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## **Groping for Autonomy: The Federal Government and American Hospitals, 1950-1990**

*Robert B. Hackey*

The contemporary U.S. health care system seems far removed from the pattern of professional dominance that characterized health care policymaking for most of the twentieth century. Prior to the 1960s, government involvement in the practice of medicine and in the financing of health care was severely limited in scope [Starr 1982; Somers and Somers 1961]. Hospital reimbursement was managed by providers through a private bargaining process with third-party payers. Blue Cross plans were the dominant third-party payers in most states by mid-century, but neither the Blues nor commercial insurers exercised significant countervailing power [Galbraith 1956] as purchasers of health care. Blue Cross plans, in particular, were created as "hospital service corporations" to provide the hospital industry with a stable revenue stream and were not predisposed to challenge the autonomy of providers [Stevens 1989]. Doctors and hospitals accepted new federal spending for hospital construction, medical research, and improved access for the poor and elderly but successfully resisted government efforts to regulate how these funds were spent.

This article chronicles the slow but steady emergence of countervailing power in the hospital industry since mid-century. The transformation of American health care policymaking reflects the federal government's growing fiscal obligations as the single largest purchaser of health care. As John Kenneth Galbraith [1956, 113] notes, "Power on one side of a market creates both the need for, and the prospect of reward to, the exercise of countervailing power from the other side." The federal government's effort to exercise countervailing power over health care providers shows no sign of abating in the future, for Medicare and Medicaid costs threaten the stabil-

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ity of the balanced budget agreement negotiated by the Clinton administration and the Republican leadership of the 105th Congress.

Concerns about rapidly rising health care costs led to the development of new institutional arrangements that infringed upon the autonomy of hospitals over the past three decades. In effect, Congress authorized Medicare and Medicaid programs to exercise countervailing power in health care financing in an effort to control the spiraling cost of federal entitlement programs. Policies that would have been unthinkable in the past—from the development of elaborate rate-setting methodologies to limitations on the capital investments and services of hospitals—were commonplace by the early 1980s [Brown 1986]. As health care costs continued to rise, hospitals chafed under an ever-increasing number of government regulations and controls. By the 1990s, decisions about the pricing and allocation of health services, standards of medical practice, and the profitability of providers increasingly rested in the hands of federal policymakers.

### *The Birth of the Health Care Technostructure*

Health providers have successfully resisted frontal assaults on their professional autonomy for decades. Efforts to enact national health insurance, which would place the federal government in the position of a monopoly purchaser of health care, met with vociferous opposition during World War I and again in the 1930s and 1940s [Kelley 1956]. Opponents of national health insurance succeeded in defining public debate as a struggle between liberty and socialism, which threatened both the quality of patient care and the core values of American society [Numbers 1982; Hackey 1997]. Although demand for health care declined during the Great Depression as consumers' purchasing power fell, few institutions existed to empower purchasers in the 1930s.

Instead of bowing to federal control, health providers crafted new institutional arrangements to finance continued expansion of the health care system. As in other policy arenas, purchasing and regulatory institutions were organized and controlled by the providers themselves [see McConnell 1966; Lowi 1969]. The political and economic climate of the late 1940s and early 1950s was particularly well suited to the emergence of a health care technostructure, for "power passes to the technostructure when technology and planning require specialized knowledge and group decision" [Galbraith 1971, 168]. Most hospitals served local markets in either a monopolistic or oligopolistic fashion; competition among providers, where it existed, typically revolved around questions of "conspicuous consumption" related to the prestige of an institution's medical staff, the scope of its available services, and the availability of new technologies, rather than to the price of services.

With encouragement from state insurance departments, hospitals responded to the fiscal challenges of the Great Depression by creating "hospital service corpora-

tions," commonly known as Blue Cross plans, to provide health service benefits to subscribers for an annual fee [Law 1976]. Unlike traditional forms of insurance, this arrangement set no fixed amount on total reimbursements for treatment, but rather agreed to cover a specified set of services for subscribers. Since the startup cost for such plans was subsidized by the participating hospitals themselves, both single hospital and community plans proliferated as a way to insure access to care for individuals and a steady revenue stream for hospitals in the 1930s. The ability of the Blues to exercise countervailing power was further circumscribed by the American Hospital Association (AHA), which prohibited competition among Blue Cross plans; each was given monopoly control over a state or geographic area within a state.

Since Blue Cross plans were closely tied to the hospital industry, most were neither champions of cost containment nor strong advocates for restructuring the existing health care system. A survey of state Blue Cross plans conducted by the U.S. Public Health Service in 1947 revealed that more than 70 percent of the board members who set policy for individual plans were affiliated with providers; 55 percent of all board members were representatives of the hospital industry, and an additional 17 percent represented national, state, or local medical societies [Serbein 1953, 119]. The creation of Blue Cross served an important purpose for hospitals, for it enabled the industry to maintain control over the pricing and use of its services. In a system where most institutions were reimbursed on a retrospective, fee-for-service basis with few controls over utilization, the hospital industry's revenue stream was secure. As Galbraith [1971, 199] notes, "Control of prices is for a purpose—for the security of the technostructure and to allow planned pursuit of its further goals. But price control does little to advance these goals unless there is also control over the amounts that are bought and sold at these prices."

Prior to 1965, direct federal involvement in health care reimbursement and regulation was confined to several peripheral areas that had a limited effect on the nation's hospitals. With no compelling fiscal interest at stake, federal officials saw few reasons to challenge the professional autonomy of health providers. Third-party health insurance was virtually unknown, as the moral hazard associated with offering open-ended health coverage dissuaded commercial insurers from entering the market [Starr 1982]. In short, while the economic turmoil facing hospitals in the 1930s offered a promising opportunity to develop countervailing power in the health sector, most buyers were unorganized individual patients who were ill-equipped to capitalize on these circumstances. Efforts to rationalize the delivery of health care through the creation of prepaid group practices during this period provoked intense opposition from health providers [Starr 1982].

The prevailing policy image of health care presented a further impediment to the development of countervailing power capable of challenging provider dominance of the reimbursement process. The policy image of an issue or problem both explains

the nature of a problem and suggests potential solutions to it [Baumgartner and Jones 1991]. Policy images reflect a set of shared understandings—they define how policies are understood and discussed by the media, decision makers (e.g., members of Congress, the president), and the public. In particular, "by contriving an appropriate image of the position, prospects, problems or dangers of the state the industrial system can insure a reaction favorable to its needs" [Galbraith 1971, 328]. For much of the twentieth century, additional spending on building new health care facilities and expanding the range of services available to the public were seen in uniformly positive terms. In 1932, the final report of the Committee on the Cost of Medical Care defined the nation's health policy agenda in terms of increasing access to care to all members of the population [Stevens 1989]. For health providers, this endorsement reflected a societal commitment to increasing investment in health care through additional support for research, infrastructure development, and the medical profession.

The Committee's agenda was soon embraced by national policymakers, business leaders, and the public. A congruence of values among providers, policymakers, and the public is not unexpected, for "much of what is believed to be socially important is, in fact, the adaptation of social attitudes to the goal system of the technostucture. What counts here is what is believed" [Galbraith 1971, 163]. The positive policy image of health providers and of additional health care spending did not lend itself to the mobilization and organization of health care purchasers, allowing hospitals and their allies (e.g., Blue Cross plans) to dominate the reimbursement process. A solid majority of citizens endorsed the expansion of voluntary health insurance coverage; free medical care for mothers, infants, and the needy; and expansion of the Social Security system to include sickness benefits [Erskine 1975]. Concerns over access, not cost containment, also dominated the health policy agenda in Congress during the 1940s and 1950s, as issue entrepreneurs sought to expand coverage to underserved groups and to increase the supply of physicians and hospitals.

### *The Politics of Accomodation: Federal Health Care Policies in the 1940s and 1950s*

The federal government's early forays into health care financing were relatively innocuous from the perspective of health providers. During the 1930s, the federal Works Progress Administration constructed and renovated hundreds of hospitals nationwide. The Lanham Act, passed in 1941, provided more than \$120 million to build or upgrade hospital facilities in geographic areas where defense plants and military bases were located as part of the war effort [see Stevens 1989, 208-11]. In the 1940s and 1950s, federal health policies were aimed at winning the political support of constituents and health providers, both of whom clamored for more, not

less, spending on health care. Beginning in the late 1940s, the Hospital Survey and Construction Act of 1946, best known as the Hill-Burton program, provided federal funds for the construction and modernization of hospital facilities and imposed few binding restrictions on providers [Lave and Lave 1974]. Federal programs subsidized care for the indigent and poor elderly, provided health services to Indian tribes under the aegis of the Indian Health Service, and cared for veterans and military personnel through a separate system of hospitals operated by the Veterans' Administration and the respective military services [Serbein 1953]. At the same time, federal support for basic medical research expanded at a rapid pace under the auspices of the National Institutes of Health (NIH). Federal research funds were also used to purchase inpatient hospital care for indigent patients undergoing diagnostic testing for cancer, tuberculosis, and venereal disease through programs administered by the National Cancer Institute and the U.S. Public Health Service [Serbein 1953, 257-60]. None of these initiatives challenged the prerogatives or autonomy of providers—all were popular distributive programs that enjoyed widespread public and congressional support.

The Hill-Burton program was designed to increase public access to quality health care services by subsidizing hospital construction. Since the prevailing view from the 1940s through the mid-1960s was that increased access to medical care would improve the overall health of the population, federal health policies during this period increased spending on health care facilities and personnel. Although Hill-Burton was intended to target benefits to rural and underserved areas, the immense popularity of hospital construction led Congress to spread program funding throughout their districts, rather than funneling funds to poorer, rural areas. Hill-Burton made it possible for members of Congress to claim credit for worthy projects in their districts on an annual basis; during the first five years of the program, more than 1,700 separate projects were approved, adding more than 80,000 hospital beds across the nation at a cost of more than \$400 million [Serbein 1953, 276-77].

Federal support for increasing health care facilities, personnel, and research during this period reflects Galbraith's [1971, 164] observation that "successful planning in areas of expensive and sophisticated technology requires that the state underwrite costs, including the costs of research and development, and that it insure a market for the resulting products." Federal policies ensured that consumer demand for health care services would continue to rise, for unions were encouraged to bargain for health insurance and other nonwage "fringe benefits" in lieu of additional compensation during the wartime economy of the 1940s to slow inflationary pressures on wages. Private health insurance coverage expanded rapidly during the 1950s, prompting many critics of national health insurance to suggest that comprehensive federal reform was no longer needed [Hackey 1997]; by the mid-1950s, more than 100 million Americans were covered by private health insurance [Stevens 1971]. Health care financing during this period illustrates Galbraith's [1971, 299] observa-

tion that "the line between public and private authority in the industrial system is indistinct, and in large measure imaginary." Over the course of a decade, hospitals succeeded in securing federal subsidies for new construction projects, lowered the cost of charity care, and increased the ability of the poor elderly to purchase their services.

The first direct federal involvement in provider reimbursement came in 1950, when Congress authorized a system of "vendor payments" to compensate health providers for free care given to persons receiving public assistance. As Rosemary Stevens notes [1989, 269], "The advent of vendor payments, with their direct assumption of government purchase of care . . . assumed, in effect, that private charity giving to the poor—by hospitals and physicians—ought to be unnecessary." This assumption became the unofficial dogma within the hospital industry and was adopted by both the federal government and AHA as the proper method for reimbursing hospitals for the cost of charity care (later known as uncompensated care). The passage of the Kerr-Mills program in 1960 expanded the federal government's role in providing coverage for the poor by subsidizing medical care for the elderly through federal matching funds provided to state medical assistance programs. While neither vendor payments nor the Kerr-Mills program had an appreciable impact on the financing of health services, both legitimated federal involvement in the financing of health care.

The implementation of vendor payments and Kerr-Mills, however, raised the ire of providers over what they perceived to be inadequate reimbursement for the costs associated with furnishing charity care. In an effort to define the terms of relationships between hospitals and purchasers of health care, the AHA published its *Principles for the Payment of Hospital Care* in 1953. The *Principles* established retrospective, cost-based reimbursement as the industry's standard operating procedure and declared that hospitals should be reimbursed for the full cost of treating a patient. Under this system, which was subsequently adopted by Blue Cross plans and endorsed by both the federal vendor payments and the Kerr-Mills program, purchasers of health care had little market leverage to control either the price or the utilization of health care services.

Each of the principal federal initiatives in the two decades following the end of World War II served important purposes for providers without threatening their autonomy. Federal investment in hospital construction under the Hill-Burton program simultaneously addressed the desire of providers for additional capital investment, of physicians for more sophisticated "workshops" [Pauly and Redisch 1973], and the public's concerns about improving access to care, particularly in the nation's poor and rural communities. The expansion of the Veterans' Administration hospital system and its close affiliation with graduate medical programs provided medical school faculty and students with a steady supply of patients on which to practice their skills. Finally, the federal government's role as a third-party payer

during this period, through both the vendor-payments program and Kerr-Mills, relieved hospitals of the fiscal burden associated with providing care for the indigent and the poor elderly. Federal investments, with few strings attached, won praise from providers as sound public policy and served an important electoral purpose for members of Congress.

### *The Dominance of the Health Care Technostructure*

The passage of Medicare and Medicaid marked a turning point in organized medicine's influence over health care policymaking. The American Medical Association's (AMA) strident opposition to any form of "socialized medicine" in the years leading up to 1965 made both administration officials and congressional leaders wary of alienating providers in drafting health legislation [Jacobs 1992]. In an effort to accommodate providers' concerns, the initial design of the Medicare reimbursement system reflects Galbraith's [1971, 307] observation that "[the modern corporation] has won an accommodation by the state to its needs that is highly favorable." While federal policymakers' decisions to accelerate depreciation of capital projects and to adopt the AHA's *Principles for the Payment of Hospital Care* as the basis for provider payment under Medicare and Medicaid ensured a smooth takeoff for the programs [Feder 1977; Thompson 1981], they ignited an inflationary spiral in the health care industry. The passage, and subsequent implementation, of Medicare marked the zenith of the hospitals' influence over health care policy.

The "adaptation of public goals to the goals of the technostructure" [Galbraith 1971, 312] occurred throughout the implementation process, as strong provider representation on the principal advisory bodies enabled hospitals and physicians to advocate for advantageous financing arrangements. Nowhere was this pattern of accommodation more visible than in the implementation of Medicare. Provider input was solicited for all key decisions regarding reimbursement, utilization, standards of care, and the certification of physicians, hospitals, and home health providers [Feder 1977]. Veiled threats about a provider boycott of Medicare, which could potentially cripple the program and embarrass the administration, continued throughout the year-long rule-making process leading up to the program's startup. The administration's concerns about a boycott of the program were reflected in the organization of the Bureau of Hospital Insurance's (BHI) principal advisory councils—the Health Insurance Benefits Advisory Council (HIBAC) and the National Medical Review Committee (NMRC). The HIBAC mediated disputes among providers, third-party health insurers, and SSA officials and considered all issues relating to the organization, financing, and delivery of program services in the year before program startup. As one of the primary policy incubators for Medicare's rule-making process, the HIBAC afforded providers significant leverage over the implementation process, for nine of the council's sixteen members were physicians

[Somers and Somers 1967, 32]. Although the membership of the NMRC had not been appointed before the program's startup, the enabling legislation mandated that a majority of the committee's nine members must be physicians and that other members should be selected from "organizations and associations of professional personnel in the field of medicine and other individuals who are outstanding in the field of medicine or related fields; except that at least one member shall be representative of the general public" [Somers and Somers 1967, 31-32].

In this context, federal officials were reluctant to fully exercise their newfound leverage over health providers. Although Lawrence Jacobs [1992] suggests that public opinion strongly influenced the implementation of Medicare, the development of Medicare's retrospective cost-based reimbursement system using fiscal intermediaries reflects James Q. Wilson's [1980, 369] description of client politics, in which an "easily organized group will benefit and thus has a powerful incentive to organize and lobby; the costs and benefits are distributed at a low per capita rate over a large number of people, and thus they have little incentive to organize in opposition—if indeed, they even hear of the policy."

If hospitals had lost the war over extending health insurance to the elderly in 1965 (see Marmor [1971] for an excellent account), they won the first battles over reimbursement in the years that followed. The end result was a boon for the industry. In addition to extending insurance coverage to a large segment of the population that had historically underutilized medical services, hospitals won federal reimbursement for the indirect costs of patient care such as capital expenditures and depreciation [Somers 1969]. Although the BHI determined eligibility and paid for Medicare subscribers' benefits, responsibility for the day-to-day operation of the program was delegated to "fiscal intermediaries," 90 percent of which were Blue Cross plans. Proponents of the concept argued that both Medicare and the hospitals would "benefit from the relationships [the intermediaries] have established with hospitals, physicians and others who furnish health care" [Feder 1977, 37].

Utilization review audits to ensure that providers did not overcharge Medicare for unnecessary services were also conducted by intermediaries, thus linking responsibility for payment and oversight within an administrative structure dominated by health providers. Furthermore, since providers were free to contract with their choice of fiscal intermediaries to handle Medicare claims processing, a Blue Cross plan that tried to "get tough" with hospitals on issues of quality and cost containment could find itself without a contract. Without strong incentives to act otherwise, few Blue Cross plans risked the financial benefits from their status as intermediaries to do the government's dirty work; most accommodated, rather than antagonized, hospitals.

Following the practice of most Blue Cross plans, Medicare agreed to reimburse hospitals on the basis of "usual, customary and reasonable" (UCR) fees and charges within a geographic area. This mode of reimbursement was decidedly inflationary,

for as the average fee level rose in an area, so did the definition of what qualified as usual, customary, and reasonable. Hospitals had no incentive to limit the growth of costs, for to do so would reduce revenues. Instead, hospitals saw Medicare as a source of funds for capital expansion and aggressively pressed for reimbursement on a "cost-plus" basis, arguing that even nonprofit institutions needed a modest surplus over their operating expenses to provide capital for renovation, expansion, and research [Somers 1969]. Providers reached a compromise with federal officials that added an additional 2 percent to Medicare reimbursements to cover "other costs" associated with providing care to program beneficiaries. As a result of this compromise, Medicare pumped millions of additional dollars into hospital coffers with no strings attached, setting off a hospital construction bonanza in the late 1960s and early 1970s; Medicare's payments to hospitals grew from \$891 million in 1966 to \$4.7 billion in 1969.

### *The End of Consensus*

After 1965, the policy image of health care changed as decision makers and the public came to view additional spending on health care as a "crisis" that had to be controlled, rather than as an "investment" in needed programs for underserved segments of the population. The passage of Medicare and Medicaid gave federal officials a direct interest in health care cost containment. The health care cost explosion in the years after 1965 led to fundamental changes in the relationship between public officials and providers and other societal interests. As the policy image of health care shifted, the interests of elected officials shifted as well; rising costs provided federal officials with a reason to intervene in the fiscal affairs of the hospital industry for the first time. Beginning in the late 1960s, cost-conscious federal policymakers looked to new institutions to exercise leverage over the industry, placing government increasingly at odds with the hospital industry technostucture. Initial restrictions on providers in the 1960s and 1970s were modest, but the scope of federal "rationalizing strategies" to control the rapidly rising cost of entitlement programs expanded over time. By the 1980s, the line between government at both the state and federal levels and the technostucture was increasingly clear, as public officials embraced the pursuit of hospital cost containment in a "government-led search for solutions to government's own problems" [Brown 1983, 45]. Until government officials possessed the statutory authority to exercise leverage over the fiscal affairs of hospitals, power over health care policymaking remained squarely in the hands of providers.

Robert Higgs [1987] contends that crisis, either perceived or real, is a precondition for the expansion of government authority. When policy debates are defined by the rhetoric of crisis, ideological opposition to the use of public authority breaks down as the public becomes anxious for government to "do something" to cope with

the crisis. The rhetoric of crisis has been a common feature in health care policy-making over the past three decades. As policymakers, the mass public, and the media trumpeted the system's ills, opportunities arose for resourceful policy entrepreneurs to assemble coalitions in support of expanding public authority over the hospital industry.

As Congress began to view health care expenditures as budget busters, rather than as investments, legislators approved a variety of cost-control experiments in an effort to limit rising entitlement spending. To do so, Congress created new institutional structures, centralized decision-making authority over hospital reimbursement and capital investment, and invested state and federal regulatory agencies with new statutory mandates and policy tools to increase their leverage over health providers and third-party payers. Since countervailing power was effectively absent from health care financing, the federal government used its growing market share to reshape the health care market in the 1970s and 1980s. Federal policies toward health care financing in the years since 1965 can be seen as a series of attempts to cope with the compromises made during the implementation of Medicare and Medicaid [Brown 1983]. After 1965, federal and state governments became the largest purchasers of hospital services, providing public officials with a direct and immediate interest in controlling the price of medical services.

The process of creating countervailing power in the health care industry, however, was incremental and slow. Federal policymakers faced the difficult task of building the government's regulatory and planning capacity in a political environment dominated by health providers. Early government efforts to regulate the hospital industry resembled Stephen Skowronek's [1982] description of American political development during the late nineteenth century, in which new institutions developed, but "governmental elites could not sustain support for efforts that threatened to undermine long-established political and institutional relationships."

### *The Trials and Tribulations of Health Planning*

Health planning appeared to offer a palatable solution to "rationalize" the organization and financing of health services in the late 1960s and early 1970s. The emphasis on planning by both federal and state governments was largely a by-product of Milton Roemer's [1961] dictum that a bed built is a bed filled; doctors and hospitals could, in essence, fill empty beds by increasing the demand for hospital services in their choice of treatments [see Pauly and Redisch 1973]. Since patients were insulated from the true cost of treatment by extensive hospital insurance coverage [Feldstein 1971; Pauly 1980, 17-20], neither doctors, hospitals, nor patients had an incentive to restrict utilization of hospital facilities. If Roemer was correct, the logical solution to rising utilization and health care costs would be to restrict the growth

of hospital facilities in the expectation that "a bed not built is a bed not used" [Dunham 1981].

The federal government's first effort to coordinate health care services under the Comprehensive Health Planning Act of 1966 [Pub. L. 89-749] has been described as a "half-hearted commitment" that achieved few tangible results [West and Stevens 1976, 175]. The Comprehensive Health Planning (CHP) Act created a planning and regulatory program on training wheels; planning agencies were dominated by provider groups, lacked technical expertise, and had little legal authority to enforce compliance with the state and local plans they developed. Since federal funding for planning agencies was contingent upon the ability of state and local matching funds, many CHP agencies were dependent on hospitals and third-party payers for funding, data analysis, and even basic information about the functioning of local health care systems [West and Stevens 1976, 179]. Given the ambiguity of the statute, state and local planners had few incentives to pursue cost control, for both state and local planning agencies emphasized needs assessment and the identification of opportunities for resource sharing and cooperation. When viewed in this light, the federal government's first attempt to control costs via health planning bears out Galbraith's prediction that a "fusion" of tasks would develop between the technostructure and the state. Pub. L. 89-749 illustrated how "members of the technostructure work closely with their public counterparts . . . in advising them of their needs" [Galbraith 1971, 395].

Federal regulation of the hospital industry increased markedly after the passage of the Health Planning and Resource Development Act in 1974 [Pub. L. 93-641] established more than 200 federally funded local health planning agencies. These new health systems agencies (HSAs), working in concert with state health planning and resource development agencies (SHPDAs), were responsible for assessing regional health needs and were expected to regulate the construction and expansion of new health care facilities. Planners, however, lacked the authority to impose effective sanctions upon hospitals [Vladeck 1979]. Even their supporters acknowledged that the new agencies were beset by multiple (and often conflicting) goals, lacked the requisite authority to pursue these goals, and offered budding planners few incentives to engage in trench warfare with local hospitals [Luft and Frisvold 1979]. In addition, as Harvey Sapolsky [1991, 822] argues, "Physicians, and more relevantly, hospital administrators, quickly discovered that the planning system could be outmaneuvered. The system was not much of an obstacle once the consultants were called in to advise."

State and federal certificate-of-need (CON) programs suffered from the same shortcoming as systemwide planning efforts; both placed too much hope on a program with multiple objectives to control health care costs [see Brown 1981; Bovbjerg 1988]. CON programs offered state and federal officials a tool to influence the decisions of health care providers to expand or modify existing facilities and serv-

ices, but efforts to decertify beds or restrict the diffusion of profitable new technologies were vehemently opposed by health providers [Carpenter and Paul-Shaheen 1984]. States with aggressive CON programs soon found themselves in court, as providers challenged the statutory authority of state and local planning agencies, the representativeness of HSAs, and the interpretation of state-enabling legislation and health-planning documents. Furthermore, the most critical decisions—those that affected the level of reimbursement for hospital services—remained beyond the scope of planners' jurisdiction.

Despite the limitations of the planning process created by Pub. L. 93-641, HSAs opened up the decision-making process to new groups. Since a majority of representatives on local planning bodies were required to be "consumers"—defined in practice as non-providers—business leaders and citizens with no formal ties to the health care industry became increasingly active in health policy debates during the 1970s and 1980s. Uncertainty reigned as new groups clamored for seats at the table and existing groups fought for representation to protect their interests [Marmor and Morone 1981].

### *The Prospects and Pitfalls of Price Regulation*

Even before the passage of the Health Planning and Resource Development Act of 1974, Congress began to experiment with other institutional levers to control health care costs. While health planning programs garnered the lion's share of attention during the 1970s, federal officials were quietly reshaping the mechanisms used to pay health providers. Health care financing reforms over the past two decades emerged from a set of arrangements aptly described by Lawrence Brown [1985] as a process of "technocratic corporatism" in which payers, providers, and government bureaucrats bargained over technical modifications to the payment system. In retrospect, Clark Havighurst's [1986] assertion that decision making in health care would increasingly devolve to the consumers of health services proved to be correct, but in an unexpected fashion. Far from the decentralized market system driven by individual choice that was envisioned by supporters of procompetitive reform, power devolved into the hands of the largest "consumers"—federal and state governments. The result was a "refederalization" of health care decision making, rather than the decentralization anticipated by conservatives [Rabe 1987].

The federal government's first efforts to limit its financial exposure were aimed at undoing some of the excesses that accompanied the implementation of Medicare and Medicaid. The first target of federal cost-cutters was the 2 percent "plus factor" granted to providers to provide working capital for facilities improvements and new services. While repeal of the plus factor in 1969 irked providers, it did nothing to change the fundamental design of the Medicare payment system. The first substantial change in Medicare's relationship with health providers did not come until the

passage of the Social Security Amendments of 1972 [Pub. L. 92-603]. Section 223 of the 1972 Social Security Act introduced a prospective component to Medicare reimbursement that limited the federal government's reimbursement of "allowable costs" for inpatient care to 120 percent of the mean for such costs for a peer group of hospitals. While the cap was gradually lowered to 108 percent of mean costs between 1975 and 1982, the Section 223 limits placed no restrictions on reimbursement for "nonroutine" operating costs associated with interest payments, depreciation, or the cost of ancillary services [Office of Technology Assessment 1986, 23].

The cap's effectiveness was limited, for the system remained primarily retrospective and cost-based; Section 223 was intended to provide high-cost "outlier" institutions with an incentive to hold down costs. Hospitals whose charges did not deviate significantly from their peer group mean were largely unaffected by these changes. Despite its limited scope, Section 223 marked a radical departure from past policy—for the first time, the federal government placed a prospective cap on hospital reimbursement, which affected a significant percentage of the institutional caseload. Section 1122 of the Social Security Amendments also strengthened the hand of state and local planning agencies by prohibiting the use of federal funds to reimburse the capital expenditures of providers for "unnecessary" projects that had not received prior approval from state planning agencies. Although relatively few institutions were adversely affected by these changes, Pub. L. 92-603's limits on allowable costs and its restrictions on capital-expenditure reimbursement represented a fundamental break from the principles of cost-based reimbursement developed by the industry over the previous two decades.

The Social Security Amendments of 1972 also produced another significant reform that would have widespread ramifications for the regulation of the hospital industry over the next decade. While the provisions of Section 223 were aimed at outlier hospitals whose costs far exceeded national peer-group averages, Section 222 of the 1972 act authorized the Department of Health, Education, and Welfare (HEW) to fund demonstration projects and experiments to test various cost-containment measures that would apply to all hospitals in a geographic area. Under the terms of the demonstration projects, HEW agreed to absorb any losses it might incur if the experiments failed to achieve their cost-control targets and actual costs proved to be higher than under HEW's own reimbursement methodology. In the long run, Section 222 had a tremendous impact on health care regulation and reimbursement policies, for it encouraged the proliferation of state rate-setting experiments during the 1970s and early 1980s.

State-level experimentation redefined the relationships between payers, providers, and government regulatory agencies, particularly in states where all hospital revenues were subject to control by state regulatory agencies [Hackey 1998]. All payer rate-setting programs achieved considerable cost savings and limited the abil-

ity of hospitals to shift costs from regulated payers (usually state Medicaid programs) to unregulated commercial insurers and paying patients [Coelen et al. 1988]. In addition to strengthening the hand of state health care bureaucracies, however, the demonstration projects funded under Section 222 provided HEW officials with opportunities for extensive policy learning. The full impact of the Section 222 waiver process was not felt nationwide until 1983, when Medicare incorporated the lessons of New Jersey's prospective hospital rate-setting methodology as the basis for its new prospective payment system (PPS).

Health care inflation occupied the attention of policymakers throughout the 1970s, as increases in hospital prices consistently outstripped the general inflation rate. After wage and price controls were lifted in 1974, hospital costs increased by \$14.5 billion from 1974 to 1975, the largest single-year increase in the nation's history [Congressional Quarterly 1978, 500]. Medicare outlays for hospital insurance increased by 387 percent in the decade following the 1972 Social Security Amendments, from \$6.8 billion in FY1973 to \$33.3 billion in FY1982; inpatient hospital care accounted for more than 65 percent of all Medicare program reimbursements by 1984 [HCFA 1988, 20-21].

After taking office, President Jimmy Carter made hospital cost control one of his top legislative priorities. In 1977, the president proposed the most ambitious attempt to regulate the hospital industry to date; the administration's proposed legislation (H.R. 6575/S. 1391) sought to cap hospital revenue growth from all sources to a 9 percent annual rate and imposed strict limits on the construction of new health care facilities. Carter actively campaigned for the bill, promising that its passage would "slow a devastating inflationary trend, which doubles health costs every five years. . . . The cost of [health] care is rising so rapidly it jeopardizes our health goals and our other important social objectives" [Congressional Quarterly 1978, 499-500]. Providers, however, argued that such extensive federal intervention was unnecessary. Hospital industry officials expressed confidence that the industry could control costs through "voluntary restraint." In 1979, Congress decided to give the industry a chance to prove itself, ending further discussion of federal price controls.

### *The Legitimation of Behavioral Controls on the Hospital Industry*

The effort at voluntary restraint by hospitals was a spectacular failure, which severely undermined the industry's credibility in Congress; national expenditures for hospital care rose 36 percent, from \$87.9 billion in 1979 to \$119.6 billion in 1981, while Medicare outlays for hospital services rose 45.6 percent in the same period, from \$21.7 billion in 1979 to \$31.6 billion in 1981 [Chulis 1991, 196]. Passage of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 [Pub. L. 97-248] sounded the death knell for the system of retrospective, cost-based reimbursement

that the hospital industry had fought to preserve [Office of Technology Assessment 1986, 23].

TEFRA imposed the most significant limitations on Medicare payments to providers since the program's inception in 1965 by extending the Section 223 limits to include ancillary departments and special care units and by imposing an absolute ceiling on reimbursement for costs associated with providing inpatient care. Under the TEFRA reimbursement formula, hospitals would only be reimbursed for the lower of a prospectively set target rate or 120 percent of the average cost per case for a peer group of hospitals [Office of Technology Assessment 1986, 23]. The new measures also provided an incentive for hospitals to improve the efficiency of their operations, since costs above the cap would not be reimbursed. In addition, TEFRA marked the federal government's first use of a hospital's case mix to determine inpatient reimbursement. Hospital per diem costs were adjusted for both the type and severity of illness on the basis of a classification system that grouped similar medical procedures into "diagnosis-related groups" (DRGs). DRGs were developed in the mid-1970s by researchers at Yale University Medical School to separate inpatient hospital procedures into a fixed number of diagnostic categories. Since patients in a DRG have similar clinical conditions that require similar treatments, they are expected to consume roughly comparable amounts of a hospital's resources.

TEFRA signaled the federal government's new willingness to use the rate of reimbursement as a lever to bring hospital costs under control. The growing burden of the Medicare and Medicaid programs led federal officials to pursue cost containment, despite howls of protest from the hospital industry and health providers. The rationalizing politics of cost containment underscored a growing divergence in the political interests of federal policymakers and the health care technostucture. Beginning in 1982, for the first time, a significant fraction of hospitals' revenues were determined on a prospective, rather than a retrospective, basis. The switch to prospective reimbursement was significant from a state-building perspective, for the adoption of a prospective payment system shifted control over hospital reimbursement from providers to the Health Care Financing Administration. Under the new system, federal bureaucrats, not hospital administrators, set reimbursement rates for all inpatient hospital services.

The TEFRA limits were viewed as a threat by the hospital industry because Medicare's new formula paid for hospital services largely on the basis of institutions' average costs. The federal government's new approach to hospital reimbursement led to the political fragmentation of the hospital industry, for while all hospitals benefited from the cost-based, retrospective system of reimbursement, some institutions fared well under prospective payment, while others struggled. As long as providers could earn additional revenues by passing along higher costs to the federal government, few incentives existed for institutions to reorganize their delivery of care. By setting a national average payment rate and adjusting payments to

providers to account for differences in their patients' severity of illness, TEFRA pitted the interests of urban teaching hospitals and trauma centers, which treated sicker than average patients, against many of their suburban and for-profit counterparts. Under TEFRA and its successor, a hospital's profitability was closely tied to its ability to keep costs below the pre-established rate of payment. To do so, hospitals treated a growing proportion of their patients on an "outpatient" basis to limit the use of resources, cut staffing, and sought to squeeze out additional economies in purchasing and "discharge planning" to minimize patients' length of stay [Iglehart 1993].

Ballooning deficits contributed to the new rhetoric of crisis and legitimated policy choices that had been politically infeasible five years earlier. Commitment to cost control was a bipartisan matter in the 1970s and 1980s, as the most sweeping price regulations to date in the health sector were introduced in 1982 and 1983 at the behest of a conservative Republican president who had campaigned on a platform of reducing government regulation and intervention in the private sector. TEFRA was a radical departure from past practice, which placed many hospitals that treated a sicker than average (i.e., high-cost) patient population at a considerable disadvantage. TEFRA did not represent a temporary inconvenience for health providers, as Pub. L. 97-248 directed the Secretary of Health and Human Services (HHS) to recommend to Congress a more permanent prospective reimbursement system for inpatient care under Medicare by 1983.

HHS had relatively few options to choose from in suggesting a comprehensive reform of Medicare's hospital payment policies. The one option that had been widely discussed within the department, however, was New Jersey's ongoing all-payer rate-setting experiment using DRGs. HCFA had pressed New Jersey officials to adopt a DRG-based system in the late 1970s to explore the feasibility of a case-based prospective payment system for inpatient hospital care [Morone and Dunham 1985]. Given its limited time frame and the absence of other viable options, HHS recommended in its December 1982 report to Congress that Medicare phase in a prospective reimbursement system modeled after the HCFA demonstration project in New Jersey. Medicare's new (PPS) was passed as part of the 1983 Social Security Amendments (Pub. L. 98-21) amid little debate after a brief four-month gestation period in Congress. The passage of Medicare's PPS followed a familiar pattern, as the hospital industry technostucture endorsed the plan and worked with key congressional leaders and administration officials to develop the new DRG-based payment system. Like the previous reforms of the nation's health care financing system during the 1970s, PPS emerged out of a relatively closed, "technocratic" bargaining process that received little attention from the media or the mass public [Brown 1985].

### *A Fraying Alliance between Hospitals and the Federal Government*

Hospital industry representatives welcomed the change from the crude and restrictive payment criteria provided under TEFRA, for PPS's treatment of case-mix differences among hospitals represented a significant advance over the previous methodology; the proposal won the endorsement of the AHA and the Federation of American Hospitals. PPS payment rates were initially set at a high level to allay provider fears of fiscal catastrophe under the new system. Indeed, the Medicare margins (i.e., net operating profits) for all hospitals exceeded 14 percent during the program's first two years, as Medicare payments per hospital discharge increased by 18.6 percent in FY1985 and 10.5 percent in FY1986 [Altman 1995]. Generous reimbursement rates in the first three years of PPS led to record profits in the hospital industry, as the net operating margin for Medicare patients exceeded 10 percent [Russell 1989] and total revenue margins for community hospitals exceeded 5 percent from 1984 to 1986. The rising tide lifted all boats, for hospitals in all ownership categories reported positive Medicare margins in FY1985 and FY1986 [Altman 1995]. During the three-year transition period from TEFRA to PPS, Medicare agreed to use regional, rather than national, averages to determine hospital costs to ease the adjustment for hospitals located in regions with above-average costs as a result of chronic labor shortages. Under this system of "blended" rates, the proportion of the prospective rate that was based on a hospital's historical costs declined over time as the share of the rate determined by national average rates increased.

Over time, however, HCFA's accommodative policy toward the hospital industry became increasingly restrictive. Medicare margins began to decline in 1986 and fell steadily until 1993. Adjustments to PPS rates fell from double digits in the program's first two years to 3.3 percent in FY1987 and lagged behind the overall rate of medical inflation for the remainder of the decade [Altman 1995]. In retrospect, the generous rates of payment under PPS designed to reassure providers that the new payment system would remain "budget neutral" in its first years seem insignificant, for Medicare reaped considerable savings under the new system as hospitals changed their behavior to conform to the incentives of a case-based reimbursement system: admissions declined, as did the average length of stay for patients [Russell 1989]. As HCFA officials began to tighten the financial screws on inpatient reimbursement during the shift from individual historical costs to lower national and regional rates, PPS operating margins for hospitals fell precipitously; by 1990, most hospitals were losing money on Medicare patients [Guterman, Altman, and Young 1990]. This was not an unanticipated consequence, for as Karen Davis and Diane Rowland [1986, 79] note, "the principal savings in the system come from limiting increases in the average payment rate over time."

The implementation of Medicare's PPS also increased fragmentation within the hospital industry by linking the level of payment to a hospital's location (e.g., urban vs. rural), teaching status, and the nature of the population served. Opposition to

PPS within the hospital industry varied considerably, as some institutions prospered while others struggled to survive [ProPAC 1994; Rosko and Carpenter 1994]. Hospitals in rural areas were seriously affected by PPS, and the rapid rise in the number of rural hospital closures during the 1980s exacerbated concerns about access to care in rural America [Christianson, Moscovice, and Tao 1993; Goody 1993]. Rural institutions began to lose money on Medicare patients in FY1987 and continued to experience net operating margins into the early 1990s [Altman 1995]. In contrast, urban government hospitals, voluntary institutions, and proprietary hospitals fared quite well under PPS despite declining operating margins. Indeed, while both proprietary and voluntary hospitals reported net losses on Medicare patients from FY1991 to FY1993, both recorded net operating profits by FY1994 [Altman 1995]. Overall, the introduction of Medicare's PPS led to statistically significant reductions in the length of hospital stays, cost per admission, labor cost per admission, and per capita hospital admissions by the mid-1980s [Sloan, Morrisey, and Valvona 1988].

Under PPS, a hospital's fiscal health depended on both its case mix (i.e., the severity of patients' illnesses) and its payer mix (i.e., the percentage of hospital revenues generated by different third-party insurers). Institutions serving predominantly poor inner-city communities were increasingly hard pressed to make ends meet by the end of the decade, despite Medicare's efforts to compensate institutions that treated a "disproportionate share" of indigent patients. Since these institutions typically had fewer patients with private health insurance plans that still paid on the basis of charges, many inner-city hospitals found it difficult to emulate the cost-shifting behavior of their suburban counterparts, in which privately insured patients were charged higher rates than those covered by Medicare or Medicaid (see Abraham [1993] for an excellent account of the difficulties facing such institutions).

PPS fundamentally changed the financial incentives for hospital reimbursement. Under the cost-based system in effect from 1966 to 1982, hospitals sought to keep patients in the hospital for as long as possible, for longer stays and additional clinical interventions increased revenues. Medicare's PPS contributed to the restructuring of the hospital industry, as the number of hospital beds, inpatient admissions, inpatient days, length of stay, and average occupancy rates fell during the 1980s, as hospitals scrambled to transfer patients to more profitable "outpatient" settings. Hospitals also acquired a financial incentive to discipline physicians who "wasted resources" by keeping patients in the hospital too long, for additional services represented either lost profits or an operating loss [Iglehart 1993]. Institutions soon adapted to the new payment system, leading to rising revenue margins for community hospitals in the late 1980s and early 1990s despite the fact that annual increases in Medicare payments per hospital discharge fell from 6.6 percent in FY1990 to 3.5 percent in FY1994 [Altman 1995]. Hospitals employed small armies of professional coders whose sole task was to determine the most appropriate and most profitable DRG for each Medicare patient admitted or treated. The use of creative DRG cod-

ing to inflate hospital revenues (known as "upcoding" or "DRG creep") added an entire consulting industry to the health care technostructure to enable hospitals to "enhance" their Medicare revenues.

### *Conclusion*

As Galbraith [1956, 136] argues, "The support of countervailing power has become in modern times perhaps the major domestic peacetime function of the federal government." Until the creation of large federal entitlements to provide health care for the elderly and low-income residents in the 1960s, however, congressional policymakers had few incentives to intervene in the internal affairs of the hospital industry. By the early 1970s, the growing cost of government-sponsored health insurance led to the development of new federal policies aimed at restructuring the incentives of the reimbursement process. The transformation in the role of the state in financing health care was accompanied by new institutional developments designed to enhance its control over hospital payment decisions. As Bruce Vladeck [1981, 215] argues, this was inevitable, for "extensive regulation of health care providers is the price we pay for not having national health insurance."

The evolution of health care financing policy illustrates a larger point about the effectiveness of countervailing power, for the growth of federal intervention was unable either to solve the government's own fiscal crisis or to stem the long-term trend toward increased health care spending. While TEFRA and PPS reduced the use of inpatient hospital services, hospitals adapted to the new fiscal climate by shifting patients to more profitable outpatient settings or to home care, which continued to operate on a cost-based, fee-for-service basis. The federal government's shift from passive accommodation of providers' interests in the 1950s and 1960s to the use of centralized behavioral controls in the 1980s led hospitals to reinvent themselves, for Medicare accounted for more than 40 percent of the average community hospital's gross patient revenues [Iglehart 1993]. The policy changes in Medicare reimbursement, which began in the early 1970s, created a "ratchet effect" [see Higgs 1987] as the Medicare program's growing share of the federal budget and its central role in preserving the balanced budget agreement led to a steady escalation of federal influence over the hospital industry. The failure of early government cost-containment initiatives led to calls for more sweeping government controls—further cutbacks in provider payments were a cornerstone of the 1997 balanced budget agreement between the Clinton administration and the Republican congressional leadership.

Although the federal government's relationship with the hospital industry resembled the "close fusion" between the state and the technostructure described by Galbraith [1971] at mid-century, over the past two decades the interests of federal policymakers and industry representatives diverged. From the 1940s through the

1960s, "members of the technostucture work[ed] closely with their public counterparts . . . in advising them of their needs" [Galbraith 1971, 395]. By the early 1970s, however, the health care technostucture faced an increasingly autonomous state whose needs had changed. New policies, in short, had produced a new style of politics [Brown 1983], as the federally subsidized cost explosion in the health care industry led to the development of a new policy image that placed cost containment, not improved access, at the top of the nation's health policy agenda. Hospitals had won the battle over national health insurance in earlier decades, but in the long run, incremental changes in health care financing steadily eroded the industry's fiscal and managerial autonomy.

### References

- Abraham, L. *Mama Might Be Better Off Dead: The Failure of Health Care in Urban America*. Chicago: University of Chicago Press, 1993.
- Altman, S. Presentation to the National Leadership Coalition on Health Care's Health Care Forum on Business Strategies held in Boston, Massachusetts, 1995.
- Baumgartner, F., and B. Jones. "Agenda Dynamics and Policy Subsystems." *Journal of Politics* 53 (1991): 1044-1074.
- Bovbjerg, R. "New Directions for Health Planning." In *Cost, Quality, and Access in Health Care*, edited by F. Sloan, J. Blumstein, and J. Perrin, 206-34. San Francisco: Jossey-Bass, 1988.
- Brown, L. D. *The Political Structure of the Federal Health Planning Program*. Washington, D.C.: Brookings Institution, 1981.
- \_\_\_\_\_. *New Policies, New Politics: Government's Response to Government's Growth*. Washington, D.C.: Brookings Institution, 1983.
- \_\_\_\_\_. "Technocratic Corporatism and Administrative Reform in Medicare." *Journal of Health Politics, Policy and Law* 10 (1985): 579-600.
- \_\_\_\_\_. "Introduction to a Decade in Transition." In *Health Policy in Transition*, edited by L. Brown. Durham, N.C.: Duke University Press, 1986.
- Carpenter, E., and P. Paul-Shaheen. "Implementing Regulatory Reform: The Saga of Michigan's Debedding Experiment." *Journal of Health Politics, Policy and Law* 9 (1984): 453-74.
- Christianson, J., I. Moscovice, and G. Tao. "A Program to Support Small Rural Hospitals." *Health Affairs* 12, no. 1 (1993): 152-61.
- Chulis, G. "Assessing Medicare's Prospective Payment System for Hospitals." *Medical Care Review* 48, no. 2 (1991): 167-206.
- Coelen, C., G. Gaumer, P. Burstein, J. Cromwell, D. Kidder, J. Kanak, N. Kelly, R. Berry, S. Menne-meyer, and E. Poggio. *National Hospital Rate Setting Study: Final Report*. Cambridge, Mass.: Abt Associates, 1988.
- Congressional Quarterly. *CQ Almanac, 1977*. Washington, D.C.: Congressional Quarterly, 1978.
- Davis, K., and D. Rowland. *Medicare Policy: New Directions for Health and Long-Term Care*. Baltimore, Md.: Johns Hopkins University Press, 1986.
- Dobson, A., and E. Hoy. "Hospital PPS Profits: Past and Prospective." *Health Affairs* 7 (1988): 126-29.
- Dunham, A. "Health Regulation: Small Successes, Predictable Failures." Paper presented to the CHAS Health Services Workshop, February 5, 1981.
- Erskine, H. "The Polls: Health Insurance." *Public Opinion Quarterly* 39 (1975): 128-43.
- Feder, J. *Medicare: The Politics of Federal Hospital Insurance*. Lexington, Mass.: Lexington Books, 1977.

- Feldstein, M. "Hospital Cost Inflation: A Study of Nonprofit Price Dynamics." *American Economic Review* 59 (1971): 853-72.
- Galbraith, J. K. *American Capitalism: The Concept of Countervailing Power*. Boston: Houghton Mifflin, 1956.
- \_\_\_\_\_. *The New Industrial State*. Boston: Houghton Mifflin, 1971.
- Goody, B. "Sole Providers of Hospital Care in Rural Areas." *Inquiry* 30 (1993): 34-40.
- Guterman, S., S. Altman, and D. Young. "Hospitals' Financial Performance in the First Five Years of PPS." *Health Affairs* 9 (1990): 125-34.
- Hackey, R. "Trapped Between State and Market: Regulating Hospital Payment in the Northeastern States." *Medical Care Review* 49 (1992): 355-88.
- \_\_\_\_\_. "Symbolic Politics and Health Care Reform in the 1940s and 1990s." In *Cultural Strategies of Agenda Denial*, edited by R. Cobb and M. Ross, 141-57. Lawrence, Kan.: University Press of Kansas, 1997.
- \_\_\_\_\_. *Rethinking Health Care Policy: The New Politics of State Regulation*. Washington, D.C.: Georgetown University Press, 1998.
- Havighurst, C. "The Changing Locus of Decision-making in the Health Sector." *Journal of Health Politics, Policy and Law* 11 (1986): 697-735.
- Health Care Financing Administration. *Medicare and Medicaid Data Book*. Washington, D.C.: U.S. Government Printing Office, 1988.
- Higgs, R. *Crisis and Leviathan: Critical Episodes in the Growth of American Government*. New York: Oxford University Press, 1987.
- Iglehart, J. "The American Health Care System: Community Hospitals." *New England Journal of Medicine* 329 (1993): 372-76.
- Jacobs, L. "Institutions and Culture: Health Policy and Public Opinion in the U.S. and Britain." *World Politics* 44 (1992): 179-209.
- Jacobs, L., R. Shapiro, and E. Schulman. "Poll Trends: Medical Care in the United States—An Update." *Public Opinion Quarterly* 57 (1993): 394-427.
- Kelley, S. *Professional Public Relations and Political Power*. Baltimore, Md.: Johns Hopkins, 1956.
- Lave, L., and J. Lave. *The Hospital Construction Act: An Evaluation of the Hill-Burton Program*. Washington, D.C.: American Enterprise Institute, 1974.
- Law, S. *Blue Cross: What Went Wrong?* New Haven, Conn.: Yale University Press, 1976.
- Lowi, T. *The End of Liberalism*. New York: Norton, 1969.
- Luft, H., and G. Frisvold. "Decisionmaking in Regional Health Planning Agencies." *Journal of Health Politics, Policy and Law* 4, no. 2 (1979): 250-72.
- Marmor, T. *The Politics of Medicare*. Chicago: Aldine, 1971.
- Marmor, T., and J. Morone. "Representing Consumer Interests: The Case of American Health Planning." *Ethics* 91 (1981): 431-50.
- McConnell, G. *Private Power and American Democracy*. New York: Knopf, 1966.
- Morone, J., and A. Dunham. "Slouching Towards National Health Insurance: The New Health Care Politics." *Yale Journal on Regulation* 2 (1985): 263-91.
- Numbers, R. "The Specter of Socialized Medicine: American Physicians and Compulsory Health Insurance." In *Compulsory Health Insurance*, edited by R. Numbers. Westport, Conn.: Greenwood Press, 1982.
- Office of Technology Assessment. *Medicare's Prospective Payment System*. New York: Springer Publishing, 1986.
- Pauly, M. *Doctors and Their Workshops*. Chicago: University of Chicago Press, 1980.
- Pauly, M., and M. Redisch. "The Not-For-Profit Hospital as a Physicians' Cooperative." *American Economic Review* 61 (1973): 87-100.
- Prospective Payment Assessment Commission (ProPAC). *Medicare and the American Health Care System: Report to the Congress*. Washington, D.C.: ProPAC, 1994.
- Rabe, B. "The Refederalization of American Health Care." *Medical Care Review* 44 (1987): 37-63.

- Roemer, M. "Bed Supply and Hospital Utilization: A Natural Experiment." *Hospitals* 35 (November 1, 1961): 37.
- Rosko, M., and C. Carpenter. "The Impact of Intra-DRG Severity of Illness on Hospital Profitability: Implications for Payment Reform." *Journal of Health Politics, Policy and Law* 19, no. 4 (1994): 729-52.
- Russell, L. *Medicare's New Hospital Payment System: Is It Working?* Washington, D.C.: Brookings, 1989.
- Sapolsky, H. "Empire and the Business of Health Insurance." *Journal of Health Politics, Policy and Law* 16, no. 4 (1991): 747-60.
- Serbein, O. *Paying for Medical Care in the United States*. New York: Columbia University Press, 1953.
- Skowronek, S. *Building a New American State*. New York: Cambridge University Press, 1982.
- Sloan, F., M. Morrissey, and J. Valvona. "Effects of the Medicare Prospective Payment System on Hospital Cost Containment: An Early Appraisal." *The Milbank Quarterly* 66 (1988): 191-220.
- Somers, A. *Hospital Regulation: The Dilemma of Public Policy*. Princeton, N.J.: Industrial Relations Section, Princeton University, 1969.
- Somers, H., and A. Somers. *Doctors, Patients, and Health Insurance: The Organization and Financing of Medical Care*. Washington, D.C.: Brookings Institution, 1961.
- \_\_\_\_\_. *Medicare and the Hospitals: Issues and Prospects*. Washington, D.C.: Brookings Institution, 1967.
- Starr, P. *The Social Transformation of American Medicine*. New York: Basic Books, 1982.
- Stevens, R. *American Medicine and the Public Interest*. New Haven, Conn.: Yale University Press, 1971.
- \_\_\_\_\_. *In Sickness and In Wealth: American Hospitals in the Twentieth Century*. New York: Basic Books, 1989.
- Thompson, F. *Health Politics and the Bureaucracy*. Cambridge, Mass.: MIT Press, 1981.
- Vladeck, B. "The Design of Failure: Health Policy and the Structure of Federalism." *Journal of Health Politics, Policy and Law* 4 (1979): 522-35.
- \_\_\_\_\_. "The Market vs. Regulation: The Case for Regulation." *Milbank Memorial Fund Quarterly/Health and Society* 59 (1981): 209-223.
- West, J. P., and M. D. Stevens. "Comparative Analysis of Community Health Planning: Transition from CHPs to HSAs." *Journal of Health Politics, Policy and Law* 1, no. 2 (1976): 173-95.
- Wilson, J. Q. *The Politics of Regulation*. New York: Basic Books, 1980.