 1992 publicly endorsed “a national health care budget—a ceiling on total health expenditures,” as part of a larger package of carefully reasoned reforms.

The internists remain very much in the avant-garde, however. The American Medical Association (AMA) is far less enthusiastic about trading income growth for regulatory relief. Political leaders, having invested heavily in behavioral regulation as a vehicle of savings and (in the eyes of some) consumer protection, may not be willing to wipe that slate clean simply because new budget controls were in place. Private payers, too, as Alan Hillman points out, may not wish to abandon micromanagement strategies in which they have come to place hope, if not confidence. Moreover, precisely because caps and global budgets
force hard choices, they also force hard questions about value for money— to which practice guidelines, outcomes research, and the like may suggest answers (hence, the lively curiosity in foreign nations about these American inventions). It may therefore be too late to negotiate a sweeping behavioral/budgetary swap. A careful redefinition of the respective roles and missions of micro- and macromanagement is long overdue and perhaps even politically feasible, but it will trigger deep conflict over the proper scope and uses of federal power.

Consensus on a reform model. Third, even if a solid coalition of key players agreed that the federal government should forge ahead with central budgetary regulation, what strategic model would command practical consensus? Throughout the evolution of federal health regulation runs an insistent turning to science for guidance: clinical norms and standards (PSROs and PROS), formulae in bed-need methodologies (CON), planning theory (HSAs), diagnosis-related groups (PPS), and of course the RBRVS system now adopted for Medicare physician payment. Central budgetary regulation, however, forces policymakers to acknowledge the reality that scientific regulation allows them to mask: Putting a lid on society’s resource commitment to health services is a bald, bold political exercise. Global budgets and constraints, whether set by straight appropriations or embodied in rules that tie health spending to larger economic indicators, are basically crude; they draw on political will and wisdom, not scientific cleverness and calculation. If cost pressures continue unabated, even a society as distrustful of central government as the United States may come to agree that picking some cap and fine-tuning it over time is more important than picking the “right” cap as judged by econometric or other scientific standards.

A correlative problem of strategic model building is not conceptual but institutional. If a global budget or set of constraints is to be adopted, enforced, and refined, some formal body must be vested with the grave authority these tasks demand. Foreign examples suggest Ministries of Health or Concerted Action groups, but would these mechanisms work in a society that disdains both bureaucratic power and interest group liberalism? Devising an acceptable decision structure would not be easy, but innovations in the 1980s suggest that the problem would not be insuperable. The multimember Prospective Payment Assessment Commission (ProPAC) and Physician Payment Review Commission (PPRC) that have guided Medicare’s PPS and physician payment reforms, respectively, are arguably one of the major recent success stories of U.S. government. Balancing interests, distilling expertise, and guiding complex new programs into practice, these bodies have revised the old political-science wisdom that federal commissions are burial grounds.
devised by politicians who hope that endless talk will exhaust calls for action. These contemporary institutional precedents suggest that the feds probably could develop an acceptable analogue for the structured negotiations required for effective central budget regulation.

**Prospects for change in the 1990s.** On balance, it would seem that the political conditions for a major change toward central budgetary regulation are beginning to be realized. Given enough time, the policy pieces may fall into place by themselves, so to speak; cost pressures may grow so severe that reform becomes inexorable. In the near term, however, the prospects for change are highly contingent, and the underlying political dynamics are difficult to discern.

The traditional pluralist model of political change in the United States, highly popular in the 1960s, contended that change stemmed from percolating demands from social forces and public opinion, as filtered through group struggles in which supportive and opposed groups marshalled resources; policy outcomes reflected the balance of power. The health programs of the 1970s and 1980s reviewed here stood this model on its head. There was little popular clamor for any of these regulatory initiatives, and no strong supportive groups demanded them. Rather, the federal government discovered and promoted them—initially over the strong objections of powerful provider groups—in hopes of easing its own fiscal aggravations in Medicare.

Health politics in the 1990s seems to be emerging as an odd hybrid. One sees strong, mounting popular pressures for change, but the electorate's concerns and demands are amorphous, diffuse, and ill focused. The groups that once fought for programs such as Medicare—for example, organized labor and the elderly—are less influential or are preoccupied with other struggles, and the main organizational forces for reform are now groups (teachers, for example) outside the health arena that fear losing further resources to it. Provider and payer groups who once worked to veto change, meanwhile, are busily promulgating and publicizing their proactive proposals for universal coverage. Most of their plans, however, assign the costs of change mainly to actors other than themselves, and these innovators may grow sharply defensive if change threatens their incomes and autonomy.

Surveying this roiling scene, political leaders recognize that their efforts to concert action toward a happy resolution could easily boomerang. In principle, many no doubt find it tempting to sit back and wait for these many discordant social forces to develop some consensus, which leaders could then rush in to ratify. Such a natural equilibrium is unlikely, however, and the pressure on leaders to "do something" continues to build. Leadership has become a calculated risk that the next president
Political leaders have so far shown little taste for the political combat that strong central budgetary regulation triggers. They have done little to date to mobilize public/private purchaser partnerships, have been as infatuated with competitive alternatives as any disciple of Adam Smith within the corporate community, have preferred to narrow the scope of conflict with providers by avoiding both the theory and practice of systemic reform, and have not explained to the electorate the workings and implications of budget caps. If the political drive for affordable universal coverage grows irresistible, these patterns will change, but exactly how is anyone’s guess. President-elect Bill Clinton proposed to establish boards that will “set annual health budget targets nationally and state by state, to guide expenditures in the public and private sectors, to develop an all-payer reimbursement system, and [to] develop incentives and guidelines for global budgetary and other . . . reforms.”

The Bush administration, meanwhile, bitterly opposed global budgets, dismissing them as “metaphysics” and equating them with the collapsed planned economics of Eastern Europe (while ignoring their impressive record in Western Europe).

Unsurprisingly, perhaps, the future of federal health care regulation in the 1990s depends heavily on the outcomes of the 1992 and 1996 national elections. Nearly thirty years have passed since the United States enjoyed a sustained period of executive/legislative cooperation. Stalemate and deadlock are not intrinsic correlates of divided government. The explosion of health regulatory and other programs bears witness to that fact—but the steps taken in such times tend to be smaller than and different from those taken in more cooperative eras and leave an accumulation of big issues around which big coalitions cannot be constructed. If the 1992 and 1996 elections give the nation a president determined to push major changes in health care policy and a Congress whose partisan and ideological loyalties lie strongly with that president, the twenty-year evolution of health care regulation may appear in retrospect as incremental but steady steps toward inevitable progress. Early in his transition period, President-elect Clinton made both rhetorical and actual moves toward reestablishing cooperation between the White House and Congress. Such executive/legislative harmony is rare in U.S. politics, however, and an equally plausible prospect is that another decade or more of uncertain strategic evolution may be required before the United States decides to adopt, and adapt, the lessons of nations that have come as close to embracing purposive and coherent regulatory policy and making it work as now seems possible.
EVOLUTION OF REGULATION

NOTES


7. The politics of rate setting have been remarkably little examined. For one account, see R.B. Hackey, “Trapped between State and Market: Regulating Hospital Reimbursement in the Northeastern States,” *Medical care Review* (Fall 1992): 355-388.


11. For a comprehensive history of AHCPR and its evolution, see B.H. Gray, “The Legislative Battle over Health Services Research,” in this volume of *Health Affairs*.


