

# Health Care Cost-Containment Regulation: Prospects and an Alternative

Clark C. Havighurst, J.D.\*

## ABSTRACT

Regulation of the health care system to achieve appropriate containment of overall costs is characterized by Professor Havighurst as requiring public officials to engage, directly or indirectly, in the rationing of medical services. This rationing function is seen by the author as peculiarly difficult for political institutions to perform, given the public's expectations and the symbolic importance of health care. An effort on the part of regulators to shift the rationing burden to providers is detected, as is a trend toward increasingly arbitrary regulation, designed to minimize regulators' confrontations with sensitive issues. Irrationality and ignorance are found to plague regulatory decision making on health-related issues, even though it is the consumer who is usually thought to suffer most from these disabilities. The author argues that consumer choice under some cost constraints is a preferable mechanism for allocating resources because it better reflects individuals' subjective preferences, has a greater capacity for facing trade-offs realistically, and can better contend with professional dominance of the resource allocation process.

In view of the unlikelihood of regulation that is both sensitive and effective in containing costs, the author proposes that we rely primarily on consumer incentives to reform the system. A simple change in the tax treatment of health insurance or other health plan premiums, to strengthen consumers' interest in cost containment while also subsidizing needy consumers, is advocated. Steps to improve opportunities for innovation in cost containment by health insurers, HMOs, and other actors are outlined briefly.

## I. INTRODUCTION

Regulation to contain the costs of medical care is appropriately viewed as a response to a perceived failure of the "market" to allocate resources to,

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\* Professor of Law, Duke Law School.

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and within, the health care sector of the economy in accordance with the public's true wishes. The problem is not so much the absolute level of health care spending—although that is disturbingly high—as our increasing lack of confidence in the mechanisms by which the private sector decides what services should and should not be purchased.<sup>1</sup> Even casual observation reveals, on the one hand, large expenditures on care whose value is very much in doubt and, on the other hand, clear needs that are being neglected.<sup>2</sup> The desire to meet unmet needs is being frustrated by our recognition that giving the system more resources will simply encourage more waste as undue availability of resources induces the system to increase further both the quantity and the quality of its output without regard to the relation between marginal costs and marginal benefits. Cost-containment regulation, in seeking to prevent the misallocation of resources within the health care industry, ostensibly sets out to solve an important public problem.

This Comment seeks to provide an overview of the cost-containment effort in the health care industry in order that its substantial limitations and its more troublesome implications can be appreciated. My purpose is to dispel the optimism of those observers of regulation who tend to view its disappointing performance to date simply as a challenge to try harder and to invest more money in the effort. Moreover, because these observers persist in the belief that regulation is inevitable and that there is no choice but to redouble our efforts, I have also felt it necessary to argue that a better approach is in fact available. My view is that we would be well advised to regard the regulatory effort only as a stop-gap and to turn our major attention toward changing the incentives of consumers and providers and toward improving their opportunities to express their preferences in a competitive marketplace.

My objective in proposing an alternative that is preferable to regulation is to counteract, if possible, our political institutions' perhaps insuperable bias toward solving problems by direct regulation even when better solutions are readily available. In his recent Godkin Lectures at Harvard, Charles L. Schultze, the chairman of the President's Council of Economic Advisers, noted and deplored government's undue propensity to adopt a "black box" approach to social intervention, "grafting a specific command-and-control module onto the private enterprise incentive-oriented sys-

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<sup>1</sup> Economist Uwe E. Reinhardt describes the issue in this way, capturing the essential point that it is market failure, not cost alone, that matters. Address by Uwe E. Reinhardt, National Health Leadership Conference on Controlling Health Care Costs, Washington, D.C. (June 26, 1977).

<sup>2</sup> The classic demonstration of these problems, which reviews the technical literature, is A. L. COCHRANE, *EFFECTIVENESS AND EFFICIENCY: RANDOM REFLECTIONS ON HEALTH SERVICES* (1972).

tem”<sup>3</sup> instead of intervening to preserve and improve, and even affirmatively employ, market forces as instruments of social control. Health policy issues, so far treated as resolvable only by regulatory means, provide a dramatic illustration of Schultze’s thesis and a test of his hope that a “steady maturing of both the electorate and political leaders”<sup>4</sup> is improving our ability to make sensible choices between public regulation and private incentives.

## II. ASSESSING REGULATION’S PROSPECTS

Early doubts about the probable efficacy of regulation in the health care industry were somewhat unfocused because they were necessarily based on extrapolation from experience in dissimilar industries, such as those regulated as public utilities and common carriers.<sup>5</sup> Those early doubts were not wide of the mark, however, and accumulating evidence about health sector regulation has done nothing to dispel them. Indeed, whereas the early critics anticipated some beneficial impact from regulation and argued only that it would be woefully inadequate to the need, the most careful studies that have been done so far have shown practically no measurable effects.<sup>6</sup> But such early returns have not much dampened enthusiasm for regulation, because it is possible to argue that it is too soon to tell. But, of course, if we must wait for a conclusive demonstration of regulation’s inadequacies, it will then be too late to do anything about it—just as it is now virtually impossible to make major deregulation moves in those industries that came under regulation in the New Deal.

Because the impending choices in health policy could commit us irrevocably to a regulatory course, a new evaluation of regulation, moving beyond analogies to regulation in other industries, now seems in order. Although data are still inconclusive and experiments are still incomplete, we are nevertheless in a better position than ever before to evaluate health

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<sup>3</sup> Schultze, *The Public Use of Private Interest*, HARPER’S, May 1977, at 43, 44.

<sup>4</sup> *Id.* at 62.

<sup>5</sup> See, e.g., Havighurst, *Regulation of Health Facilities and Services by “Certificate of Need,”* 59 VA. L. REV. 1143 (1973); Noll, *The Consequences of Public Utility Regulation of Hospitals*, in INSTITUTE OF MEDICINE, *CONTROLS ON HEALTH CARE* (1975).

<sup>6</sup> E.g., Salkever and Bice, *The Impact of Certificate-of-Need Controls on Hospital Investment*, 54 MILBANK MEMORIAL FUND Q.: HEALTH AND SOCIETY 185 (1976); Hellinger, *The Effect of Certificate-of-Need Legislation on Hospital Investment*, 13 INQUIRY 187 (1976); Special Section, *Prospective Reimbursement*, 13 INQUIRY 274 (1976) (results here are mixed but hardly reassuring). Unpublished studies of the PSRO program, conducted under the auspices of the Health Services Administration of HEW, show negligible impact on utilization and costs.

This is not the place to examine these and other studies, which give rise to substantial disputes over methodology and other factors. The text statement is perhaps debatable, but the lack of demonstrable success is striking.

sector regulation on its own merits, with improved understanding of what it must seek to achieve and what specific obstacles it must confront. While the earlier analogies were useful in framing the pertinent questions, it is clear that health sector regulation is in many respects *sui generis*. Among other things, it employs some unusual and perhaps promising regulatory mechanisms—particularly the health systems agencies, or HSAs—which were designed in large measure specifically to avoid some of the problems which regulation has encountered in other settings and about which the early critics of regulation warned.<sup>7</sup> But, while such institutional factors may suggest that regulation in the health sector could outperform regulation in other industries, the cost-containment job that regulators have been asked to do with respect to health care is far from easy compared to other regulatory assignments.

### III. COST CONTAINMENT AS RATIONING

Although the regulators' task in the health care industry is variously stated, the job to be done involves nothing less than rationing health care—preventing patients from receiving and providers from providing care that they believe would be beneficial. This is not a regulatory function that will be popular with or easily understood by a public which has been told that there is a right to health care and which has come to expect a high standard of care and easy access to it.<sup>8</sup> In effect, the regulators have been charged with reducing, one way or another, what has come to be seen as the most tangible indicium of "quality" in medical care—namely the quantity of services rendered both in the individual case and in the aggregate. They have been asked to say "no" to more and better health services under circumstances where everyone immediately concerned in a specific treatment decision is inclined—because they do not face the costs—to say "yes." Although some means of limiting the consumption of health services is clearly required, public regulation may be incapable of achieving this specific goal.

The rationing objective is usually obscured in the rhetoric describing the function of various regulatory programs in the health sector. Thus, Professional Standards Review Organizations (PSROs) are said to be primarily concerned with the quality of care, not cost containment; under

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<sup>7</sup> The HSAs, as local planning agencies, could make an interesting difference if they were dedicated to "hard" planning, but there are many signs that planning methodologies are weak and that politics plays a predominant role. On the general problem, see Havighurst, *supra* note 5, at 1194–1204.

<sup>8</sup> Usually rationing involves simply giving equal portions to each within broad functional categories defined by objective circumstances. Rationing health care requires parcelling out medical services in accordance with relative need, which entails comparing incommensurables and making myriad social valuations, all in a context fraught with potential personal tragedy.

the banner of quality assurance some “unnecessary” care and “overutilization” can perhaps be eliminated, but the medical profession’s *de facto* control of PSROs assures that cost considerations and the rationing objective will be kept distinctly secondary.<sup>9</sup> Certificate-of-need agencies are usually charged with preventing “duplication” and forestalling the construction of “unnecessary” facilities but are seldom, if ever, publicly instructed to create artificial shortages; yet meaningful cost containment requires that supply be curtailed not to meet, but to contain, demand.<sup>10</sup> Similarly, the ostensible purpose of most hospital rate-setting agencies is to squeeze “inefficiency” out of the system, not to force hospitals to cut back services; nevertheless, some cutbacks are certainly essential if costs are to be appropriately controlled.

#### IV. RATIONING AS A POLITICAL “HOT POTATO”

The semantic obscurity under which regulation is practiced reveals the political and social touchiness of the subject being regulated. A powerful taboo surrounds public discussion of trade-offs between citizens’ lives and health on the one hand and the public’s financial resources on the other. This taboo causes regulators to be reluctant to fight many battles in the “quality/cost no man’s land”—that area where, although additional medical inputs are undeniably beneficial, there is real doubt that the benefits are worth the cost.<sup>11</sup> Even though effective cost-containment regulation seems to call for the sophisticated techniques of benefit/cost analysis, regulators will naturally shy away from such tools, because their use would require placing explicit values on individuals’ lives and health.<sup>12</sup> Given their political vulnerability, the lack of public understanding, and their own moral trepidation in the face of providers’ claims, regulators are unlikely to be able consistently and forthrightly to address the trade-offs involved in rationing health care and to have due regard for other uses of resources.

One consequence of regulators’ difficulties in challenging directly what

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<sup>9</sup> See Havighurst and Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 NW. U.L. REV. 6 (1975); Havighurst, Blumstein and Bovbjerg, *Strategies in Underwriting the Costs of Catastrophic Disease*, 40 LAW AND CONTEMPORARY PROB. 122, 150–53 (1976). These sources argue, among other things, that PSROs could “ration” better if they were seen not as regulatory agencies but as agencies to define and appropriately limit the coverage of federal health programs.

<sup>10</sup> Responses to a questionnaire recently circulated by the author indicated that 40 of 44 HSA administrators feel that “to eliminate duplication of services and save the costs of underutilized capital assets” is a better statement of the purpose of certificate-of-need laws than “to limit the availability of facilities as a means of forcing providers to make hard choices about their use.” See also Havighurst and Blumstein, *The Role of PSROs*, *supra* note 9, at 33–35; Havighurst, Blumstein, and Bovbjerg, *Catastrophic Disease*, *supra* note 9, at 145–50.

<sup>11</sup> See Havighurst and Blumstein, *The Role of PSROs*, *supra* note 9, at 17.

<sup>12</sup> See generally Havighurst, Blumstein, and Bovbjerg, *Catastrophic Disease*, *supra* note 9, at 138–53.

passes for "quality" in medical care is that, to be effective, regulation must somehow avoid addressing the medical merits of specific cases and concentrate on grosser forms of control. One reason why almost no one expects PSROs to make more than a marginal contribution to cost containment is that they purport to assess the medical merits of individual utilization decisions, which can usually be questioned only if one is willing to compare the benefits and costs of treating an individual patient. Much greater hope is currently reposed in limiting the availability of health facilities (through certificate-of-need programs) and the amount of hospital budgets (through rate setting), two approaches that impose resource constraints on providers and thereby shift to them the difficult task of rationing care among those who seek it. Indeed, regulation in the health sector has shied away from asking public authorities to make the hard case-by-case decisions and has moved in subtle ways towards making providers do the rationing. Precisely because the regulators, like Ado Annie in *Oklahoma*, "cain't say 'no,'" they have sought to shift the burden of doing so to the providers. The PSRO program does this explicitly, but certification of need and hospital rate setting programs do it as well.

The policy of forcing providers to do the rationing job is based on an unarticulated assumption that limiting the resources available to providers can induce them to allocate those resources to their best uses, providing those services that are most valuable to patients and omitting those services that are least valuable. But hardly any thought has been given to whether providers can realistically be expected to serve primarily public needs rather than their own preferences and values in performing this allocative function. Despite the lack of assurance on this score, regulation is being implemented in a way that perpetuates the very provider dominance which has produced excessive emphasis on high-technology acute care rendered in institutional settings while neglecting more routine needs of large populations and which has therefore been an important source of the health sector's problems in the first place. It is far from clear that the limited consumer participation provided for in health planning and resource development can overcome provider influence on any issue where the claims of "quality" are plausible.

Providers' economic interests and their traditional "cost-is-no-object" orientation make it doubtful that they can be counted on to cooperate fully in helping the regulators achieve their rationing objective. Indeed, far from sparing the regulators embarrassment in their efforts to limit the health sector's spending proclivities, providers can be expected to expose the regulators' veiled attempts to erode what providers will characterize as the quality of care. In exercising their substantial discretion in the allocation of regulation-limited resources, providers may find it convenient to threaten cutbacks in just those highly visible areas where the regulators are most vulnerable and under the most pressure to keep the resources flow-

ing. Thus, the politics of such regulation could easily produce a “hot potato” game in which providers are better insulated against political pressures and can force public decision makers to take the heat. Under these circumstances, socially appropriate stringency will not often be achieved.

## V. JUDGING REGULATION'S EFFECTIVENESS

Even the most pessimistic observer cannot be sure that regulation will be totally ineffective in the health care industry or that no change in the direction or pace of cost escalation will occur as controls take hold. Some regulators may prove adept in managing the political environment and in developing a constituency for cost-containment efforts, and some providers may adopt relatively responsible attitudes toward regulation and change their behavior in material respects. For these reasons, regulation sometimes will seem to have had a beneficial effect when compared with past experience in a particular area or with contemporaneous experience in places where regulation has been less skillful or providers more recalcitrant. But such apparent successes are likely to be marginal in magnitude and difficult to replicate universally. Proponents of regulation will nevertheless single out the more successful programs to prove the efficacy of their chosen methods and will view unimpressive average performance only as evidence of the need to try harder and to invest more money in the regulatory effort. They may also yield to the temptation to equate vigorous regulatory activity, such as frequent denial of certificate-of-need applications, with regulatory success, when in fact regulation may have had only minimal impact on its most important targets—that is, on cost and capital investment.<sup>13</sup>

Regulation will frequently seem advantageous because it is measured only against the alternative of doing nothing, not against other promising policies that might have been, but were not, tried. Indeed, when adopted at the national level, regulation forecloses experimentation, not only making success or failure hard to recognize but also making the optimum strategy undiscoverable. While it is quite possible that some kind of equilibrium eventually will be reached where pressures to control costs and pressures to increase them will be in rough balance, there is no reason whatsoever to

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<sup>13</sup> George Stigler and Claire Friedland have observed that “innumerable regulatory actions are conclusive proof, not of effective regulation, but of the desire to regulate.” Stigler and Friedland, *What Can Regulators Regulate? The Case of Electricity*, 5 J. LAW & ECON. 1 (1962). Counting applications and denials may be meaningless since multiple applications to build a certain facility or to invest the same funds are possible. Also, applications granted are not always acted on, suggesting that not all are equally serious. Furthermore, planners take credit for modifying proposals—e.g., cutting a 10-story hospital down to 5—yet applicants may have inflated their requests. Empirical studies are necessary to document real changes. Compare Salkever and Bice, *Impact of Certificate-of-Need*, *supra* note 6, with Bicknell and Walsh, *Certification-of-Need: The Massachusetts Experience*, 292 NEW ENG. J. MED. 1054 (1975).

think that the political processes yielding that result will have come anywhere near finding the socially optimal level of spending on health care. Instead, excessive spending on health care, buying too much of a good thing, is likely to continue as a direct consequence of the strategic advantage that providers enjoy as a result of their control of the high ground overlooking the quality/cost no-man's-land.

## VI. ESCALATING ARBITRARINESS IN REGULATION

Because it is unlikely that the present regulatory facade will be finally accepted as legitimizing the costs now being incurred, government, in seeking more effective control, can be expected to turn increasingly to its only available counterstrategy against providers' refusal to accept the rationing burden. That strategy is to move toward more arbitrary forms of regulation, thereby reducing the potential for confrontations with providers over specific quality/cost trade-offs and increasing the necessity for providers to accept without recourse the unwanted burden of rationing services. This expectation of escalating arbitrariness is confirmed by the Carter Administration's recent proposals to put a 9 percent "cap" on annual hospital cost increases and another "cap" on aggregate capital investments by hospitals.<sup>14</sup>

Arbitrariness of the sort reflected in the Carter proposals can be publicly justified only by charging providers with gross irresponsibility, and Secretary Califano's assertions about the "fat" and inefficiency in hospitals,<sup>15</sup> although a distortion, can be seen both as an attempt to justify extreme measures and as an expression of frustration about regulatory achievements to date. Indeed, the Carter proposals are themselves a confession of the failure of the regulatory approaches originally conceived for the health sector. Although regulation was intended to embody a toughminded, planning-oriented approach to medical care, this has not materialized and, for the reasons stated above, seems not to be in the political cards. Judging from Secretary Califano's remarks, it may be that, rather than face the hard trade-offs openly on their merits, government regulators will find it politically preferable to appear overtly antiprovider, even dictatorial, and to have their adverse impacts on "quality" chalked up to general obtuseness rather than to callous cost-consciousness in resolving health care spending issues on a case-by-case basis. Even though such

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<sup>14</sup> "The Hospital Cost-Containment Act of 1977," H.R. 6575, 95th Cong., 1st Sess. (1977). Another current example of emerging arbitrariness in regulation is National Guidelines for Health Planning, 42 Fed. Reg. 48,501 (1977). See "Numbers Game" by HEW Concerns Critics of Draft Guidelines for Health Planning, HEALTH PLANNING AND MANPOWER REPORTS, November 28, 1977, at 2.

<sup>15</sup> E.g., Interview with Joseph A. Califano, Jr., Secretary of HEW, on NBC's "Today" Show (October 11, 1977).



arbitrariness may in fact be the most responsible regulatory policy because it is the most likely to be effective, the courts may be hard to convince that they should tolerate regulation that misrepresents the facts and avoids the hard decisions. But too much "due process," openness, and explicitness will preclude stringency, which, although socially appropriate, is politically unpalatable.<sup>16</sup>

The scenario of escalating arbitrariness as a strategic response to providers' ability to force the implications of health care spending issues into the open leads ultimately to an approach similar to that offered in Senator Kennedy's proposed Health Security Act: a fixed budget for the health care system as a whole. While achieving absolute control over total health care costs, that proposed solution would leave internal allocation of the system's resources largely to political processes that are extremely difficult to assess. Many of the same intractable decision-making difficulties that currently exist would remain, and it seems likely that, despite all efforts to introduce citizen participation, providers would continue to exercise disproportionate influence over the uses to which resources are put, if not over absolute levels of spending. Thus, despite long experience with a fixed budget and central planning, the British National Health Service remains more heavily committed to high-technology acute care than seems appropriate given that system's limited resources and unmet needs in such areas as long-term care for the elderly, the chronically and mentally ill, and the handicapped.<sup>17</sup> Even if professional influence could be overcome in the world of Health Security, it is unrealistic to think that a public consensus exists about the standard and style of medicine to be provided. Treating the allocation of health care resources as a subject for political compromise means depriving some of what they would willingly purchase and giving others what they would not, even if their resources were adequate. Moreover, the equality among income classes striven for in such a system could easily prove more symbolic than real, as qualitative differences prove resistant to change.

## VII. REGULATION VERSUS PRIVATE CHOICE

Health care varies greatly in value, some of it being of priceless benefit and other care not being, in any defensible sense, worth its cost. Although

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<sup>16</sup> See Havighurst, Blumstein, and Bovbjerg, *Catastrophic Disease*, *supra* note 9, at 155-57; Blumstein, *Constitutional Perspectives on Government Decisions Affecting Human Life and Health*, 40 *LAW AND CONTEMP. PROB.* 237 (1976).

<sup>17</sup> See R. CROSSMAN, *A POLITICIAN'S VIEW OF HEALTH SERVICE PLANNING* 26 (1972); Bosanquet, *Inequities in the Health Service*, 17 *NEW SOCIETY* 809, 912 (1974). Moreover, even though Britain has achieved a commendable emphasis on primary care and family practice, this allocational success resulted more from the preexisting and largely fortuitous subdivision of the medical profession into consultants and general practitioners than from any special success in combatting professional solidarity or in changing professional values.

versions of this long-neglected insight have been increasingly embraced in health policy discussions in the 1970s, its full implications have yet to sink in. For example, many observers who give lip service to the insight that only limited benefits are yielded by much health care remain fervently attached to the symbolic goal of comprehensive benefits and equality of access to high-quality services. Yet the emerging sophistication about health care's value should suggest placing less emphasis on providing the poor with an ideal standard of health care and more emphasis on providing them with other things, many of which, such as better housing and nutrition, might be more productive of improved health.

The new awareness about medicine's uncertain benefits also has yet to overcome the tendency of policy makers and other observers to disparage private choices between health care and other things. Yet increasing skepticism among commonly recognized authorities about the value of health care at the margin suggests (1) that the range and subjectivity of consumers' preferences with respect to medical care does not necessarily signify consumer ignorance or irrationality and (2) that different people can come rationally to different conclusions about what quantity and quality of services to buy. Although individual consumers' decisions can always be questioned, most consumer choices are made with the benefit of professional advice, or by employment (or other) groups whose sophistication cannot be doubted. Moreover, private choices are made with information concerning personal preferences that obviously is not available to anyone except the individuals involved. In a democratic society, private decisions might be viewed as having comparative or even absolute legitimacy on this account alone.

As a substitute for private decisions, regulation leaves much to be desired. Not only does it suffer from almost totally irremediable ignorance about individual cases—both the precise medical circumstances and the subjective preferences of the parties affected—but it also lacks data on societal preferences concerning the value of health care in comparison with other possible uses of society's limited productive capacity. Although it is common to attribute irrationality only to consumers, it is clear that irrationality systematically afflicts health system regulators because politicized regulation allows symbolism to overwhelm forthright benefit/cost comparisons. Moreover, the interest-group bargaining implicit in the American concept of regulation perpetuates a high degree of provider influence, leaves out many other pertinent values and interests, and assigns weights on the basis of "clout," not merit. It is doubtful that health sector regulators can earn higher marks for knowledge, rationality, general soundness, or democratic validity than consumers making decisions with professional and other available advice and under appropriate incentives to conserve resources.

Regulation is failing to solve the resource allocation problem in the

health sector because it proceeds on wrong premises concerning the capabilities of public decision makers. But, even if it should succeed in imposing effective controls, it would do so at the expense of important values. While holding out the promise of a "right to health care," it would simultaneously define that right narrowly and arbitrarily and would almost certainly deny or indirectly curtail the consumer's right to purchase care that he might wish to have but which the regulators chose not to make available. Regulation's chief tendency is thus toward narrowing consumers' range of choice, enforcing a false consensus, and obscuring the wide variations that exist in both consumer preferences and medical practice. Contrary to what both the political debate and professional ideology imply, there is no "one right way" to deal with most health problems. Rather than relying on government alone to chart our course, it may seem more appropriate in a pluralistic society to widen opportunities for consumer choice under meaningful cost constraints.

#### VIII. OUTLINE OF A MARKET ALTERNATIVE

As some of the foregoing truths begin to dawn, the logic of turning resource allocation decisions in the health sector over to public decision makers may no longer seem as unassailable as it once did. At the very least, we should be led to look with renewed interest at the possibility that workable alternatives to regulation may exist. If they exist anywhere, they most likely lie in the direction of strengthening market incentives and assuring competition at critical points in the market for health services and health services financing. Although this Comment is not the place to make the complete case for a new departure in health policy,<sup>18</sup> it should at least be observed that a case can be made for seeking to improve the private market's resource-allocation capability through a program based on the following elements:

(1) *Change in the tax law to eliminate the current incentive to overinsure against health care needs.* Although seldom recognized as the distorting force it is, the tax law is a major contributor to unwarranted cost escalation in the health sector. By making health insurance a tax-free fringe benefit for both income tax and Social Security tax purposes, the tax law has long stimulated the purchase of more insurance—that is, more comprehensive coverage—than people would otherwise purchase. This excessively comprehensive insurance has in turn increasingly allowed providers to pre-

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<sup>18</sup> For a fuller discussion of this issue, see Havighurst, *Controlling Health Care Costs: Strengthening the Private Sector's Hand*, 1 J. HEALTH POLITICS, POLICY & LAW 471 (1977); Havighurst, *The Role of Competition in Containing Health Care Costs*, Address to the Federal Trade Commission Conference on Competition in the Health Care Sector, Washington, D.C. (June 1-2, 1977).

scribe and render more services of a more expensive variety than people would be willing to pay for out of pocket, thus misallocating resources. Even more importantly, the tax law penalizes health insurers' cost-containment efforts by taxing as wages any saving in health insurance premiums that an employer might pass on to his employees. For these reasons, the prevailing belief that regulation is required to solve the cost problem, because the private sector cannot do the job, is in large measure traceable to the tax law's excessive subsidization of health insurance.

To correct the problem, it is not necessary to eliminate the tax subsidy altogether, but a limit on the amount of the subsidy is essential to deter excessive coverage—by making it purchasable only with after-tax dollars. A shift to a system of limited tax credits could achieve the desired effect without increasing the tax bill of the average taxpayer. Moreover, the subsidy thus provided would be uniform for all taxpayers, instead of larger for those in higher brackets, and would cause underinsured persons to increase their coverage. By allowing lower-income people larger credits and refunding the credit in cash if the tax due did not absorb it, a kind of "national health insurance" could be achieved. Most important, use of tax policy as a vehicle for national health insurance would strengthen, rather than destroy, private incentives for cost containment and reduce, rather than increase, the need for regulation.

(2) *Encouragement of active competition between and among health insurers, HMOs, and new models of health care financing and delivery, such as Dr. Paul Ellwood's "health care alliances."*<sup>19</sup> It is in choosing a prepaid health plan or health insurance coverage that consumers are in the best position to give effect to their preferences and to face, at least indirectly, the trade-offs among the quantity, quality, efficacy, style, and cost of services. It is important to realize that, partly because of the tax-induced distortions of demand described above, competition among health plans has in the past been weak in stimulating innovations to contain costs, and many promising approaches have heretofore never been tried. Private cost-containment efforts, while a kind of rationing, are preferable to public controls because they are essentially consensual, not coercive, and permit the benefits of economizing to accrue to the affected group. The sensitive politics of cost containment, though still a factor in the administration of private controls, are less likely to prevent appropriate levels of stringency from being approached.

(3) *Removal of legal and other restraints on innovation in cost containment by employers, unions, health insurers, and others.* Aside from the tax laws, the greatest obstacles to private cost-containment initiatives are the restraints

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<sup>19</sup> See *A New Scheme to Force You to Compete for Patients*, MEDICAL ECONOMICS, March 21, 1977, at 23.

long practiced by members of the medical profession against unwanted limitations on their freedom to ignore costs. The antitrust laws are conveniently available to overcome such restraints and clear the way for competitive innovation by insurers and others.<sup>20</sup> With the antitrust laws and competition at work, provider dominance could be undercut to a degree not possible in a regulated system. Indeed, it is an important insight that, in a system dominated by government, concerted political action by providers is constitutionally protected and bound to have a powerful effect, whereas in a market-oriented system providers are prohibited from taking collective action to prevent change in the consumer's interest.

(4) *Change in the means of subsidizing the purchasing power of Medicare and Medicaid eligible persons so as to allow their cost consciousness to play some part in the containment of health care costs.* A voucher system (or a system of refundable tax credits) could be designed to permit Medicare and Medicaid beneficiaries to exercise, within limits, a choice between additional health benefits and cash. Although it seems sensible to encourage the private sector to offer a range of options to voucher-carrying beneficiaries of public programs, the existing Medicare and Medicaid programs would also be improved by revitalizing the remainder of the market, because that step would make such concepts as "usual and customary fees" and "customary practice" meaningful once again and therefore valuable as yardsticks for public programs.



Although interest in strengthening competition in the health sector has recently picked up a bit, no one in Congress or in the Carter administration is currently working on the design of a legislative program based on the foregoing principles.<sup>21</sup> Our vast policymaking apparatus appears instead to be pursuing the impossible dream of effective regulation and, trapped by self-fulfilling prophecies about regulation's inevitability, is letting slip past the last clear chance to organize a health care system in which consumers with professional help, rather than regulators or organized providers, would dictate the appropriate level and type of health care spending and the appropriate degree and methods of cost containment. Perhaps the scenario presented here of increasingly limited freedom of choice, increasingly arbitrary regulation, and an increasing squeeze on

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<sup>20</sup> See Havighurst, *The Role of Competition*, *supra* note 18.

<sup>21</sup> However, Professor Alain Enthoven, working as a part time consultant for HEW, has developed a substantial proposal for a "Consumer Choice Health Plan" that is currently being circulated in the bureaucracy. While this proposal contemplates somewhat less competition and somewhat more regulatory dictation than the proposal sketched here, it is unique among national health insurance proposals in the extent to which it would permit resources to be allocated by relying on the decisions of cost-conscious consumers.

providers, designed to force them to accept the burden of rationing care, may yet scare some influential and far-sighted providers, employers, and consumer groups into seeking a responsible and workable alternative that would keep more of the crucial decisions in the hands of the individuals directly concerned.