Chapter - 13

Experiences from policy interventions in the United States (US) directed or otherwise affecting the private health sector

Experience from the United States of America (US) have relevance for India in many respects. Both have mixed health care delivery systems. The dominant American ethos is to favour free enterprise and small government. It will be interesting to see, how the US has handled various issues relating to the private health sector. Moreover, the dominant American ethos is to favour free enterprise and small government. Hence the health care policy and regulatory environment for private HCIs in the US can give some idea about what would be the most liberal boundary regulation of health care institutions, elsewhere. Hence, we briefly review experiences from the US of policy interventions directed or otherwise affecting the private health sector. We recognise that the policies pursued by the federal and state governments in the US can not be adopted as such. Our intention is to inform the Indian health policy process about experiences from other parts of the world. We chose the US health systems because of some similarity with the Indian situation and ready availability of literature with us. We touch upon one after the other, the following major policy interventions; (a) licensing and accreditation, (b) nonprofit health insurance corporations like the Blue Cross, (c) tax exemptions for health insurance, (d) capital subsidy by federal government for construction of hospitals, (e) health services planning and certificate of need regulation by most state governments (f) health maintenance organisations, and (g) peer review and practice guidelines. Our presentation of each of these areas is very brief and is intended to generate awareness and interest for further study whereever required. At the end of the chapter, we provide a still more distilled summary of these health policy interventions in the US. Note, however, that it will be naive to mechanically transplant policy instruments tried elsewhere, without any further examination of their usefulness and feasibility in the local context.

I. Licensing and accreditation

Licensing and accreditation is by now a well accepted norm in the US (Fein, 1986 p118). In addition to licensing of health care professionals to practice, most state departments of health have a hospital licensing board charged with

the responsibility of granting license for establishment and operation of hospitals. The intention behind these licensing requirement is to assure minimum standards of facilities and quality of care.

For example, the Illinois Hospital Licensing Act. 1953 states its purpose as follows *"to provide for the better protection of the public health through the development, establishment, and enforcement of standards (1) for the care of individuals in hospitals, (2) for the construction, maintenance, and operation of hospitals which, in light of advancing knowledge, will promote safe and adequate treatment of such individuals in hospital, and (3) that will have regard to the necessity of determining that a person establishing a hospital have the qualifications, background, character and financial resources to adequately provide a proper standard of hospital service for the community."*

The Iowa code 135B dealing with licensing of hospitals states its purpose as *"to provide for the development, establishment and enforcement of basic standards (1) for the care and treatment of individuals in hospitals and (2) for the construction, maintenance and operation of such hospitals, which, in the light of existing knowledge, will promote safe and adequate treatment of such individuals in hospitals, in the interest of the health, welfare and safety of the public."*

Voluntary accreditation systems have developed in addition to the state licensing mechanism. Chief among these is the Joint Commission for Accreditation of Health care Organisations (JCAHO). Accreditation by JCAHO is sought after by health care institutions, since it has acquired credibility. In fact, the JCAHO accreditation is also recognised by the federal government for purposes of Medicare and Medicaid reimbursements.

II. Blue cross insurance plans

We have already cited observations by Gray (1991 p36) revenue deficit was the major problem faced by hospital managers in the US for most part of the 20th century. Hospitals could not realise enough revenue to cover the operating expenses. The problem became acute during the depression years from 1929-39. Bad debts increased. Fein (1986) to reduce the incidence of bad debts hospitals introduced prepaid plans insuring provision of hospital services. These prepaid plans first developed as prepaid contracts between hospitals and their clientele to avoid insurance regulatory authority. Prepaid plans by single hospitals had certain limitations mainly the lack of choice of hospitals. To overcome this situation groups of hospitals wanted to set up multihospital prepaid plans. But the insurance regulatory authorities would ask for establishment of a joint stock company with financial reserves. The hospitals, however, could not afford to set apart the required reserves. Many people believed that the insurance

regulatory requirements were not appropriate for the health care sector. Regular insurance companies need a reserve to pay out claims. In case of prepaid health care plans, the insurer hospitals were promising services and did not have to pay out cash. Since stability of these hospitals was not so much in question, people felt there would not be any difficulty for the hospitals to meet their service provision commitment. Consequently, there was no need to provide for reserves. Most hospitals were nonprofit charitable institutions. It would have been difficult for them to set apart the required reserves in order to be eligible to operate prepaid hospitals service assurance plans. New York was the first state to enact a law allowing for a new type of organisational entity called nonprofit hospital corporations. This legislation conferred special advantages and responsibilities on prepaid multihospital service plans. These are referred to as Blue Cross plans. These plans were exempted from insurance regulatory laws. In view of their nonprofit status, they also had tax exemption. In return, for these benefits, the Blue Cross plans were expected to serve the entire community and provide insurance plans affordable by persons with moderate to low income. Their accounts and rate structure could be examined by public bodies. The American Hospital Association prepared a model legislation to promote spread of Blue Cross type of plans to other states in the US. Blue Cross expanded from "one plan in 1933 to 17 in 1936, 48 in 1939, and 74 by 1943" (Fein, 1986).

III. Tax waivers for health insurance

Fein (1986 p22-26) describes how federal tax waivers for employer funded health insurance packages stimulated growth of health insurance which in turn contributed to stability of health care institutions. The federal tax code allowed employers to count health insurance premium for employees as cost of doing business. The employees who received the insurance coverage were also not taxed for its money equivalent. Thus the federal government provided indirect subsidy to health insurance packages purchased by employers for their employees.

IV. Capital Subsidy by US Federal Government for Hospital Construction from 1946-74 under the Hill-Burton Programme

During the depression years (1929-39) and second world war few hospitals were built in the US. Existing hospitals were not updated. Existing hospital capacity was badly distributed among states, rural and urban areas within the states. To reduce the imbalance in distribution of hospital capacity the US Congress enacted the Hospital Survey and Construction Act of 1946 popularly referred as the Hill-Burton Programme. The goal was to (a) increase

supply of hospitals beds and (b) improve distribution of medical services. The Hill-Burton program provided capital subsidy, through the respective state governments, for construction or modernisation of public or nonprofit health care institutions including hospitals, ambulatory care centres, and diagnostic facilities. Upto two third of the total cost of construction could be covered. The program was in operation from 1948 till 1973. By 1971 10748 projects covering 4.7 lakh hospital beds and 3083 out-patient facilities had been assisted (Lave and Lave, 1974). The program financed between 6 to 16% of hospital construction costs and upto 12% of other medical facility construction costs during the period of its operation. It required development of state plans before grant of loan guarantee could be given for construction of modernisation of a health care institution. The state plans had to conform to standards of requirement set by the surgeon general. The law also set a normative maximum of 4.5 general hospital beds per 1000 population within which the surgeon general had to operate in setting norms for each state. More funds were allocated to rural areas where shortage of beds was acute. It was also believed that increase of hospital facilities in rural areas would attract more physicians to practice in those areas. The following summary of the programmes impact on development of health care facilities in the US is extracted from an evaluation by Lave and Lave (1974).

The Hill-Burton program had a significant effect on the change in hospitals beds per capita in different states of the US between 1947 and 1970. Total hospital bed stock in the US decreased from 9.5 bed per 1000 population in 1947 to 7.7 per 1000 in 1970. The decline in total hospital bed stock was mostly in chronic disease hospitals due to lower incidence of tuberculosis, availability of domiciliary treatment for tuberculosis and mental illness. Short term general hospital stock in the US increased from 3.3 to 4.3 per 1000 beds during this period. In 1970, distribution of short term hospital bed capacity across states was more balanced. The coefficient of variation of short term beds per capita in various states reduced from 0.24 in 1947 to 0.19 in 1970. The correlation between state income per capita and shot term hospital beds per capita decreased from 0.62 in 1947 to -0.15 in 1970. Thus the inter state distribution of hospital beds in the US had become more equal.

An important concern about the impact of such capital subsidy schemes is whether the additional hospital stock created due to the program was used? In 1970 average bed occupancy rates in Hill-Burton-supported hospitals was higher than all nonprofit hospitals. Support by the Hill-Burton program was associated with lower occupancy rates. However, this was mainly attributable to the preference given by the program to small hospitals. Since small hospitals tend to have lower occupancy, the Hill-Burton programme support would show a correlation with lower occupancy. Lave and Lave studied hospital occupancy

data after controlling for the effect of size and found that the association between the program support and lower occupancy was not significant. On the whole Lave and Lave concluded, that the Hill-Burton program did not significantly reduce occupancy levels, although specific examples of over capacity could happen.

Sponsors of the Hill-Burton programme believed that building hospitals in under-served areas would attract physicians to those areas. Lave and Lave found that the programme did affect the distribution of physicians. The increase in hospitals beds per capita had a statistically significant association with the number of physicians.

The capital subsidy under Hill-Burton programme was not available to forprofit health care institutions. It was believed that this exclusion should have hurt the proprietary hospitals. In 1947, proprietary hospitals accounted for 21% of short-term hospitals and 10% of short-term hospital bed capacity. By 1970, the number of proprietary short-term general hospitals had reduced to 9% and its share of beds had reduced to 5%. Lave and Lave examined the factors responsible for this change and tested a hypothesis if the Hill-Burton program was responsible for the decline of proprietary short term general hospitals in the US. The percentage change in proportion of proprietary short-term hospitals and beds were regressed on variables like personal income per capita, percent of population over 65 years, the Hill-Burton measure etc. The regressions did not explain much and suggesting that other variables may be responsible. Decline in market share of short-term proprietary hospitals was less in areas with growing population and increase in share of elderly population who would require a higher rate of hospitalisation. The effect of Hill-Burton program was equivocal. In six of the eight regressions, the Hill-Burton program was associated with a shrinkage in the market share of proprietary hospitals. However, the size of the effect was small. Hence, Lave and Lave (1974) concluded that the Hill-Burton program probably caused a decline in the relative importance of proprietary hospitals, but the effect was not important.

V. Health services planning and certificate-of-need (CON) regulation in the US

In 1959 Roemer and Shain published results of their study on utilisation of hospital services under third party insurance. They believed that excess hospital beds would generate additional demand. Normally, market forces would limit over provision. But the health care sector is characterised by market failure particularly in an environment of third party insurance coverage. Since all costs are reimbursed by the insurer, neither the hospitals, nor the doctor or for that matter the patient has an incentive to limit unnecessary utilisation of hospital

services. So it was argued that increase in hospital capacity would tend to increase utilisation. This linkage of growth in hospital capacity to rates of utilisation was commonly referred to as the Roemer's law. Each state in the US has some form of certificate-of-need (CON) law to regulate acquisition of capital stock by health care facilities. The state certificate-of-need agencies operate according to the respective state health system plans. In 1974, the federal government introduced a comprehensive system to control capital investment in hospitals under the National Health Planning and Resources Development (NHPRD) Act. Under this law, the state certificate-of-need (CON) agencies were authorised to review the need for capital expenditure by providers under Medicare and Medicaid reimbursement, in addition to their earlier responsibilities. Hospitals had to obtain CON for capital expenditures exceeding $150000. The intention was to limit availability of hospital beds and expensive hospital equipment. However, the program met with a strong criticism. The NHPRD requirement for Medicare Medicaid reimbursement was disbanded in 1984. However, the CON requirements at the state level continue to operate in most states.

VI. Health maintenance organizations (HMOs)

In 1973, the US Congress passed the HMO Act. to encourage growth of institutions that integrate health insurance and health care delivery. Traditional private insurance plans tend to encourage over utilisation of health care resources on account of moral hazard. The health care institutions do not have much incentive to control costs and limit utilisation. Since HMOs combine the insurance function and health care function, these organisations have an incentive to contain costs and limit utilisation. The subscriber's choice to leave an HMO for another or to a different kind of insurance plans is a balancing force acting on the HMO to maintain quality of care. Different forms of HMOs exist like the prepaid group practices (PGP), independent practice associations (IPA), etc. Fein (1986) observes that the number of HMOs in the US increased from 33 in 1971 to 377 in 1985. The subscriber base increased from 3.6 million to 16.7 million during the same period. The HMO subscribers in 1985 constituted 8% of the US population at the time. Fein (1986) believes that the US federal government's HMO programme had a substantial impact on development of HMOS.

VII. Peer review and practice guidelines

In 1989, the US Congress created a "Forum for Quality and Effectiveness in Health Care" within the Agency for Health Care and Policy Research (AHCPR). This Forum's task is to arrange for the development, periodic review and updating of (a) clinically relevant guidelines that may be used by physicians, educators,

stock of those areas. Most American states have some kind of certificate-of-need (CON) law to regulate of expansion of hospitals and acquisition of expensive equipment by health care institutions. Although the federal certificate of need program under the National Health Planning and Resources Development Act has been discontinued, the state certificate of need programs are continuing. To slow-down rapid increase in health care costs the US federal government has been encouraging setting up of health maintenance organisations (HMOs) which combine health insurance and health care provision functions. There are many programmes in US to improve quality of health care. Some important initiatives by the federal government include, (a) peer review organisations, and (b) development and dissemination of clinical practice guidelines.