HEALTH CARE COST-CONTAINMENT:

A PARADIGM FOR THE PUBLIC

ADMINISTRATOR

by

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TABLE OF CONTENTS

	Page
ABSTRACT	vi
1. INTRODUCTION	1
Problem Statement	3
Regulation vs. Competition: A Philosophy of Change	4
Causes of Health Care Inflation	5
Regulatory Approach	6
Competitive Approach	8
Overview	10
2. CAUSES OF HEALTH CARE COST INFLATION	12
Compulsory Licensure	12
Third-Party Payment	13
Fee-for Service Pricing	14
Impact of the Tax Laws	15
Consumer Ignorance	17
3. FEDERAL GOVERNMENT POLICY: A HISTORY OF REGULATION	19
Hill-Burton Act	19
Certificate of Need	20
Medicare-Medicaid	20
Rate Regulation	22
Utilization Review	23
State Regulations	23
Regulatory Effects	24
4. REVIEW OF PRIVATE SECTOR INITIATIVES	29
Motivation, Research and Analysis	29
Alternative Delivery	32
Alternative Financing	33
Coalitions	34
Varied Initiatives	35
Program Design	37
Data Collection	37

TABLE OF CONTENTS--Continued

	Page
5. THE NEED FOR STATE AND LOCAL INITIATIVES	42
6. COMPREHENSIVE COST-CONTAINMENT PROGRAMS	49
Communication of the Problem	49
Data Collection and Analysis	51
Elements of a Cost-Containment Program	53
Influencing Participants	56
Collaboration	57
Social Marketing: Communicating the Solution . . .	58
7. SUMMARY	62
Recommendations	65
Areas for Further Research	67
BIBLIOGRAPHY	68

ABSTRACT

This paper develops a model of the basic elements necessary for health care cost-containment programs. It is written as a guide for public administrators; however, it is also applicable to any manager contemplating a cost-containment program. The paper begins with a description of the problem of spiralling health care costs, emphasizing the effects of federal budgetary measures which shift health care costs from one segment of the population to another. It reviews other causes of health care cost inflation and the regulatory measures that have been used to curb rising costs. The paper outlines a need for public sector participation in cost-containment activities by addressing the effects on state and local budgets of inflated health care costs and cost shifting. From a review of current cost-containment initiatives, elements essential to a comprehensive program are presented in a recommended model program. From this model a program can be devised for individual localities. The paper stresses that, although there is no one best strategy for containing costs, concerted action of any kind leading to increased awareness by the public is essential.

CHAPTER 1

INTRODUCTION

Expenditures on health care services have risen more rapidly than expenditures on most other goods and services in the American economy. Annual health care expenditures have increased in the past decade from 6.6% of the gross national product (GNP) in 1970 to 10.8% of GNP in 1984, consuming an increasing portion of all goods and services produced in the United States (M. Feldstein 1985).

The Reagan administration and prominent economists such as Martin Feldstein (1985) list the rising cost of health care as a major economic problem in the United States. These costs, they say, have placed a strain on publicly financed health care programs, on employers who provide health benefit coverage for workers and their dependents, and on those workers and other individuals who must pay for medical care from their own personal resources.

Many private sector employers are recognizing health care benefits as a major cost of doing business, a cost which is influencing their profit margin and their ability to compete in international as well as national markets. These employers are becoming involved in containing health care costs and are beginning to pressure state and local governments for their cooperation (Mid-America 1983).

Public administrators, as employers themselves, share many of these same concerns. They also have concerns for the protection of

their constituents in a changing health care system. Many of these constituents are those whose health care is not covered by employer benefits. Ignagni (1985) asserts that up to 75 million people under the age of 65 are without health insurance or lack adequate protection; only 50% of individuals and families living below the poverty line are now covered by Medicaid. These populations, along with the elderly poor, are a growing concern for public leaders.

Containing the cost of health care expenditures is a new agenda for the public administrator and one of increasing importance. The ability to set a long-term agenda for reaching acceptable goals may depend on how well the administrator understands the history of the problem and how alternative cost-containment strategies will affect local populations.

The purpose of this paper is to encourage state and local public sector leaders to enter the health care cost-containment arena, and to suggest strategies that will enable them to address the health care cost issue both as an employer and as a public administrator responsible for the uncompensated care of individuals who lack financial resources. The main theme of the paper is to provide a background which will give the public administrator a better understanding of the health care cost problem and the changes going on in the health care system today. Many of these changes are raising concerns at state and local levels where public administrators play an important role.

Problem Statement

Many of the changes going on in the health care system today have shifted costs to the consumers themselves. As more and more individuals pay more and more of the costs for health care (as the federal government, insurers, and other third-party payers pay less), some will seek less health care. There is a growing population in the United States, however, which is losing access to any health care because of prices (Ricardo-Campbell 1982, Tell et al. 1984, Feldstein 1985, Sorkin 1981).

For more than a decade, Congress and the executive branch have tried to stem spiralling health care costs through various regulatory actions at the federal and state levels. Recent legislation, for example, shifts a significant portion of federally funded Medicare payments to the elderly themselves. Of the federal government portion, providers are reimbursed an amount equal to only 60% of the charges made for care. Providers are allowed to bill the Medicare patients directly for only a part of the remaining amount; portions not collected are shifted to the rest of the population in the form of higher charges. Paul Feldstein (1983), health economist, points out that this is not containing costs, except for the government.

As these cost shifts raise health care charges, the price of insurance coverage also rises. Businesses that are the largest purchasers of insurance may seek cost-containment programs which will again shift more of the cost of health care to the general public (Feder et al. 1984).

Shifting costs in medical care has been around for some time (see Kessel 1958). It may now become more acute with the Federal Trade Commission's announcement in May 1985 that health care providers would now be exempted from price discrimination regulations. This ruling will encourage the large purchasers of health care (government, business, and insurers) to bargain vigorously for reduction of their own costs. If these cost reduction efforts are pursued with little or no regard for the effects on other segments of the population, the American people will suffer an increasing disparity of access to health care services (Sidel 1985).

Regulation versus Competition: A Philosophy for Change

In a climate of disagreement about an effective, workable solution to the health care cost problem, two seemingly opposite approaches have been taken: a regulatory strategy and a competitive strategy. Under the present health care system where consumers hire physicians to choose the type and amount of services rendered, the highest payments go to the providers who use resources most intensively (Hadley 1984). The regulatory strategy would limit these services by law, making the individual provider or consumer financially responsible for excessive services. The competitive strategy would utilize economic incentives to encourage consumers in choosing providers who have the expertise to make cost-effective decisions in health care (P. Feldstein 1983, Sorkin 1984).

Health policy analysts favoring the competitive strategy recommend focusing attention on making available less costly alternative choices

for health care and providing information to consumers about the choices available (Luft 1984, P. Feldstein 1983, Ricardo-Campbell 1982, Gaumer 1984, Sorkin 1984).

State medical societies have historically imposed severe restrictions on this competitive approach. Federal legislation recently overruled state restrictions limiting this competitive approach. More complete federal legislation is still pending due to strong negative lobbying from the American Hospital Association and the American Medical Association. Certain states, however, are beginning to lead the way with cost-containment programs and state legislation allowing the availability of less costly health care alternatives.

Causes of Health Care Inflation

In recent years, free-market economists such as Martin Feldstein (1985) have suggested that runaway inflation in health care costs is the result of perverse incentives that promote overutilization of health services and unnecessary spending for health care. Specifically they cite:

"The third-party payment system." Most health care expenditures are paid for by third-party payment organizations (commercial health insurers, Blue Cross and Blue Shield organizations, Medicare and Medicaid) that insulate the consumers of health care from the actual costs of care at the time it is provided. Health practitioners, aware that most bills will be paid for by some third party, have few constraints on the types or quantity of services they order or provide.

The third parties themselves also play a largely passive role in controlling costs (Ricardo-Campbell 1982).

"Fee-for-service payment to physicians." Most independent physicians charge for their services on a service-by-service basis. Under this arrangement the more services practitioners render, the more compensation they receive. Physicians determine both the quantity and the prices of the services they render. The consumer plays virtually no role in this process (Roemer 1971).

"Cost reimbursement for hospitals." Most third-party payments to hospitals are made on the basis of the costs to the institutions of providing patient services. As a result, there are no incentives to constrain spending, since lower costs mean lower revenues and more spending means greater revenues. There is virtually no price competition among hospitals and no shopping around for care by prospective patients. Physicians usually dictate the necessity of a hospital admission and where that admission will be (Sorkin 1984).

"Impact of the tax laws." The tax treatment of health benefits distorts the provision and purchase of health insurance by encouraging more coverage than warranted and thereby increasing the demand for health services (USCBO 1984).

Regulatory Approach

Most of the public policy responses to rising health care costs have taken the form of economic regulation. Advocates of various regulatory steps to control health spending have held that the health care industry is inherently anti-competitive and have demanded

regulatory responses. The main supporters of regulation in the health sector are the American Medical Association (AMA), the American Nursing Association (ANA), the American Hospital Association (AHA), and other provider organizations (P. Feldstein 1983). Some of the regulatory responses enacted by Congress have been:

"Planning controls on hospital capacity" through certificate-of-need programs (CONs) that require prior approval from regional agencies before hospital expansion can be undertaken.

"Utilization controls" over hospital services by requiring hospitals to develop hospital utilization review programs and by creating a national system of professional review organizations (PSROs) to review the appropriateness of hospital care financed by the Medicare and Medicaid programs.

"Establishment of limits on physician fees" under Medicare and Medicaid, and by direct controls over fees during the economic stabilization program (of wage and price controls) during the early 1970s.

"Controls over hospital spending" through a variety of means, such as limits to health reimbursements under Medicare and Medicaid, hospital rate-setting and budget review programs in various states, direct controls during the economic stabilization program, the three-year effort of the Carter Administration to have enacted limits on annual increases in hospital spending, and Medicare prospective payment to hospitals on the basis of diagnosis (DRGs).

Competitive Approach

These regulatory steps, free market supporters argue, have not only failed to stem rising health care costs, they have actually helped raise costs to health consumers (Ricardo-Campbell 1982). What is needed instead, in the free market view, is a complete restructuring of the entire health system, away from regulation and toward competition (P. Feldstein 1983).

The advocates of the pro-competition strategy recommend major changes in employment-based health benefit programs and in the overall tax treatment of such benefits. Some also suggest that the principles of competition be extended to the design of public health care programs as well (Tell 1984). Among other things, these advocates support legislation that would eliminate much of the present regulation in the health industry and rely instead on competitive forces to produce an economic and efficient health care system (M. Feldstein 1985). There are four principal elements to the pro-competition approach:

"Periodic multiple choice." Each consumer of health services should be offered periodically the opportunity to enroll in any one of several qualified health care plans.

"Fixed dollar subsidies toward benefit protection." The amount of financial help that a consumer might receive toward the purchase of health plan membership (whether from an employer, Medicare, Medicaid, or under the tax laws) should be in the form of a fixed dollar amount, frequently called a "voucher." Persons choosing more costly coverage would have to pay the extra cost themselves.

"Equal rules for all competitors." There would be a uniform set of rules, such as those governing minimum benefits, premium setting practices, etc., for all health plans.

"Providers in competing economic units." Physicians and other health care providers should be encouraged to join together in economic units (e.g., health maintenance organizations (HMOs) or preferred provider organizations (PPOs)) that would compete to offer quality health services at the most competitive price.

The Reagan administration began development of its competitive strategy in the summer of 1981 (Omnibus Reconciliation Act of 1981). Since 1982, the Department of Health and Human Services approved a number of grants, contracts, and waivers of current reimbursement methods for the development of Medicare and Medicaid competition demonstration projects.

A multitude of legislative proposals have been introduced in the last few years which would encourage competing health and insurance plans to provide beneficiaries with a more informed choice among the competing alternatives (USCBO 1984). Unfortunately, politicians have appeared to reach a stalemate on the health care issue, however, other sectors of the economy are continuing the search for solutions and are initiating creative programs (Goldbeck 1985).

It is regrettable that any discussion in Congress of reforming health care policy has resulted in the medical establishment crying "socialized medicine" (Ignagni 1985). This characterization has effectively closed much of the debate on health care reform. However, with both business and labor taking the lead in health care cost

containment, the climate is right for renewed debate and action. If the United States is to establish an equitable health care system, public administrators will need to initiate debate and action at state and local levels, keeping in mind an overall goal of achieving a specific level of access to health care for the total population rather than a specified volume and mix of services according to their costs (Tell et al. 1984, Feder et al. 1984, Lee & Hadley 1979).

Overview

Following this overview of the health care system, and to make it easier to visualize the disincentives for efficient health care, Chapter 2 presents a more detailed description of the perverse incentives which have created a demand for excessive health care. Chapter 2 also points out some of the strategies which might be used to counter these disincentives.

Chapter 3 provides a history of the federal government's regulatory involvement in the health care system. With an explanation of the rationale for policies which were thought to be both inevitable and beneficial, the public administrator can better understand the patchwork of federal regulations and their effect on health care costs.

Chapter 4 provides a synthesis of nationwide private sector cost-containment initiatives, many of which are applicable to the public sector as well. It also points out the seriousness with which the private sector views the health cost problem, suggesting that major changes are likely in the immediate future.

Chapter 5 describes examples of the limited number of public sector programs and details the need for public administrators to become involved with state and local initiatives.

Chapter 6 then presents a model of the elements necessary for a comprehensive cost-containment program that should enable the public administrator to create a comprehensive health care cost-containment program for a specific locality.

Chapter 7 summarizes the paper, presents recommendations and points out areas for further research.

CHAPTER 2

CAUSES OF HEALTH CARE COST INFLATION

There is such general agreement on the causes of spiralling health care costs that few investigators have studied them in recent years. Elliot Wicks said in an opening statement to Montana's newly formed committee to investigate health cost-containment:

> Although there is often fundamental disagreement from state to state about how to solve the problem, there is very little disagreement about the cause of rising health care costs, such as the aging of the population and general price inflation, but few will disagree that the unique features which contribute to a market failure in the health care sector are the principle cost-influencing factors. In other words, because of the peculiarities of medical care as a good and the manner in which we pay for this service, health care providers have no incentives to be economical.

It is important to anyone contemplating a cost-containment program to understand the disincentives created by the unique features Wicks mentions. Any long-term solution to health care costs must address each of these perverse incentives if the result is to be cost-containment and not merely a shifting of the costs to other payers. A brief description of the major disincentives follows with example strategies for attacking each one.

Compulsory Licensure

Sorkin (1984) cites the barrier of compulsory licensure as the most significant interference with a competitive market in the health

industry. Licensing boards in every state have prohibited physician substitutes, e.g. nurses, physicians' assistants (PAs), and other aides, from giving any type of medical treatment unless that substitute is hired by a physician. Under the historical method of fee-for-service financing, the consumer is charged the same price whether the physician or his aide delivers the service. One of the major strategies for developing a more competitive health care market is based on allowing well trained physician substitutes to treat many minor illnesses and diagnose whether patients need physician care or not, thus providing less expensive health care alternatives.

Ancillary health care groups such as registered nurses and medical technologists have all successfully lobbied Congress for regulations which prevent hospitals from hiring unlicensed persons for health care related duties, although these less expensive unlicensed persons may perform these duties in a physician's office.

Studies have shown (Stigler 1971) that in almost every case of occupational licensure it is the professional and not the consumer who has sought licensure. This implies that the professional benefits through limited supply more than the consumer. Suggested cost-containing strategies would modify licensure restrictions and liberalize licensing boards (Gaumer 1984).

Third-Party Payment

Most health care expenditures are paid for by third-party payment organizations (commercial health insurers, Blue Cross-Blue Shield, Medicare and Medicaid). This insulates the consumer from the actual

cost of care at the time it is provided. Health practitioners, aware that most bills will be paid for by some third party, have few constraints on the type and quantity of services they provide. The third parties themselves also play a largely passive role in controlling costs (Grossman 1982). Strategies aimed at the third-party payment system must address all parties involved: the consumer, the health care provider, and the third-party insurer. Increasing first-dollar cost sharing for the consumer, along with provider restraints which limit the number of services provided per diagnosis, and more prudent purchasing of insurance are a typical combination used in redesigning benefit packages. Cost-containment strategies in this area are the most likely to result in cost shifting either to the consumer or to other individuals. Benefit redesign needs careful balancing, monitoring, and in some cases regulation.

Fee-for-Service Pricing

Another frequently cited cause of health care inflation is fee-for-service pricing of health care, whereby providers charge for each service provided. A fee for each service is established by providers in each area, which then becomes the usual-customary-rate (UCR). Providers may charge more or less than the UCR, thus making it a source of confusion for the consumer. The UCR is used as a base for insurance reimbursement. Medicare reimburses, for example, at a rate of 60% of the UCR, Medicaid at 40%. Other insurance policies usually state what percent of the UCR they pay. Some areas have kept their UCRs very high, in which case most Blue Cross policies (which pay 80% of UCR)

will pay for almost the total charge. Insurance rates in these high UCR areas are also very high (P. Feldstein 1983, Sorkin, 1984, Hadley 1984).

UCRs are a concern to employers who provide benefits to employees working in different rate areas, more than one city or county, for example. Insurance companies tend to price their policies according to the area of highest UCR; these rates may vary almost 100% from one city or county to the next (Mid-America 1983). This variation has encouraged some states to require a single rate within their state, a "universal rate" established from an average of rates in each area. A regulatory solution such as "universal rates" also has the advantage of exempting the state from Medicare's new diagnosis-related-groups (DRGs) financing method.

Impact of the Tax Laws

Another area for concern of government is the tax treatment of health benefits which is favorable to insured individuals in a number of different ways. This tax treatment includes the exclusion and deduction of premiums for employment-based benefits, the medical expense deduction, and the health insurance premium deduction (USCRS 1984).

The most important tax subsidy found in the Internal Revenue Code regarding health benefits is the exclusion from personal income taxation of the payments made by an employer for a health plan (Sec. 105 of the Code). This "employer exclusion" creates a tax shelter for workers who receive part of their compensation in the form of health

benefits rather than in wages that would be subject to personal income tax (USCBO 1984). Martin Feldstein (1985) argues that this tax feature lowers the net cost of the non-taxable fringe benefits and thereby creates more of a demand for the benefit than would exist in the absence of such an incentive. The value of this tax feature increases with rising marginal tax rates, i.e., the benefit is greater for those in higher brackets than for those in lower brackets.

Certain non-reimbursed and itemized expenses for medical care and for medical care premiums can be deducted from gross personal income. Present law (Sec. 213 of the Code) permits such deductions to the extent that they exceed 5% of the adjusted gross income (AGI). Drug expenses for prescribed drugs or insulin in excess of 1% of AGI may be counted to determine whether the 5% threshold is reached. These criteria are intended to establish that the taxpayer has had "extraordinary" health care and drug expenses that reduce the ability to pay taxes. The value of this itemized deduction, like all deductions, also rises with income. The deduction can be taken only by persons who itemize their personal tax returns (USCBO 1984).

The Internal Revenue Code permits employers to deduct as business expenses contributions to employee health plans regardless of the design or features of such plans (Sec. 162(a)). Some of the sponsors of pro-competition legislation would permit continued employer deductibility of such contributions only if certain cost-containing requirements were met (Dole 1983).

Federal subsidies provided through the tax code are called "tax expenditures," which are revenue losses to the Treasury arising from a

provision in the tax code that extends special or selective relief to certain groups of taxpayers. According to the President's FY85 budget proposal, FY85 tax expenditures for health will total $35.7 billion, including $28.2 billion for the employer exclusion and $3.4 billion for the medical expense deduction. In addition, the tax subsidies for health benefits also result in losses to state income taxes and lower Social Security and Medicare revenues, totalling approximately $10 billion. As a result, tax subsidies for health benefits comprise one of the largest federal programs to finance health care (USCBO 1984).

Consumer Ignorance

The inflationary effects of consumer ignorance is an important consideration in any successful cost-containment program. Paul Feldstein (1983) states, "In the market for medical services, information is not only far from perfect, it is almost nonexistent." According to Victor Fuch (1972), no other industry exists where the consumer is as dependent upon the producer for information concerning a product and its quality. Patients are usually unaware of the quality, accessibility, and price of health care services available from different sources. Therefore, the consumer (patient or benefit purchaser) is unable to choose less expensive substitutes without spending time and money searching.

Information to consumers about their choices of care is not always freely given. Consumer questions may be evaded by physicians who perceive them to be a doubting of their knowledge or integrity. The rationale for not making available to the public information on the

quality, accessibility, and prices of health care providers has been that only physicians are competent to judge what health care should be available and what prices these service should cost. On the basis of this rationale, physicians have been allowed to monitor their own competency, set the price of the services performed, and choose those who are delegated to perform certain services for them (Luft 1984, Ricardo-Campbell 1982, P. Feldstein 1983, Sorkin 1984).

With government cost-containment efforts shifting greater cost responsibility to the consumers themselves, it is becoming evident that consumers must be given more information about their choices for health services and the price of these services. Business and labor collaborated in supporting the passage of data disclosure legislation during the 1984 Congressional session and have begun maintaining data banks of this information so that they can be more prudent in their purchases of health benefits. Public leaders must ensure the availability of this information to all health care purchasers, not only to those with collective purchasing power.

With an understanding of the above-described disincentives and their inflationary effect on our national health care system, it is now appropriate to detail the patchwork of federal regulations which have been put into place over the last three decades to cope with spiralling health costs. Chapter 3 covers the history of federal regulations.

CHAPTER 3

FEDERAL GOVERNMENT POLICY: A HISTORY OF REGULATION

Governmental policies can be used to either increase or decrease the supply and demand for health care services available to consumers. Increasing the supply or number of health care providers, according to economic theory, should lower the prices. If there were only one hospital bed available, those who were able would pay dearly to use it. The one bed would then become a luxury item. Governmental policies have been used over the years both to increase supply or demand and to decrease supply and demand. None of these policies has had the desired effect of containing costs. Recent policies, in fact, appear to be making health care a near luxury for an increasing number of people who are least able to afford health care (Feder et al. 1984).

Hill-Burton Act

To increase the supply of hospital beds and make them more readily available to everyone, the government passed the Hill-Burton Act in 1948. This act subsidized billions of dollars of hospital beds according to a formula allowing construction where hospital beds numbered less than 4.5 per thousand population; 5.5 beds were allowed where the population density was less than 6 persons per square mile (Sorkin 1981). These funds were available only to nonprofit hospitals who also received a no-tax subsidy. Each state received a share of the federal

Hill-Burton funds and many new hospitals were started, but only in areas where they would not compete with existing hospitals. Hospitals not eligible for Hill-Burton funds could, of course, still build with alternate sources of financing. While enlarging access to health care in rural areas, the act did little to coordinate rational hospital investment (P. Feldstein 1983, Balter 1980).

Certificate of Need

In the mid-1950s Congress passed the Comprehensive Health Planning Act. Health planning agencies were set up in each state, and attempts were made to improve hospital planning. Wendling and Werner (1980) conducted a study which attempted to explain the passage of these Certificate of Need (CON) laws. They found that continued expansion in the number of hospitals had created a competitive position among hospitals that threatened the large hospitals which held favored positions. CONs became a way of keeping out the competition and were strongly supported by the American Hospital Association (AHA). The introduction and development of alternative care units such as health maintenance organizations (HMOs) was greatly retarded. The public interest view of CONs was, of course, to control hospital expenditures by limiting access to a hospital bed by controlling the supply (Ricardo-Campbell 1982, P. Feldstein 1983).

Medicare-Medicaid

In 1965 Congress passed major health care legislation, Medicare and Medicaid, "Medicare" for the health care of the elderly, "Medicaid"

for the poor. Prior to that time the government outlay was approximately 25% of the total expenditures made for health care. After 1966, government outlay sharply increased and by 1975 represented 42% of total health care expenditures (Sorkin 1984). With the government paying full prevailing costs for the care of low-income and elderly patients, these patients now had not only increased access to health care but were able to receive an increased number of services per illness, thereby greatly increasing the demand for medical care.

Treatment for the low-income and elderly had largely been confined to state and locally subsidized hospitals before 1966. Many of these patients were now sent by their physicians to private hospitals with government paying the additional cost. With this increased demand for health services and government paying the bill for those services, CON districts relaxed their controls and private financing expanded the number of beds and services in existing hospitals. Within a short period of time health care had become big business (Salkever & Bice 1979).

Foreseeing the profits in health care, more insurance companies entered the market to compete with the non-profit, hospital-controlled Blue Cross and physician-controlled Blue Shield. Unions demanded more health insurance benefits for their workers. Employers gave non-union workers more benefits to keep them from unionizing. The health care bills of almost all Americans were paid by "someone else" (Sorkin 1984).

Rate Regulation

In the 1970s, with health care costs having an increasing impact on the federal budget, the government developed a renewed interest in health care cost-containment. Rate regulation and expenditure limits were put into effect in an attempt to limit the amounts government was paying for each individual service. The government began to reimburse hospitals at a rate of 60% of their declared cost for treating Medicare patients. This rate was still based on each individual hospital's costs, however, and the higher the cost, the higher the reimbursement. Medicaid soon followed suit with an even lower reimbursement rate. Hospitals responded by shifting this lost cost to private patients by increasing overall charges. Studies have shown that these rate decreases were also followed by increased utilization, that is to say, patients received an increased number of tests and services resulting in an overall increase in federal health care costs (Salkever 1972, P. Feldstein 1983).

Blue Cross began rate limitations by negotiating with each individual hospital on the basis of their anticipated yearly budget costs. Their reimbursement rates, although higher than Medicare and Medicaid, are substantially less than the full charges to the patient without insurance, or to the patient with other than Blue Cross insurance. Recent changes in Federal Trade Commission regulations (May 1985) have now made it possible for all insurance companies to negotiate reimbursement rates. The lost revenues are again made up by non-insured patients (M. Feldstein 1985).

Utilization Review

Another regulatory program, utilization review, began with amendments to the Social Security Act to rectify the overutilization situation. The major emphasis of the Professional Standards Review Organizations (PSROs) has been to examine the appropriateness of Medicare patients' length of stay in hospitals. The federal government required that all providers receiving Medicare funds set up a PSRO with government funding. These organizations were made up of physicians and other health care providers monitoring each other's patient care patterns. Continuing studies have shown the PSROs have had no overall effect on hospital utilization or admissions (Dobson 1978, Bice 1980). In 1981 the Congressional Budget Office reported that "the [PSRO] program consumes more resources than it saves society as a whole" (USCBO 1981).

State Regulations

A majority of states currently have some form of state rate regulation of hospital expenditures. Paul Feldstein (1983) notes that while a few states have mandatory regulations in which all hospitals must participate, most state programs are voluntary. Where only Medicaid and Blue Cross patients are covered by the regulatory process, hospitals can still increase their charges to other payers. In 1983 only Maryland and Washington State had mandatory regulations which limited the total charges made to all patients including Medicare patients. Studies concluding that mandatory rate regulation appears to

have held hospital cost increases down have identified seven states as being mandatory regulatory (Biles et al. 1980, Coelen & Sullivan 1981, Melnick et al. 1981, Sloan 1981). Where mandatory rate regulation has been successful, the programs have either established maximum limits on annual percentage increases or used a more stringent formula for base rates. In most states the requirements have been less precise and hospitals have a great deal of influence over the rate-setting process.

Regulatory Effects

Ruchlin and Rosen (1980) demonstrated that in the short run hospitals are able to manipulate utilization and use cost shifting to forestall the impacts of tight controls. Eventually, however, as in New York, an increased number of hospitals were forced to close. Feder, Hadley, and Mullner (1984) point out that, unfortunately, many of these hospitals serve the indigent population.

In 1976 it was estimated (Carroll 1978) that forty-one million Americans under the age of sixty-five had no private insurance for medical services. This group includes persons whose employers do not provide insurance and who cannot afford to purchase insurance themselves, or choose not to do so. It also includes persons who would purchase insurance, but because of certain previous illnesses are not eligible to do so. Carroll estimates approximately 40% of this population are eligible to receive some assistance through various public programs, leaving twenty-five million with neither public nor private insurance.

Ignagni (1985) reports that in the 1980s the medically indigent population has increased at an alarming rate. During the 1981-1982 recession unemployment rose to over eleven million. Most of these workers lost their health benefits almost immediately. Those eligible for individual policies found the cost to be three or more times the cost of group plans. The majority of laid off workers, already under a severe financial strain, chose to forego medical insurance (USHCFC 1985).

Another important group of uninsured persons under age sixty-five are widows. Often having been insured under their husbands' employment plan for twenty to thirty years, they now find themselves paying exorbitant rates for individual policies or doing without health insurance. In some cases surviving spouses have received notification of loss of insurance at the same time they are making funeral arrangements. Not fully comprehending the meaning of these notices, many are unaware of the loss of insurance until they are faced with medical bills years later. Although challenged in the courts, under present Employee Retirement and Income Security Act (ERISA) regulations it is a legal procedure (USHCFC 1985).

Lynn Etheredge (1984) cites increased health care costs as the major economic risk for the over sixty-five age group as well. Federal budget decisions, she says, have not been made on the basis of the welfare of the elderly, and even after three years of budget cuts Medicare's costs are still rising at 16% per year. In the past few years several billion dollars of cost shifts from Medicare to the

elderly beneficiaries themselves have raised both deductibles and the required premium for physician care.

In the last few years severe cuts in governmental funds available to the states for health care have created a public policy of relying on charity to finance indigent care. At the same time, changes in hospital financing that restrain third-party payments and create more competition for "high-paying" patients are reducing the willingness to provide free care in both proprietary and voluntary hospitals. Increasing amounts of free care can only be delivered from public hospitals subsidized at local taxpayers' expense. Feder (1984) noted that paradoxically where the need for free care is the highest, local taxpayers are the least able to support it. Health care providers' behavior towards free care in the 1980s seems to be comparable, Feder says, to behavior in the 1920s where strained budgets necessitated enforcing a prudent ratio of paying for indigent patients, in other words, rationing free care.

Government regulations can be seen to have increased both the number of hospital beds and the demand for those beds. These regulations have encouraged existing institutions to expand both the number of beds they have and the number of services they provide. They have also limited the number of competing institutions. They have not succeeded in containing costs or increasing access to health care. They have, however, allowed the shifting of costs no longer collectible from government to other payers. This, in turn, has contributed to the rising cost of health care by encouraging higher prices, which has subsequently increased the number of medically indigent.

Brian Abel-Smith (1985) sums up health care regulation in the United States saying:

> ...there appears to be a broad consensus that certain instruments which were once expected to help control the cost of health care not only failed to work but could never have worked.... It is now widely believed that all regulating agencies inevitably get taken over by the regulated. Thus, PSROs, CONs, and other comprehensive health planning were all bound to fail.

Martin Feldstein (1985) and other economists argue that regulations have not been successful because they have failed to take into account the unique features of the American health care system which have created perverse incentives for providers to "overtreat overinsured patients."

That the United States is confronted with a funding crisis which will affect all categories in the federal budget is not news. But the degree to which health programs will continue to be targeted for cuts is of great importance. Public administrators should be both informed as to the problem and alert that the relationship between budgetary and health policy reform is tightening. The necessity for responsible policies should not be overshadowed by the demand for deficit attention.

According to Jack Meyer (1985), director of the American Enterprise Institute's Center for Health Policy Research, regulatory efforts that control health spending without changing the basic inefficiencies have headed the United States towards an inadequate and inequitable health care system. We are now experiencing, he says, "long-term headaches" which are the result of "short-term relief measures" used during the last two decades.

The spiralling cost of health care no longer allows business to tolerate a patchwork regulatory approach which protects provider interests. Business is beginning to speak up for its own interests in the cost of health care. In the following two chapters initiatives in cost-containment from both the business sector and the public sector will be discussed.

CHAPTER 4

REVIEW OF PRIVATE SECTOR INITIATIVES

As much of the current governmental health cost saving program has effectively shifted additional costs to private employers (Etheredge 1984, Beiber 1985), the private sector has been spurred to lead the way with its own cost-containing initiatives. Employers across the country are realizing they do not have to continue being passive payers for medical care. They are becoming informed participants in the health care field, playing an active role in restraining health care costs. This new role is not only good business, it has become a necessary part of business.

Motivation, Research, and Analysis

Business has become involved in health care because the health care portion of employee benefit costs amounts to more than 11% of total payroll costs, $62 billion for health insurance alone (Gibson & Waldo 1981, Health Research Institute 1981). Also, improved data collection and analysis have helped business define and identify health cost problems (Tell et al. 1984).

Business has begun to recognize its collective health care purchasing power. A growing supply of health care providers, together with the collaboration of area business purchasers, has strengthened this power. It has been shown that when faced with the prospect of

losing a large segment of business, insurance carriers will make considerable concessions. In the Chrysler crises, for example, Blue Cross waived millions of dollars in premiums in return for Chrysler's continued business (Ricardo-Campbell 1982).

The economic pressure of shrinking profits has encouraged business organizations to study the problems from their perspective. A 1979 study by the Chamber of Commerce of the United States' National Chamber Foundation concluded that "under present insurance and reimbursement arrangements, neither consumer nor provider is rewarded for wise use of costly resources." In The Control of Health Care Costs (Mid-America 1983), blame was placed equally on health care payers (employers), user (employees), and providers (hospitals and physicians).

Business economists, looking to solutions, recommend utilizing principles that business has long found to be effective. Enthovan (1978), for example, relates the law of diminishing returns to health care. He showed that it is statistically possible to measure which services are most cost-effective by relating health outcome to more in-hospital days for a patient with a given diagnosis, relating the probability of a correct diagnosis to the number of diagnostic tests, and looking at the relation of health status for a given population to the percentage of the population to which an elective surgical procedure is applied.

Enthovan's notion is far from new. Lemuel Shattuck (1850) in the 19th Century wrote of his concern how the people of the Commonwealth of Massachusetts could most effectively use their resources to promote the

health of the population, a problem he considered too large to be left exclusively to physicians (Enthovan 1978).

Since that time virtually every service and diagnosis has been examined and studied to determine the most efficient use of services and treatment. State and federal regulations, however, have encouraged providers to ignore the practice of statistical evidence and go with the perverse incentives which favor overtreatment in a third-party payer system (Mid-America 1983).

Representative empirical studies range from single diagnosis, such as Lembcke's (1952) study where a lower per capita rate of operations for appendicitis was not associated with higher appendicitis death rate, to Wennberg and Gettelsohn's (1977) collective study. Lembcke found that patients in areas with high rates of appendectomy would have been no worse off if the rate of operations had been reduced to that of the low rate areas.

Wennberg and Gettelsohn found there was no evidence that patients living in high use, high cost areas have greater medical need, or that more health is produced. It is not possible, they said, to argue that these areas are better or worse off. Enthovan (1978) noted that studies such as these show a great deal "flat of the curve" medicine is being practiced in the United States today. These applications of health care resources which yield no discernible health benefit are a primary target in the private sector's cost-containment initiatives.

Alternative Delivery

Striving for increased competition among health care providers, industry strongly encourages the use of alternative delivery systems. This business-led initiative may not only be a more efficient way to provide medical services but a more popular one. In a recent MarketPULSE (1985) survey 82% of the respondents reportedly favored ambulatory surgery, wellness programs, and preventive screening clinics to traditional fee-for-service physician office visits.

Particularly in large companies, the installation or expansion of a corporate medical department has become popular. Routine physicals and sick calls may be performed here at a reduced cost. Referrals are made to ambulatory surgery centers when applicable, recommendations are made on the use of birthing centers, and management of necessary hospitalization can be reviewed by corporate health officers. Self-insured companies frequently provide in-house preventive care to dependents (Greenman 1983).

Wellness programs in the work place have been effective in reducing medical care utilization. Shepard's (1985) study of employer based wellness programs found that those with ongoing financial incentives produced the best long-term results. Financial incentives are being added to many benefit-redesign packages; many of these encourage the use of alternative financing plans such as HMOs which provide a comprehensive health care plan on a prepaid capitated basis.

Alternative Financing

The Reagan administration ruling in 1981 requiring that all employers with more than 25 employees offer an HMO option to employees, if one is available in the community, has greatly expanded the number of HMOs competing in the marketplace. HMO activity has increased in popularity primarily because of low premiums and increased benefits. As their locations expand and inter-use between HMOs in varied locations increases, they should become even more popular (Luft 1984).

The growing number of self-insured firms have provided a prime client base for Preferred Provider Organizations (PPOs). PPOs are providers identified as efficient health care providers and contracted with for provision of care to employees at negotiated rates. The birth of the PPO movement was largely stimulated by the Martin Segal Company, a benefits consulting firm. Denver was the first community in the nation to establish operational preferred provider plans. At least 100,000 union trust fund members and their dependents are eligible to use any one of six PPOs which include over 1000 physicians and six hospitals.

In a growing climate for alternatives to fee-for-service health care, the complacency of the past decade on the part of physicians and hospitals is giving way to more aggressive marketing and diversification ventures. Hospitals are affiliating with HMOs, and PPOs are merging together in order not to be left out (Tell et al. 1984).

Coalitions

Business collaboration on health cost information projects has been a major first step in many communities. Business leaders recognize that they cannot proceed with major initiatives without data which clearly points to the most efficient providers (Tell et al. 1984). These collaborations have led to the organization of coalitions for the purpose of exchanging ideas and experience in order to better analyze community-wide health care cost problems (Channell 1985).

Business coalitions formed for the purpose of controlling health care costs for member organizations are all agreed on the problem; the methods used to accomplish the overall goals, however, are varied. Some coalitions have focused on educational programs, while others have concentrated on utilization review and promotion of alternative delivery systems. Most coalitions have recommended benefit redesign and health planning activities. All are in a continual process of data collection to provide new information on efficient health care.

A summary statement of coalition objectives is provided by the Clearing House on Business Coalitions for Health Actions (1982):

> Familiarizing members with health care issues.
> Identifying cost containment alternatives.
> Providing information on federal, state, and local health policy initiatives.
> Encouraging employer/employee initiatives.
> Educating management about health issues.

Coalition activities focus on initiatives that reflect the political and social values of their individual areas as well as local market forces and industry characteristics.

Varied Initiatives

In areas where strong regulatory programs for health care have been traditional, coalitions are likely to build upon existing regulations. A Maryland coalition, for instance, has as one objective, "to monitor and influence interaction among community health planning, quality assurance, and hospital prospective budget review," which means they are active in order to influence regulatory compliance. Pennsylvania's Lehigh Valley Business Conference on Health is incorporated specifically as a politically active agency which allows it to lobby and take an active open role in representing area corporation interests in health care legislative activities (Greenman 1983).

Utah, at the other extreme, aims to be a catalyst stimulating competitive market forces. San Diego Employers' Health Cost Coalition is also primarily pursuing nonregulatory solutions. This is consistent with San Diego's conservative perspective, being "historically and geographically isolated from state government" (Tell et al. 1984). In addition, California state legislation, in allowing the MediCal program negotiated discounts, has encouraged San Diego employers to negotiate similar discounts for themselves.

In Iowa both legislative reform and private approaches are being pursued. Business here has a close relationship with state government. The Iowa Governor's Commission of Health Care Costs is financed with 75% private and 25% public contributions. The need for improved data collection and analysis of hospital utilization and costs led to the formation of the Health Policy Corporation of Iowa (HPCI) as the

primary vehicle for implementing proposals agreed on by business, government, providers, and insurers collectively (Musser 1985).

In Denver a primary focus has crystallized on the cost per hospital admission. Purchasers here have also reacted against premium increases of up to 40% for many firms (Fox & Tell 1983). Denver's coalition activity is still in an early stage of cultivating a cooperative relationship between business and government. Many small firms without a dominant industry leader have made it more difficult here to form a collective business voice.

Large and influential businesses can command a considerable degree of purchasing power with health providers, and are able to negotiate preferred provider and prudent purchasing arrangements. This ability should provide substantial incentive for smaller firms to pool their purchasing power in making similar arrangements. Purchaser coalition activity has become the central vehicle for the promotion and diffusion of health cost management initiatives (Greenman 1983).

The strength of local labor unions may frequently influence purchaser activity, particularly activity which increases employee cost-sharing. Unions have been receptive to a variety of benefit changes which balance cost-sharing with benefit expansion. Many unions are beginning to negotiate for health care dollar contributions rather than for specific benefit provisions. Union trusts may then use these dollars to shop around for the best price and purchase health insurance for their members (Fox & Tell 1983).

Community coalitions are organizing state coalitions also. Not only does a statewide base add strength to their purchasing power, it

gives business a united voice against possible intensified provider protection action. Business is no longer tolerating a political stalemate on local levels; they are proceeding on their own behalf to reverse cost escalating incentives (Goldbeck 1985).

Program Design

Although various community coalitions may have a predominant strategy, industry's attack on health care costs is multifaceted. In most cases a broad range of initiatives are being pursued simultaneously. Businesses recognize the need for a balanced approach combining both individual firm and joint coalition projects.

Internal benefit-design changes usually seek to reduce unnecessary hospital admission, reduce unnecessary length of hospital stay, and encourage employees to become more informed and wiser consumers of health care, along with promoting alternate treatment options and treatment settings. Requiring second opinions, preadmission certification, and outside utilization review to monitor the efficiency of in-hospital stays are all cost management strategies aimed at producing changes at the provider level.

Data Collection

One of the more important contributions, if not the most important, from the business sector is their knowledge of a need for data collection, a base not only from which to make decisions but also from which to measure results. Believing that one of the prime causes of the weak health care market has been the lack of comparative price

and service information (Mid-America 1983), private sector coalitions began initiatives which created the major data collection efforts. In many unregulated states, it is virtually impossible to obtain comparative data. Without such information employers, unions, and individual consumers find it extremely difficult to make well-informed decisions when choosing among health care providers. The most extensive and complete systems appear in states where business and government are closely aligned (Greenman 1983).

One such closely aligned state, Maryland, was the first state to establish its own cost-containment program of rate-setting. Although rates are set by law, these rates still vary greatly among individual hospitals and physicians, as they are based heavily on historical data from each provider. Therefore, the need still exists for a data collection system which allows health care purchasers to compare prices and services from the different providers. In Maryland the reporting of financial data is mandatory, and any user may request the information. The total estimated saving attributed to their collection system amounts to $1.4 billion (Keane et al. 1985).

The Maryland state legislature created the Health Services Cost Review Commission (HSCRC) in 1971. Keane cites the importance of the HSCRC developing methodologies to assure reasonably priced health care for all purchasers, as well as establishing a uniform accounting and reporting system for data collection purposes. The commission is required to make annual disclosures about hospital finances and utilization levels. This regulatory philosophy stresses the availability of adequate data concerning hospital prices, services, and utilization

levels as a key ingredient in the development of a more satisfactory health care market.

The data is available to all purchasers and providers, public and private. The commission is currently setting payment rates applicable to all public and private payers, the rate schedule being derived from analysis of the data collection base (Keane et al. 1985). This strategy, all-payer rates, prevents the shifting of costs to those with less purchasing power and is a strategy that Mid-America (1983) would like to see all coalitions initiate. Even under an all-payer system, however, prices still vary greatly among the various providers, depending on their historical cost base.

There are various data information systems available across the country. One example is Blue Cross's PROBE (Performance Reporting of Blue Cross Experience). Peres (1985) reports that considerable employer purchasing power is needed to obtain these reports on a regular basis. Except in a few local communities, it is very difficult, if not impossible, for an individual consumer to obtain cost comparison data.

Since 1983 Iowa's mandatory data reporting is collected and dispersed by the Iowa Health Data Commission. Data here is collected from third-party payers, including self-insured employers. The commission's intent here is to change the health care marketplace through competition; therefore, involving insurance carriers includes them as an integral part of the system. Musser (1985) reports that the Health Policy Corporation of Iowa (HPCI) under contract to the commission is

currently identifying audiences for which the data needs to be modified and relayed in varied formats. This should help individual consumers.

An example of how consumer groups and community organizations can participate in both collecting and dispersing data on health care options comes from California. Local community groups here are the best source of information for the individual consumer; one of these called "Plaintree" operates out of a storefront in San Francisco. In addition to price data, this consumer group organization provides health educational information of all kinds (Ricardo-Campbell 1982). Another source of public information in California is provided by the Center for the Study of Services in San Francisco which publishes a magazine entitled Checkbook. This magazine focuses on local products and services, including health care (Luft 1985).

There would appear to be compelling advantages for collaborating in the collection of data. A data system designed for both public and private use is more efficient and costs can be shared. Public leaders can often apply pressure in collecting information, and also in dispersing it. State and local administrators may need additional pieces of information collected (e.g. on uninsured persons receiving treatment or being refused treatment, providers with over-utilization patterns on subsidized patients, or providers who heavily use cost-shifting to boost revenues).

Private sector initiatives such as the ones described in this chapter have produced cost savings to the businesses involved. They have also produced a heightened awareness on the part of all participants in health care of the intentions of business employers to

aggressively pursue the containment of health care costs. This heightened awareness, along with continued action, should ultimately provide cost-containing changes in the health care system (Greenman 1983).

After this review of the private sector's cost-containment actions, it is appropriate in the following chapter to show the need for action in the public sector, particularly at state and local levels.

CHAPTER 5

THE NEED FOR STATE AND LOCAL INITIATIVES

Governor-appointed task forces are assessing the health care cost problem in a growing number of states. A National Governors Council report (1984) says that a big reason for this current interest is an increased involvement in the Medicaid program. Periods of recession in the last few years have increased fiscal pressures on states encouraging them to limit not only their increased share of Medicaid funding but also their increased health care purchases as major employers.

Until recently state employers, along with the private sector employers, have merely negotiated the level of benefits with employees and then left the system alone. The basic issue has been who would pay for health care, the employee when he became ill or the employer through insurance coverage. The private sector is now becoming involved in changing utilization and unit costs. State employers have many of the same incentives to limit their payout for health care, but also they have additional obligations in providing for the unemployed and other populations not considered in private sector initiatives.

The political stalemate among elected officials at the federal level indicates that government either can't or doesn't want to do the job. The present administration opposes a regulatory approach and little is expected to happen in the near future at the federal level. Medicare's recent change to a more restrictive reimbursement for

hospitals shows that the federal government is interested in cutting its costs, if not necessarily the system-wide costs. "If measures to stop hospitals from making up this shortfall by cost-shifting to other payers are to be initiated, it will have to be at the state level" (Wicks 1985).

As private sector employers are becoming aware of health care costs as a major expense of doing business, they are increasing pressure where their economic clout is often strongest, at state and local levels. These employers are pushing for state government cooperation in changing the legal environment to enable cost-containment steps to be taken, and for using the regulatory authority of government to mandate in certain cases changes in providers' behavior.

Innovative states are entering the health care arena in a number of ways. Public employers are beginning to actively support Health Maintenance Organizations (HMOs). In Boston, Denver, and San Diego government employees represent the largest single source of HMO enrollment for many plans. Private industries have subsequently adopted many of the innovative benefit-design features that state governments have experimented with (Tell et al. 1984). The Prudential Insurance Company, for example, after successfully developing a home health program for state employees in Denver is now offering the benefit to other employers.

County government in San Diego was among the first counties to establish a fixed-premium contribution policy (voucher) for all insurance plans offered. This has encouraged employees to select less costly plans. Enrollees choosing plans with premiums less than the

employer's contribution receive a credit for additional benefits (Leibenson & Spies 1983).

City government in Greenville, North Carolina leads the way in wellness programs (Cox & Israel 1985). In a self-insured city with a population of 38,000 and 408 employees, city administration has been implementing a new program called "Wellness for Working People." The program includes all levels of the city's work force, and is aimed at achieving more control over the cost of the city's self-funded hospitalization program. Established as a long-term project rather than a quick fix, the program utilizes resources from a nearby university and shows considerable thought given to the advantages of early detection and treatment versus the expense of later care.

State and local governments need to assess other innovative programs that have proven successful for business. One such program is "case management review for utilization." Reviewing health care utilization by internally hired health officers (frequently nurses with utilization training) or entrepreneurial companies who specialize in case review has proven to be one of the most cost-effective programs (Mid-America 1983). Public administrators should seriously consider new initiatives that have proven successful in better management of health care funds, funds that have been contributed by the taxpayer.

Public administrators, in addition to considering the best use for health care dollars, need to participate and pay close attention to coalition activities in their regions. Characteristics of the individual industries within a coalition area may affect cost-containment initiatives. Where the employers share a similar orientation such as

agriculture or high-tech, they tend to share common goals and speak with a unified voice on health care issues. Some of these goals may not be compatible with the public interests of equal access as well as cost-containment. However, some coalition activity may be aimed at pursuing policies which will reduce industry's immediate health care bill despite the fact that those policies may intensify cost-shifting in the short run for other purchasers. For example, aggressive substitution of ambulatory surgery for inpatient care may reduce an employer's expenditures but may also shift costs to other hospital users if the hospital is allowed to raise its prices to offset the loss of that business (Greenman 1983).

Business leaders who participate on hospital boards of trustees have begun to experience conflicting goals of commitment to the hospital's continued growth and expansion versus concern with the excess health costs this growth may create. Educational efforts sponsored by public leaders and university groups as well as business firms are needed to counter growth and expansion for the sake of prestige or self-perpetuation (Tell et al. 1984).

Employer coalitions may choose certain health care options because they prefer to avoid potential conflicts. They may, for example, pressure for regulatory solutions to rising costs because of reluctance to address employee and union objections to increased premiums and cost-sharing. They may be reluctant to antagonize health care providers by introducing reimbursement reforms because of community ties or economic relationships, in which case employers are likely to

emphasize excessive cost-sharing instead of systems intervention (Tell et al. 1984, P. Feldstein 1983).

Government and business are the two large purchasers of health care. Etheredge (1984) reminds us that in 1976 the Council on Wage and Price Stability called on the private sector to work toward controlling health care costs as an alternative to federal controls. This call has been again strongly voiced by the Reagan Administration (Greenman 1983). The involvement of business is growing, but its focus is drifting away from Washington and toward a more concentrated attention on local health care activities (Inglehart 1981). The public sector can make use not only of business' local focus but of business' style of using communication effectively in meeting their goals.

The problem that may occur if business groups advise political leaders that they can contain their own health costs without government assistance, is that political leaders are likely to let them do so, and the nation may continue with separate payment arrangements for the elderly and poor (Etheredge 1984).

Under current proposals of the Advisory Council on Social Security (1984), over $115 billion (60%) of the proposed savings to the system would be in cost shifts to the aged themselves. Alternative proposals are being advanced by Senators Kennedy and Gephardt, former opponents of regulatory and competitive measures, which build on state-based health cost-control programs and allow both regulative and competitive measures to be used in meeting national objectives. It seems likely that in the near future Medicare and Medicaid cost-containment programs will be administrated at the state level (Etheredge 1984).

In any case, it is certain that public administrators as well as legislators will need a firm grasp of the health care problem in order to make the necessary decisions needed on a local basis. The important point to be learned is that alternative sources for health care at varying prices are becoming available, even well established in many parts of the country. The public sector needs to analyze the most efficient and equitable ways to use these alternatives for the health care of those within public responsibility.

There are few, if any, states that do not at this time have at least a committee looking into health care costs. The majority of these are headed by community business leaders who, although participating on a voluntary basis, nevertheless have a decided special interest in the committee's recommendations. These business leaders are well informed on health cost problems and prepared to resolve these problems by actively participating in the health care process. Public administrators need to assume a similarly active role in resolving those cost problems that are immediately resolvable; they also need to be aware of, and prepared for, increased pressure from business and labor to assume a more aggressive position on health care policy. An integrated approach which addresses cost-shifting and uncompensated care as well as profit margins is necessary for long-term results. This approach requires public as well as private participation.

Willis Goldbeck (1985) writes that regardless of the method used, competitive or regulatory, action and communication of that action is "the central and most important initial ingredient of cost management

success." In Chapter 6 we turn to a review of the critical role that communication plays in health care cost-containment strategies.

CHAPTER 6

COMPREHENSIVE COST-CONTAINMENT PROGRAMS

Communication of the Problem

Communication campaigns to inform and influence the public are a familiar and indispensable part of public service programs. From early pessimism of the success of such campaigns, as reflected by Bauer (1964) in "The Obstinate Audience," the mood of communication research has grown more optimistic, as indicated by the article "Some Reasons Why Information Campaigns Can Succeed" (Mendelsohn 1973).

Much of the public campaigning related to health care has been limited to a particular problem or disease such as anti-smoking (Srole & Fischer 1973, Straits 1966, Horn 1978), cardiovascular risk prevention (Maccoby 1977, Farquhar 1977, Alexander 1980), and vaccination programs at times of high risk (USDHHS 1980). In 1974, however, the Canadian government published a report emphasizing the use of goal setting strategies for improving specific health problems which in turn would lead to improved health for the nation (Lalonde Report).

The United States adopted this goal setting strategy in 1979 with the Surgeon General's report on health promotion and disease prevention called "Healthy People." The Surgeon General's report identified priority areas and appropriate actions influencing and assisting both individuals and organizations to accept more responsibility and to be

more active in matters affecting mental and physical health. Terris (1985) reports that, since the Reagan administration's deep cuts in federal funds for preventive health programs and other community health services, little has been done in the public sector to set goals or coordinate programs of prevention, wellness, and cost-containment.

Effective communication projects, however, are being initiated in varied locations aimed at local concerns. In Denver, state government is playing a role in educating and raising health care purchaser awareness by publishing the State Department of Health's Health Cost Management Newsletter for Purchasers. This publication is largely geared to business purchasers of health care plans, but much of the content is applicable to all sectors. In Colorado, the key to cost-containment is seen to be in health care plans which provide incentives for using less costly alternative facilities. In lieu of an active coalition, state government is promoting wiser purchasing of health care by communicating information on the availability of alternative facilities (Fox & Tell 1983).

A community level task force in Minnesota recently published a report entitled "The Price of Life: Ethics and Economics," an informative message to policy makers recommending balancing cost versus benefit of high-tech health care. Excessive use of high technology is thought to be a major problem for communities in Minnesota. A community organization is attacking this problem by distributing information to consumers, providers, and policy makers (Minnesota Coalition 1985).

In Pennsylvania, administrators of the Public Employees Health and Welfare Fund, after extensive research, began their preventive health

care program with a focus on dependent children, and a base of communicating information of the program's benefits. Research pointed out that many programs for adults have been abandoned because it is extremely difficult to attempt change in adult lifestyle. There is ample evidence, however, of the benefits of preventive measures for children; measures such as immunizations and early detection of health problems have been shown to avoid costly medical treatment in the future. Communication of these benefits has been responsible for the wide acceptance of the dependent children program (Sessa 1985).

Iowa State University, through Bankers Life, has a similar preventive care plan that covers the whole family. They report some indication that increased preventive physician visits have reduced utilization of chronic and acute care physician services. From the inception of the program, the expected results have been communicated to the recipients (Matlin 1985). Not only is communication of the available programs necessary, but communication of the beneficial results to be gained is also necessary.

Data Collection and Analysis

An adequate data collection system is an important first step in a comprehensive health care plan which intends to contain health care cost as well as provide benefits. An adequate analysis must be made for every segment of a comprehensive program as to its effectiveness, efficiency, and quality. A program is effective if it reaches the desired population and provides access for that population to increased health. The quality of a program is measured by the increased health

of its participants. Efficiency is considered to be more quality for less money (Sorkin 1981, P. Feldstein 1983, Enthovan 1980).

Purchasers of medical care, whether that care is preventive or acute, need to be prudent in their choices. Do the patients get better? Do the recipients of preventive care avoid expensive illness at a later date? Efficiency cannot be measured unless these questions of quality are satisfactorily answered. Providers who efficiently meet these goals should be the providers of choice. Employers, union groups, and government programs who purchase health care should reward efficient quality providers by giving individual consumers the means to identify these efficient providers and the incentives to choose them over less efficient providers.

McClure (1985) likens these statistical concepts to batting averages. It is impossible for the individual consumer to determine the quality and efficiency of a provider from a single limited experience any more than a single time at bat will indicate the overall quality of the ball players and their batting averages. Only purchasers who review the claims from many providers for the health care of many consumers are in a position to assess the efficiency of the various providers.

Consultants who are experts in efficient, quality medical care can be hired to identify efficient providers, less efficient providers, and also providers who have demonstrated unacceptable quality. Reputable firms nationwide are able, by using computerized statistical analysis and subsequent onsite investigation, to make good practical estimates of the quality and efficiency of individual providers.

McClure (1985) cites the example of the Brewster-Jacobs system which assesses the clinical status of the patient at admission for severity, and again for a 10-day outcome. This system reports the percentage of a provider's patients with a clinically acceptable outcome from a given initial severity and the provider's cost to achieve these outcomes.

Increasing numbers of hospitals are using these systems to monitor their own performance as well as the performance of their staff physicians. Boston's Beth Israel Hospital, for example, reduced the level of inappropriate care from 30% to 15% within 9 months using a new statistical information system (Bloem & Restuccia 1985).

The need for additional data which identifies certain target groups who may benefit from specific health programs has encouraged larger employers and business coalitions to design their own data collection systems. States and local communities are frequently sharing the benefits of local data systems as well as the costs. This approach allows localized problems to be quickly identified and programs can be modified on an ongoing basis. Collaboration between the public and private sector not only decreases the cost to each for data collection, but encourages a unified approach in containing health care costs.

Elements of a Cost-Containment Program

Most cost-containment actions are aimed at influencing the manner in which the public uses health care services. A comprehensive program includes health education, disease prevention, rehabilitation, and

benefit design which are all combined and intermingled into a common theme of making both individuals and groups aware of and more responsible for their own health welfare.

Although it is almost impossible to absolutely separate and categorize communication and education efforts for health care cost-containment, programs can be divided into three areas: health programs, benefit redesign, and alternative facilities and financing.

"Health programs" which can be instituted fall into three areas: primary, secondary, and tertiary.

1. Primary (prevention of illness) programs are generally targeted at specific groups. Health promotion programs vary from prenatal nutrition and well baby clinics to exercise and meals on wheels for the elderly. Specific disease prevention programs, also included in this group, are most effective when targeted at high-risk groups such as weight loss, anti-smoking, and cholesterol reduction in heart disease.

2. Secondary programs are designed to promote early diagnosis and disability limitations. Educational programs, publications, and screening tests would be included along with specific disease group participation programs. Programs included here must include medical utilization review for appropriateness of treatment to the illness (second opinion, outpatient surgery, home health care, etc.). Pre-illness educational programs help eliminate the necessity for crisis intervention.

3. Tertiary prevention programs involve rehabilitation of chronic disease and permanently disabled group. Community volunteer groups are

important here in providing alternatives to inpatient medical care for disabled and retired workers. Drug and alcohol rehabilitation as well and physical and mental programs must be considered also.

Many of these programs are of interest to both the private and the public sector; collaboration of both sectors should be encouraged in all of them.

"Benefit-redesign" should include cost sharing, alternatives to hospitalization, and utilization review.

1. Cost-sharing takes three forms: deductibles, coinsurance, and premium sharing. Each of these approaches focuses on different concerns; the combination of all three reinforces in the employee the prudent use of health services. No one should be impoverished in a cost-sharing program; likewise no other insurance (carried by the consumer or other party) should be allowed to negate the cost-sharing feature.

2. Alternatives to inpatient hospital care can often provide better or less expensive service in an alternative setting. Benefit plans should be designed to cover services only when performed in the most efficient setting by efficient providers.

3. Utilization review programs are designed to monitor the appropriateness of utilization, the efficiency of the provider facility, and the necessity of medical care. Utilization review needs to be carried on concurrently with treatment as well as pre-admission certification and mandatory second opinion.

"Alternative facilities and financing" are becoming more important in the public sector as Medicare and Medicaid patients are being cared

for under capitated plans such as HMOs which handle the total health care of enrolled individuals. Rehabilitation centers, home health care and hospice are less expensive alternatives for long-term illness and frequently are able to provide a more specialized care. Care for long-term and terminal illness is for the most part only reimbursed in a hospital setting. Leslie Libow (1985), professor of geriatrics at Mount Sinai School of Medicine, reports that almost 30% of Medicare's $75 million budget goes to maintaining people in their last few months of life. Public purchasers of health care plans need to insist on plans which reimburse less expensive alternative facilities.

Influencing Participants

The ability to initiate and effectively influence participation and acceptance of a health care cost-containment plan will depend largely on the communication efforts to gain public support. The type and strength of public education appropriate in different localities and for different actions must be carefully balanced in recognition of both provider and third-party payer concerns. Social influences can be either positive, neutral, or negative. An appropriate combination of both positive and neutral influence along with the elimination of negative influence is desirable.

"Positive influences" include regulation, substitutions, and economic sanctions. Regulations may be necessary to modify licensing boards, allow alternative providers, allow access to alternatives for everyone (not limited only to young healthy workers), and to control or eliminate cost-shifting by providers. Substitutions must be encouraged

in benefit-redesign, e.g. surgicenters, birthing centers, and emergency clinics. Economic sanctions such as tax penalties may be used to counter noncompliance or overutilization.

"Neutral influences" may be appropriate alone, particularly when first steps are being taken in communicating the problem and the need for a cost-containment program. Neutral influences are published warnings, educational programs, and moderate economic incentives. These influences must remain an ongoing part of any program.

"Negative influences" should be identified and eliminated. The best example of a negative influence in a public program for health care cost-containment is where state and local governments continue to offer the most complete and expensive health care coverage. Another common negative influence is allowing smoking in the work place while supporting a quit-smoking program.

Collaboration

A comprehensive cost-containment program which considers the incentives of consumers, providers, and third-party payers and guards for what Tell (1984) calls "gaming on the parts of the varied actors in the system" is likely to achieve the greatest success. It must be remembered that the public sector is only one part of a comprehensive cost-containment program. Public leaders must be prepared to join local coalitions in a knowledgeable way and to participate in forming coalition policy which includes not only appropriate cost-containment measures but also includes public interests as well as private.

One such public interest, for example, the growing population of Americans at or nearing the age of Medicare coverage, has also become a concern of the private sector. Industry is beginning to use educational programs designed to keep valuable older workers vital, both physically and mentally (Donchin 1985). Large companies such as Atlantic Richfield and DuPont are specifically targeting their retirees for educational programs on health care utilization (Ostroff 1985).

Collaboration with the private sector concerning these common interests will increase the chance of successful cost-containment through a broader and unified approach. Incorporating social marketing which utilizes commercial resources is an important financial consideration. Corporations have not only the funds to wage public campaigns, they also have access to the most sophisticated advertising campaigners. Intense private sector interest in containing health care costs is encouraging their cooperation with state and local leaders.

Social Marketing: Communicating the Solution

An orderly flow of information is necessary between all participants. Mid-America (1983) cites the most effective programs as those with a comprehensive plan for information which includes wellness, protection, education, and a menu of alternatives. In early attempts to utilize alternative health care providers (Luft 1984, Ricardo-Campbell 1982), California provided MediCal beneficiaries with a mere summary list of options along with a price for that option. The differences in benefits of each plan were not explained, nor were the

advantages of one plan, for example, to children and another to older people.

On the other hand, currently in the Florida HMO rush to sign up Medicare patients under new HCFA rules (April 1, 1985), some elderly constituents are being barraged with advertising, causing some concern they may not know exactly what they are signing up for. Rep. Lawrence J. Smith (D-Fla.) noted that some HMOs were even offering chicken dinners as incentives for Medicare patients to sign up (Smith 1985).

The need for utilizing the commercial sector in the distribution of information becomes apparent when the expense of fully describing all the available alternatives is considered. It remains to be seen, however, how well the public is served by letting the private sector do it all. The success of the Florida program will depend on how fully and truthfully the advertising represents the services being offered.

There are political aspects to almost any public program aimed at modifying public attitudes. Such campaigns almost always involve competing interests. The general good or benefit to society may or may not be to the benefit of special interest groups. Interest groups not benefited will, of course, campaign on their own behalf, giving an opposing view. This opposing campaign is likely to be much better funded and organized than the public campaign. Therefore, any public campaign attempted without first going through the necessary steps to gain its own interest group supporters is likely to fail (Chaffee 1981).

A full blown political war on health care cost issues was recently waged in the Arizona media. Traditional health care providers,

physicians and hospitals, defeated Arizona's business backed coalition move to pass laws regulating hospital rates. Jolly (1985) estimates campaign costs at $4.00 a vote, with hospital lobbyists outnumbering coalition representatives 10 to 1. Both sides spent the bulk of their campaign funds ($4 million) on paid advertising.

As industry remains an important source of funding for public programs, social purposes will more frequently be attempted through commercial marketing techniques. The social marketing concept (Solomon 1981) consists of a combination of public health-oriented social action programs and commercial distribution and marketing systems. This concept is becoming visible in health care cost-containment programs which are compatible with the overall goal of cultivating a mass market for health care at the lowest possible prices, often through existing outlets.

Social campaigns based upon commercial marketing programs emphasizing marketing variables such as product design, distribution, and cost are most likely to succeed. Social marketing has become a specialized area in itself. Phillip Kotler (1975) describes marketing with the public sector as:

> The design, implementation, and control of programs seeking to increase the acceptability of a social idea or practice in a target group(s). It utilizes concepts of market segmentation, consumer research, idea configuration, communication, facilitation, incentives, and exchange theory to maximize target group response.

Many of these marketing concepts have applicability to the design and implementation of health care programs. One critical marketing

philosophy frequently overlooked in public campaigns is that the goal of a marketing campaign should be to meet consumer needs and wants. That is, the focus of a campaign should be the groups it is designed to serve, and not the members organizing the campaign. Marketing, social or otherwise, is an exchange to meet their individual needs (Kotler 1975). In the public sector, the public benefits are often overlooked. This is apparent in health care systems, but it becomes most obvious to those seeking the means to acquire health services (Quadagno 1984). Although Weibe (1952) said that brotherhood can be sold like soap, private programs tend to ignore less profitable segments of the population, while public programs often specifically need to reach these hardest to reach segments.

This chapter has detailed the necessary elements in a health care cost-containment program. Each of these program segments is designed to counteract a specific cost-inflating factor and must be combined in an integrated fashion for total cost-containing results. Making these programs available does not ensure automatic results, however. The problem of high health care costs must also be communicated to the public in a manner which relates the benefits of participation to each individual. Social marketing is recommended here as an effective means of influencing public acceptance of cost-containment programs.

The last chapter summarizes the paper and offers recommendations for a program design.

CHAPTER 7

SUMMARY AND CONCLUSIONS

Health care cost inflation has affected every segment of the economy in recent years. Rising at a faster rate than other goods and services, health care costs have caused both business and government to rethink their health care policy. The federal government, after having created a patchwork of conflicting regulations, has reached a legislative stalemate and adopted a solution of shifting costs away from the federal government. Greater portions of Medicare and Medicaid have been shifted to the recipients themselves, to state government, and to the health care providers. These costs have been passed on by providers in the form of higher prices to the consumer.

The business sector, feeling the effects of government's cost shifting with rising insurance premiums at a time of shrinking profits, has begun its own cost-containment initiatives. Business' efforts are largely aimed at promoting competition into the health care system. Although business strategies vary in emphasis from one locale to another, they include:

- The promotion of health and wellness programs designed to make employees more conscious of staying well.
- The redesign of benefit plans to include cost sharing; incentives to use alternate treatment facilities (e.g. outpatient and surgicenters); and offer a menu of health plans from which the employee must choose according to his own health needs and willingness to pay for extra benefits.

- Alternative financing arrangements with providers at lower costs for services, or by a capitated rate.

- Data collection of prices and total costs of health services from which to identify efficient providers, and assist in bargaining for discount health care coverage.

State and local governments have, in a few cases, adopted some of the same strategies. In even fewer cases, they have encouraged legislation which supports these strategies such as mandatory reporting for data collection related to health care costs. The majority, however, have taken a passive role.

State and local governments, as employers, have many of the same interests in lowering health care costs as the private sector. In addition, they have an increasing portion of Medicaid financing as well as a growing number of medically indigent for which they are responsible. With a growing agreement that the unique cost producing incentives in the medical economy can be changed with concentrated effort, now is the time for public leaders to become involved in these changes.

The incentives for health care providers to use more resources instead of less include:

- Barriers to entry such as compulsory licensure.

- Lack of consumer choice.

- Third-party payers which insulate consumers from cost consideration when seeking health care.

- Fee for-service pricing where each service is charged for.

- Usual customary fees set by provider's cost.

- Tax subsidies which encourage increased health benefits.

- Lack of consumer information as to both prices and alternatives.

Considering the political, social, and historical differences between localities, it is difficult, if not impossible, to predict the advantages of one particular initiative over another in all cases. A comprehensive program which takes into account the local environment and the climate of provider sentiment, as well as consumer action, is most likely to be acceptable to all participants.

There appears to be no one best strategy. Aggressive cost-containment action, regardless of which approach is used, may be the most important ingredient in containing costs. Results appear to be proportional to the heightened awareness of the action. This implies that effective communication should be a basic part of the successful cost-containment program.

State and local leaders, therefore, need to be aware of the communication principles which apply to public information campaigns, and encourage the private sector to collaborate in designing an integrated approach to health care cost-containment.

Many of the educational and health promotional programs which have been instituted in the private sector are identical to those needed in the public sector. Small and medium size companies frequently lack programs because they lack both the funds and the expertise. Collaboration on these programs would encourage wider participation and enable small business employees as well as the unemployed access to the programs.

New initiatives the public sector should consider include:

- Mandatory reporting regulations where necessary for an adequate data base from which to identify efficient providers.

- Some limits may need to be set on discounts offered by hospitals and other providers to large purchasing groups to eliminate cost-shifting.

- Open enrollment may need to be established on alternative care programs so that all persons are able to participate.

As other sectors look to their own best interests, state and local administrators must avoid becoming the only base left for collecting shifted health care costs.

Integrated examples of cost-containment initiatives are distinctly in a minority in 1985. The isolated innovative responses to the problem of health care costs outlined in this paper should serve as important considerations for communities contemplating action. An integrated comprehensive plan, however, should be the overall goal for significant long-term cost-containment results.

Recommendations

1. Data collection is the first step in the development of cost-containment strategies. Although health data is collected by a variety of groups such as government, insurers, and providers, that data is not always available or presented in a form useful for cost-containment. Specific data needs should be defined, and a system developed to collect that data on an ongoing basis.
2. Care utilization can be analyzed from the collected data to identify the most efficient providers. Utilization review, however, must be an ongoing effort which includes mandatory second opinions, preadmission certification, and concurrent review of care plans. In order to obtain willing participation of consumers, educational

programs need to be implemented to communicate the rationale underlying consumer cost savings.

3. Alternative delivery system projects should be identified as substitutes for costly high utilization care which can better be provided in a specialized center, such as outpatient surgery, wellness clinics, and preventive medicine.
4. Benefit plans must be redesigned with incentives for lower utilization which reward wellness instead of merely reimbursing illness.
5. Alternative financing methods must be created where providers are reimbursed competitively according to their efficiency and effectiveness. Contracts and capitation rates may be considered as optional incentives.
6. An informational clearing house must be established where both the public and the private sectors can coordinate data collection and share resources. From here educational and informational programs can be developed which should:
   a. Communicate to the general public the benefits of becoming involved and taking more responsibility for their own health welfare.
   b. Coordinate and make available to the public primary, secondary, and tertiary health programs.
   c. In collaboration with the private sector, define an appropriate coordinated pattern of incentives which may be necessary to encourage participation.
   d. From continuing analysis of a data collection base, adjust strategies to meet local interests and community environment.

Areas for Further Research

Much of the published material on health care cost-containment is based on conjecture from limited studies. Foundations, such as the Robert Wood Johnson Foundation, are funding numerous long-term research programs concerning the long-term effects of intensive cost-containment activity. There is, however, a need for numerous research efforts to document whether each of the varied approaches has actually slowed the rate of health care cost increases. More empirical research is needed into public opinion and participation to ensure that programs are providing access and meeting the needs of individual localities. Research must also be designed to study the quality of health programs with respect to the increased health status of participants in order to ensure that programs will return the desired results of long-term health care cost savings.

BIBLIOGRAPHY

Abel-Smith, Brian. 1985. Who is the odd man out?: the experience of western Europe in containing the costs of health care. Milbank Memorial Fund Quarterly 1:1-17.

Alexander, J., N. Maccoby. 1980. Use of media in lifestyle programs. Behavioral Medicine: Changing Health Lifestyles P.O. Davidson ed. New York: Brunner Mazel.

Balter, Michael. 1980. The best kept secret in health care. The Progressive 11:35.

Barocas, V., M. Morrison, I. Wu. 1985. Older worker options: middle age work force prompts need for new approaches. Business and Health 5:25-29.

Beiber, O.F. 1985. Bargaining for equitable, affordable health care. Business and Health 5:20-24.

Benham, L., A. Benham. 1975. Regulating through the professions: a perspective on information control. The Journal of Law and Economics 10:1121.

Bermas, N., P. Lauro. 1985. What does graduate medical education cost? Business and Health 5:12-13.

Bice, T.W. 1980. Health planning and regulation effects on hospital costs. Annual Review of Public Health Vol. 1. Palo Alto, Calif.: Annual Reviews Inc.

Biles, B., C. Schramm, G. Atkinson. 1980. Hospital cost inflation under state rate-setting programs. New England Journal of Medicine 18:1340.

Bloem, K., Restuccia, J. 1985. Efficiency in academic medical centers. Business and Health 10:33-37.

Bradley, M. 1980. Economics. Glenview, Ill.: Scott, Foresman & Co.

Carroll, M.S. 1978. Private health insurance plans in 1976: an evaluation. Social Security Bulletin 41 9:3.

Chaffee, S. 1981. Mass media in political campaigns: an expanding role. Public Communication Campaigns E. Rice & W. Paisley ed. Beverly Hills: Sage.

Channell, B., E. Bernacki. 1985. Covering catastrophic illness. Business and Health 7:22-23.

Chamber of Commerce of the United States. 1979. Health/action: how to improve and contain health costs. Washington D.C.: Chamber of Commerce of the United States.

Clearinghouse on Business Coalitions for Health Action. 1982. Managing health costs: strategies for coalitions and business. Washington D.C.: Chamber of Commerce of the United States.

Coelen, C., D. Sullivan. 1981. An analysis of the effects of prospective reimbursement programs on hospital expenditures. Health Care Financing Review 1:586.

Cohen, H. 1980. On professional power and conflict of interest: state licensing boards on trial. Journal of Health Politics, Policy and Law 2:291-303.

Cox, J.E., R.G. Israel. 1985. Healthy life styles for Greenville, N.C. Business and Health 5:41-42.

Dobson, A. 1978. PSROs: their current status and their impact to date. Inquiry 6:27.

Donabedian, A. 1968. Promoting quality through evaluating the process of patient care. Medical Care 6:181-202.

Donchin, G. 1985. Vitality for an aging work force. Business and Health 5:30-32.

Dole, R. 1983. In remarks to Congress on S. 640. Congressional Record 3:S1906-S1908.

Enthovan, A. 1980. Health plan: the only practical solution to the soaring cost of medical care. Reading, Mass.: Addison Wesley.

————. 1978. Cutting cost without cutting the quality of care. New England Journal of Medicine 22:1229-1238.

Etheredge, L. 1984. An aging society and the federal deficit. Milbank Memorial Fund Quarterly 4:525-543.

Farquhar, J.W. 1977. Community education for cardiovascular health. Lancet 11:1192-1195.

Feder, J., J. Hadley, R. Mullner. 1984. Poor people and poor hospitals: implications for public policy. Journal of Health Politics, Policy and Law 9:237-250.

Feldstein, M. 1985. In recorded statement at hearings held by Senate Health Care Financing committee. March 10.

Feldstein, P. 1983. Health care economics. New York: John Wiley & Sons.

Fox, P.D., E.J. Tell. 1983. Private sector health care initiatives: a case study of the Denver area. Washington: Lewin and Associates.

Fuch, V. 1972. Health care and the United States' economic system: an essay in abnormal physiology. Milbank Memorial Fund Quarterly 2:224.

Gaumer, G. 1984. Regulating health professionals. Milbank Memorial Fund Quarterly 3:380-416.

Gibson, R.M., D.R. Waldo. 1981. National health expenditures, 1981. Health Care Financing Review 1:1-35.

Goldbeck, W.B. 1985. Publisher's note. Business and Health 4:1.

Greenman, B.W. 1983. Business/health care coalitions in profile. Madison, Wisconsin: Institute for Health Planning.

Grossman, M. 1982. Government and health outcomes. American Economic Review 5:192.

Hadley, J. 1984. How should Medicare pay physicians. Milbank Memorial Fund Quarterly 62:275-299.

Health Research Institute. 1981. Health cost containment: a second biennial survey-participant report. Walnut Creek, Calif.

Horn, D. 1978. Who is quitting - and why. Progress in Smoking Cessation 6:12.

Ignagni, K. 1985. Labor forum: joint labor-management support for a national health care policy needed. Business and Health 4:54-55.

Inglehart, J.K. 1981. Health care and American business. New England Journal of Medicine 306:120-124.

Jolly, M.A. 1985. Election post-mortem: Arizona hospital, business health cost fight fizzles. Business and Health 4:48.

Keane, J., M. Solnick, H. Cohen. 1985. Data use in Maryland. Business and Health 4:7-12.

Kessel, R. 1958. Price discrimination in medicine. Journal of Law and Economics 10:451.

Kotler, P. 1975. Marketing for non-profit organizations. Englewood Cliffs, N.J.: Prentice-Hall.

Lalonde, M. 1974. A new perspective on the health of Canadians - a working document. Ottawa: Government of Canada.

Larson, C. 1983. Persuasion. Belmont, Calif.: Wadsworth.

Lee, R.H., J. Hadley. 1979. Physicians' fees and public medical care programs. Health Services Research 2:185-203.

Leibenson, D., J. Spies. 1983. Private sector health initiatives: a case study of the San Diego area. Washington: Lewin Associates.

Lembcke, P.A. 1952. Measuring the quality of medical care through vital statistics based on hospital service areas. American Journal of Public Health 42:276-286.

Libow, L., M. Waife. 1985. Contributions of geriatric medicine. Business and Health 10:38-40.

Luft, H.S. 1984. A medicare voucher system. Milbank Memorial Fund Quarterly 2:300.

————. 1985. Personal communication to the author. August.

Maccoby, N. 1977. Reducing the risk of cardiovascular disease: effects of a community-based campaign on knowledge and behavior. Journal Community Health 3:100-114.

Mankowicz, F., J. Swerdlow. 1978. Remote control: television and the manipulation of American life. New York: Times Books.

MarketPULSE. 1985. Survey on use of alternative delivery systems. Hospitals 6:81-84.

Matlin, M.M. Insuring for preventive care of the total family. Business and Health 9:12.

McClure, W. 1985. Buying right: how to do it. Business and Health 10:41-45.

McCombs, M., D. Shaw. 1972. The agenda setting function of mass media. Public Opinion Quarterly 36:176-187.

McGuire, W.J. 1981. Theoretical foundations of campaigns. Public Communications Campaigns Rice & Paisley ed. Beverly Hills: Sage.

Melnick, G., J. Wheeler, P. Feldstein. 1981. The effects of hospital rate regulation on hospital costs and utilization, 1975-1979. Inquiry 4:347.

Mendelsohn, H. 1973. Some reasons why information campaigns can succeed. Public Opinion Quarterly 37:50-61.

Meyer, J. 1985. Incentives vs. controls. Business and Health 7:56.

Mid-America Coalition on Health Care. 1983. A policy statement by the benefits committee on the Mid-America coalition on health care. Kansas City, Mo.: Coalition Clearinghouse.

Minnesota Coalition. 1985. The price of life: ethics and economics. Minneapolis: Minnesota Coalition for Health Costs, Health Association Center.

Musser, M.J. 1985. Information key to competition in Iowa. Business and Health 4:18-21.

National Governors' Council. 1984. Joint state and corporate strategies to reduce health care cost escalation. Washington D.C.: Center for Policy Research.

Navarro, V. 1975. The political economy of medical care. International Journal of Health Services 1:753.

————. 1970. A stochastic and deterministic model of medical care utilization. Health Services Research 1:342.

Ostroff, J. 1985. Toward an informed older consumer population. Business and Health 5:33-36.

Pauly, M., M. Satterthwaite. 1981. The pricing of primary care physicians' service. Bell Journal of Economics 4:317.

Peres, A. 1985. Users groups: a model for data collection, analysis. Business and Health 4:12-19.

Quadagno, J.S. 1984. From poor laws to pension: the evolution of economic support for the aged in England and America. Milbank Memorial Fund Quarterly 3:417-446.

Reinhardt, U.E. 1973. Proposed changes in the organization of health care delivery: a review and critique. Milbank Memorial Fund Quarterly 2:169.

Ricardo-Campbell, R. 1982. The economics and politics of health. Chapel Hill: University of North Carolina Press.