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Government and Health Care Costs:
The Influence of Research on Policy

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The federal government's growing concern about the costs of health care now dates back almost fifteen years, when it became clear that the acceleration of federal budget and national health costs after the passage of Medicare and Medicaid was not just temporary. The first comprehensive proposals for a health cost strategy were made during the early 1970s. On the advice of health policy experts, the Nixon administration decided that the health care system was in a crisis and presented sweeping proposals for both market and regulatory efforts. The administration envisioned expanding the number of health maintenance organizations (HMOs) from 30 to 1,700 in just five years and enrolling 40 million people by 1976. Its national health insurance plan featured state regulation of hospital budgets and physicians' fees, with federal controls if a state failed to act, and higher cost sharing in private insurance.

In an assessment of what has happened over the past fifteen years, several features stand out.

- The nation did not enact comprehensive health financing reforms, and health care costs have continued to rise rapidly. National health spending, which totaled $75 billion in 1970, passed $400 billion in 1985. The federal government's spending for the Medicare and Medicaid programs grew from $10 billion in 1970 to nearly $95 billion in 1985.
- Without comprehensive federal legislation, progress on structural change of the health care system has been substantial but slow. After more than a decade of federal development support, HMOs enroll about 7 percent of the population. Four states now have mandatory all-payer hospital rate regulation, and thirty-five states have some form of rate review for at least one class of payer.
- The leading reform ideas still include the encouragement of competition through prepaid systems of care, such as HMOs and preferred provider organizations (PPOs); federal legislation to establish state cost control programs for hospital costs and physicians' fees, with federal controls if the states do not institute them (the KennedyGephardt bill); and increased cost sharing in private insurance.

In retrospect health policy research had conveyed to government officials, even fifteen years ago, the essential points that health care costs were on an uncontrolled, highly inflationary path, that comprehensive, systemic changes were necessary to bring them under control, and that regulation and market incentives should be combined in this effort. Subsequent health research has deepened knowledge of the problem, provided much more solid evidence on the probable results of various reform proposals, and contributed in many ways to policy developments and changes.

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We should be dissatisfied, however - and very concerned - about the rate at which the nation's health costs have steadily increased. As professional policy analysts, we all understand that powerful economic, political, and cultural forces enter into the formulation of health policy. Nevertheless, perhaps the most sobering lesson of the past fifteen years is how extraordinarily powerful - and difficult to deal with - those forces are. Looking to the future, we face even greater difficulties in trying to balance the benefits and costs of future growth in the health system.

Health policy research has an important and expanding role in efforts by the government and the private sector to address issues of health financing and costs. This paper offers some information, thoughts, and perspective on the work involved, including the following:

• an overview of how health research has influenced the federal government's policies for dealing with health costs
• a discussion of the chaotic marketplace of ideas about health policy and the changing competitive fortunes of the disciplines involved
• some observations on the processes through which health research is effectively translated into health policy
• a few suggestions about how to draw on lessons of the past so that health research can make even more effective contributions to health policy in the future.

Health Policy and Health Policy Research: An Overview

Health policy researchers frequently worry about whether government decision makers will use their work. The lessons of the past fifteen years certainly suggest that this ought not to be a major concern. The federal government has shown an extraordinary interest in research about ways to reduce health care costs and how well such measures work, and a substantial number of reform ideas and research results have found their way into the policy process. Indeed, in retrospect one might wish that federal officials had been somewhat less eager to rush into nationwide implementation of some ideas, such as professional standards review organizations (PSROs), health systems agencies, and diagnosis-related groups (DRGs).

It would be dangerous to conclude, however, that all health policy research has led to the same conclusions about optimal health policy or that it has all been used to advance a common agenda. Indeed, the following review suggests that the influences have often been diverse.1

Health Resources: Hospitals, Health Professions, Technology. The nation's hospital bed supply has been a continuing concern of federal health policy, both when it has been seen as inadequate and when it has been seen as excessive. A view that the nation needed more hospital beds led to the enactment of the Hill-Burton program in 1946, and a consensus that the nation had an excess supply led to elimination of the program in 1974. Research on the need to restrain further growth in hospital beds to prevent unnecessary use and higher health costs also gave rise to other measures: the national health planning program in 1974, certificate-of-need legislation in most states (and complementary Section 1122 provisions in the Medicare statute), and national guidelines for hospital supply - four beds per 1,000 population and an 80 percent occupancy rate.2

The federal government's programs of aid for training in health professions have also been strongly affected by research findings and the prevailing views on how to restrain health care costs. Starting in the mid-1960s, the federal government sharply increased its financial efforts to overcome shortages and slow the inflation of health care costs by
expanding enrollment in schools training students for health professions. Research showing potential savings from the use of professionals who are not physicians led to the addition of such federal programs as aid for physicians' assistants, nurse practitioners, and team dentistry. Evidence that primary care physicians used expensive hospital care less frequently than other specialists gave rise to subsidies for more residency positions for such physicians.

As medical school enrollments were starting to peak, research and policy analysis at the Department of Health, Education and Welfare - later formalized in the report of the Graduate Medical Education National Advisory Committee (GMENAC) - concluded that the nation would soon have an oversupply of physicians, particularly in many specialties. These findings were buttressed by other research suggesting that a rising supply of physicians, instead of reducing costs, actually increased national health spending, particularly with fee-for-service billing and the apparent lack of competition in the health care sector. Consequently, by the early 1980s cost considerations led to the elimination of most federal assistance programs for training in health professions and to limitation of the entry of foreign medical graduates. 3

Medical technology has long been recognized as having a major role both in improving health care and in increasing costs. Concerns about the need for more research on the cost effectiveness of new medical technology led to the establishment of the National Center for Health Care Technology. Under a different administration, however, concern that such research could slow technological innovation and cost reductions helped terminate the center. The roles of the Office of Technology Assessment and the National Academy of Sciences in technology assessment have recently been expanded. 4

Health Planning. Health policy research has also played a role both in the initial development of health planning activities and in the subsequent disenchantment with them. Inadequacies of the Comprehensive Health Planning voluntary program led to far more regulatory planning legislation in 1974, with a nationwide system of certificate-of-need requirements, health systems agencies, state health planning and development agencies, and state health coordinating councils. Several years later, however, studies evaluating these new efforts found that health planning was usually ineffective in controlling capital expenditures. Similarly, advocates of greater competition in the health sector argued that, where health planning was effective, it actually raised costs by protecting the franchises of unneeded and inefficient hospitals. Federal support for health planning has been sharply curtailed. 5

Health Maintenance Organizations. The federal government's nationwide effort to expand HMOs in the 1970s was based on research showing that they produced substantial savings for their patients. After more than a decade of further research, the savings claims still seem valid. Nevertheless, research has also highlighted "adverse selection" - the tendency of people to enroll in HMOs only when they will gain financially. Such selection makes it difficult for the Medicare program and employers to save money when they offer HMO coverage as an option. Moreover, although the expansion of HMO enrollment was impressive, it fell far short of the optimistic expectations that HMOs would become the model for mainstream medical care. In conformity with the Catch-22 of program evaluation - that programs are either judged successful and recommended for termination for having fulfilled their purpose or judged unsuccessful and recommended for termination for not having fulfilled their purpose - the HMO development program was phased out for having successfully demonstrated a cost-saving option. 6

Professional Standards Review Organizations. Research has played a role both in new utilization review initiatives and in subsequent disillusionment with those initiatives. In the early 1970s, data on the Medicare program showed substantial regional differences in admissions and lengths of stay. Limited data from pilot projects suggested that major savings could be obtained by removing utilization review from hospitals and fiscal intermediaries and turning it over to external organizations of physicians. Subsequently, formal evaluations conducted by the Department of Health and
Human Services (HHS) and the Congressional Budget Office showed that PSROs were not cost effective and led to proposals to abolish them and to their reorganization into professional review organizations (PROs). 7

**Prevention.** Research on the possibilities of preventing poor health, partly stimulated by Canada's Lalonde report, led the Department of Health and Human Services, particularly its Centers for Disease Control, to do extensive work in the late 1970s to arrive at nationally achievable goals in a number of areas. But health services research has also raised doubts about available techniques for changing individual behavior and has thus moderated enthusiasm for government-sponsored efforts to implement those goals. 8

**Health Care Financing.** Much of the research into health care costs has focused on the financing of health care, and as a result most of its important aspects are better understood. There is little disagreement today with the propositions that health service providers respond to financial incentives, that open-ended payment of hospitals and physicians is inflationary, or that payment by third parties helps to increase health care costs. Studies of state hospital rate-setting commissions have produced a fairly broad body of evidence that they can be workable and save money and analyses of a number of the technical issues in their design. Such research contributed directly to the adoption of a prospective hospital payment system for the Medicare program in the Tax Equity and Fiscal Responsibility Act of 1982. 9

One of the most dramatic outcomes of health policy research has been the development of DRGs and their adoption as the basis for Medicare hospital fees in the 1983 social security legislation. Now that the system is being implemented, a great deal of research is under way to evaluate its effectiveness and to assist in the mid course corrections necessary to deal with technological change, severity adjustments, productivity targets, unbundling, volume adjustments, capital and teaching costs, and the combination of hospital, regional, and national weights. 10

No review of how health research has influenced policy should fail to mention the Rand health insurance experiment. Costing nearly $100 million and more than ten years of effort, it was the major research project of the 1970s. The study established, with an authority that is unlikely to be seriously questioned, that out-of-pocket costs significantly affect the use of health care services. The study seems destined to have a major impact on both government programs and private health insurance. 11

Research on long-term care has also led to important cost containment initiatives and to policy reversals. Through the early 1970s a strong element of policy thought held that adding coverage of less expensive services would reduce overall health costs - that coverage of outpatient care, for example, would be more than offset by lower hospital expenses. Research on the number of people inappropriately hospitalized who could be served in less expensive settings brought about the expansion of nursing home benefits. The number of people inappropriately placed in skilled nursing facilities who could be served in less expensive settings led to the expansion of benefits for intermediate-care facilities. And the number of people in all three types of institutions who could be served outside institutions led to rapid growth of home health and related home services. But subsequent research on such developments also suggested that lower per unit costs do not save money if volume increases, as it often did. Today conventional wisdom would probably be summarized as "an add-on service is an add-on cost," and policy makers are extremely reluctant to expand long-term-care benefits in any major way. 12

In contrast to the development of research and policy in other areas, the physicians' market and alternative fee-for-service payment policies have received much less attention. This phenomenon still puzzles me. One explanation is that all the administrations in the 1970s believed that existing evidence already showed that current policies - based on "usual, customary, and reasonable" reimbursement - were clearly wrong and should be replaced with regulated fee schedules. Other factors have been the exceptional difficulty of obtaining adequate data for such research and the
inadequate explanatory models for physicians' behavior and pricing decisions. 13

Despite all the action, controversy, and chaos, the past fifteen years have produced a much more reliable research base for government policy. Except for payment of physicians, nearly every major idea on the political spectrum about how to restrain health costs has been tested. Research has played a key role in bringing these ideas forth as credible proposals and has frequently provided reliable evidence about how much more limited the results often prove in reality than the original proponents claimed or hoped. As a result we now have a more reliable book on major issues in the control of health costs, particularly the three major strategies of state hospital rate setting, HMOs, and cost sharing.

The Intellectual Ferment

The evolution of health policy research and health policy described in the previous section has been far from predictable or even orderly. 14 Views about the health care system, the possible effects of reforms, and the desirable courses of action have diverged widely, even wildly.

There is no simple way to make sense of this chaos or of the apparent lack of resolution of many issues unless we see the marketplace of policy ideas as probably the most intensely competitive and rapidly changing feature of the health care system. It includes not only many different customers (with different preferences) but also many suppliers and products. And while these interelite disputes have raged, the evolution of the health system has usually proceeded quite independently of the intellectual policy debate about what should be happening. Nevertheless, for present purposes we can usefully sort out what has been going on as being shaped by three academic-professional disciplines, two ideologies, and a recurrent idea reemerging in different forms.

The Academic and Professional Wars, Many health policy debates can usefully be read as involving competition among three major academic-professional traditions: public health, economics, and medicine.

The public health tradition has been largely concerned with determining the needs of groups of people and matching resources to those needs. It has thus been most influential in efforts both to expand and to regulate the supply of health resources and to change the organization of health care. The health planning program and its guidelines, as well as the analyses of the supply of health professionals by GMENAC and others, could be described as having their intellectual home in this tradition. Proposals for government-sponsored reorganization of the health system, such as more primary care, community health centers, and prepaid group practice, can also be associated with this way of thinking about health policy. Such contributions were a rich source of government health policy and programs well into the 1970s.

The influence of economics on health policy began growing early in the 1970s. Economists, usually by nature as well as by professional indoctrination, are suspicious of professionally determined needs and their use in prescribing the available supply and organization of services. They tend to emphasize notions of consumer sovereignty, investigate how actors are and can be influenced by economic motives, and suggest widespread use of financial incentives rather than regulation.

Such ideas have been controversial in the health policy arena, particularly among public health professions. Notions of encouraging physicians and hospitals to respond to anything other than their professional judgments or the sharing of costs by patients as a "barrier" between patients and providers have occasionally been viewed as reprehensible. Policy proposals whose intellectual home is in this economic tradition have included cost sharing by
patients, DRGs and other prospective payment systems with incentives, vouchers, and competition through HMOs and PPOs. Also in this tradition are critiques of health planning and of market-distorting demand and supply subsidies, ranging from tax treatment of employers' health insurance contributions to government programs for increasing the supply of health professionals.

Some observers may view the growing role of economic concepts in shaping government health policy as evidence that economics is inherently superior to other disciplines in addressing health policy issues. A different view would be that the public health tradition is most useful for problems of unmet needs and resource shortages and economics more useful for problems of excess supply and the consequent economic behavior of an industry undergoing rapid financial and organizational changes and increasingly competing to attract business. As the size and nature of the health sector have changed, so too have the ideas on government policies to deal with it.

Medicine is the third major profession whose ways of thinking about health care strongly influence health policy. The view of medical schools and physicians of optimal national health policy could be summarized as (1) find the best people to be physicians and give them the best training; (2) get physicians and patients together; and (3) have everyone else do (and pay for) what the physician decides is best for the patient. Although public health and economics professionals have built a strong case about the problems of this view and debated (frequently against one another) about how to restructure the health system, the evolution and enormous growth of the health sector have largely come about as a result of how physicians view medical care. Perhaps one measure of the ascendancy of the medical profession is that it has not yet even had to field an intellectual champion to justify its role. Indeed, government health policy in the 1970s and 1980s, through PSROs and PROs, has strengthened the physicians' power to determine appropriate medical care.

Opposing Ideologies. The policy debates produced by professional rivalries have been further complicated by passionate political ideologies. Perhaps because health care is so important and still at issue, it has been a particular focus for those who believe that the government's role must be sharply expanded or cut back. Proposals as divergent as nationalizing the health care system and cashing out existing government programs through vouchers were both strongly advocated in the 1970s, and supporting research results were assembled by all the parties. In such an atmosphere research was frequently used to advance or attack ideological agendas. Viable and enactable proposals for addressing health costs were frequently of secondary importance to committed participants, and reasonable compromises were often difficult or impossible to achieve.

A Recurrent Idea. Most reform ideas of the past fifteen years have been built around the need to manage hospitals' and physicians' services within limited budgets. Many policy debates during this period should be read less as discussions of fundamentally new ideas than as disputes about assigning the management role to one or another actor in the health care system. The HMO creates a new organization to undertake this management role; the independent practice association uses medical societies; vouchers let the individual manage his own care; capitation payments allocate the management responsibility to a "gatekeeper" physician. Advocates of community health centers (CHCs) envision an optimal health system with CHC managers. Others see the community hospital managing the budgets and resources for area wide health care or tertiary care centers as headquarters for a regionalized health system. Organizational arrangements now being debated include having the employer take the lead in negotiating and arranging for health services (through PPOs) and assigning such a role to health insurance companies, as recently proposed by the Midwest Business Group on Health. Some national health insurance proposals advocate the federal government as the best overall manager, while state rate-setting proposals assign that role to state governments and community maxicaps to local communities. Over the past fifteen years, nearly every actor in the health system has had an
advocate for reorganizing the health system to provide it with management authority over hospitals' and physicians' services.

Since most of these models can and do coexist, it is unclear whether public policy ever will - or should - choose to exclude any of them. Nevertheless, we should be able to draw a useful lesson from these debates. Reform proposals are often less about real health care issues and more about the autonomy, status, and income of existing actors (particularly in relation to one another) than one would surmise from reading the intellectual arguments about the issues supposedly being discussed.

How Health Research Becomes Health Policy

The past fifteen years have seen the development of a very effective, though informal, communication network for bringing health policy research, ideas, and proposals into the government decision-making processes. For those interested in health policy research, how and how well those processes work are a matter of continuing interest.

Few presidents, HHS secretaries, senators and congressmen, or corporate executives spend much time reading academic journals. They depend mostly on their staffs and on selected advisers, particularly (for legislators) among their constituents. Since few can be trusted advisers to decision makers, the importance of having strong, experienced professional staffs who can mediate between researchers and decision makers cannot be overemphasized. Such staffs learn the issues, options, and facts, monitor developments, request specific policy research, and distill the information for the decision makers for whom they work. Successful translation of research into policy requires communicating with the people in these staff positions and paying attention to their concerns.

Three kinds of institutions facilitate this process for the federal government: the National Health Policy Forum, specialized publications, and health policy consulting and research centers. Washington-based lobbying activities by the health sector have also grown explosively.

The National Health Policy Forum has played a key role for more than a decade in bringing researchers and health sector professionals to Washington for meetings with congressional and executive branch staff. The forum has been a major factor in ensuring a timely, balanced flow of information into the policy process, both through these meetings and in the flyers it circulates, which provide background information on health policy issues.

A second communication medium that has developed rapidly in recent years consists of specialized publications, often based in the Washington area. These newsletters and journals collect and disseminate information of particular interest to health policy staff.

Finally, policy research centers and policy consulting firms have an increasingly important role in the transmission of knowledge. HHS, for example, has made long-term arrangements with several research centers for continuing assistance in health policy analyses. A number of policy research firms, many of whom employ former government researchers and analysts, also assist government decision makers. These firms also transmit expertise on health cost issues developed in Washington over the past decade to state governments and corporate actors who are becoming involved in health policy.

Despite the record of the past fifteen years and the government's increasing need to address rising health care costs, the communication between research and policy may not flow as smoothly in the future. As those familiar with the problem know, recent reductions in staff have lowered the capacity of several government offices to address issues
of health costs. The workload of remaining staff members is particularly heavy, and the burden on several perennially understaffed committees and offices has increased as the government legislates new, complex Medicare and Medicaid legislation and is besieged by policy analyses from lobbyists. The capacity of government staffs to escape from such day-to-day pressures is increasingly strained. All involved will need to work at the communication process.

**Conclusion**

Nearly twenty years after the enactment of Medicare and Medicaid, the federal government has recently broken the link between Medicare's payments to hospitals and physicians and what these providers ask to be paid. The government and the $400 billion health industry are thus on the threshold of what will be an increasingly and intensely conflictual process for dealing with health care costs. Health policy research may be able to make very important contributions to the multibillion-dollar decisions that lie ahead. A few suggestions follow.

- First, researchers must continue to emphasize that the nation's health cost problems have systemic roots and require systemic change. We have a responsibility to provide consumer warning labels for the latest brands of snake oil so that decision makers are dissuaded from believing that the answers are easy and quick or that a new program wrinkle or a few more years for markets to develop will solve the problem.
- Second, researchers can contribute by continuing to bring forth evidence on how the health system is treating uninsured and vulnerable populations and institutions. These groups cannot afford high-priced lobbyists, and research is needed to make sure that reliable information on their problems is available in the decision process.
- Third, better data systems must be devised to serve both policy researchers and payers for health service. As many government officials and business groups have discovered, they have almost no ability to monitor and assess many cost and quality developments because relevant, timely data are not available. Researchers should play a major role in the design of national, statewide, and areawide data systems that can be used to improve research, cost and quality, regulation, and competition. Such data will be needed particularly by the federal government as it begins to monitor much more complex developments in health care, such as the responses to DRGs and systems for setting physicians' fees.
- Fourth, a major challenge is to develop more reliable guides on the contributions that various competitive and regulatory measures can make to balancing costs and benefits for different types of services in different market environments and to evaluating major changes in payment policies and in providers' behavior.
- Finally, researchers must communicate their findings and insights effectively to a rapidly expanding audience of those in the private sector and in state and local governments who make decisions about health financing issues, as well as to federal officials and their staffs.

**Notes**