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Non-governmental health planning: Is the Rochester approach an alternative to regulatory certificate of need?

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Abstract
Objective: Health planning is the process of identifying community needs for health care, facilities and technology and allocating resources to meet those needs to the exclusion of redundant capacity. Health planning in the United States was pioneered in Rochester, New York through private sector efforts but today, health planning is generally understood in the US as referring to a governmental function: "certificate of need" regulation. Yet health planning need not be, and indeed is not today, an exclusively governmental function. The original conception of a health planning agency as a civil society-based, non-governmental organization survives in Rochester. This study assesses the, viability of this private option as an alternative to regulation.
Method: Outcomes of applications to a, non-governmental health planning entity in the Rochester region (CTAAB) were compared to, outcomes from the state agency (DOH) for two adjacent regions.
Results: The non-governmental, approach to health planning appeared to be more restrictive, with the Rochester region spending less. There are numerous extraneous commas in the text as it appears on my screen. Are they part of the document? Iif so, they need to be removed. If they were not added to the document, the document does not look right in the Online Proofing application. Overall and in particular, utilizing less advanced imaging.
Conclusions: The Rochester NY region, appears to demonstrate that cooperative efforts by stakeholders can lower health care costs. For such, voluntary efforts to succeed, policymakers need not regulate—they can engage with community, leaders by convening them to analyze local utilization patterns, review options for chartering or, subsidizing non-governmental organizations to implement planning, and delineate safe harbors from, antitrust or other potential liability arising from collective action

Introduction

In the United States, health planning refers to "mechanisms for identifying community needs, assessing capacity to meet those needs, allocating resources, and resolving conflicts" related to health facilities and technology [1]. It is rooted in

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the conviction that over-supplies of health care resources results in their over-use. Health planning was pioneered in Rochester, New York in the early 1960s [2]. These seminal efforts were led almost entirely by private sector actors that bore the financial consequences of over-utilization. Today, however, health planning is generally understood in the US as referring to a governmental function: the requirement that a state issue a "certificate of need," or CON, in order for a facility to open, expand capacity, or install certain types of technology. At present, 37 American jurisdictions (36 states and the District of Columbia) maintain CON programs. 14 states abandoned theirs following the end of the federal mandate to implement them [3].

There is considerable skepticism as to whether certificate of need regulation has been successful in achieving its purpose of containing health care costs. Much of that skepticism stems from doubt that governmental bodies are well-equipped to exercise this function.

But health planning need not be, and indeed is not today, an exclusively governmental function. The original conception of a health planning agency as a civil society-based, non-governmental organization survives in Rochester. The story of its apparent success provides a unique opportunity to engage policymakers of all ideological stripes in a dialog about the dissemination of new technology. In a political climate that may be hostile to new regulations, or skeptical of claims that more competition is harmful rather than helpful, the non-governmental option is available as a "third way" of addressing the problems that health planning was intended to solve.

Is the Rochester approach to health planning a viable or superior alternative to certificate of need regulation? This article describes the evolution of Rochester's system, and the concurrent course of certificate-of-need regulation as it progressed, and then receded, in the United States. It reviews literature on its efficacy, and concludes by presenting recent data to compare outcomes from Rochester's non-governmental process to the exclusively regulatory approach that is employed in two neighboring regions.

The problems addressed by health planning

Health care in the US is plagued by a number of problems, mostly arising from the predominant fee-for-service (FFS) system of payment and the perverse incentives it creates [4]; as well as unit prices that are significantly higher than in peer nations [5]. Perhaps the most prominent problem created by FFS payment is the overutilization of technology driven by so-called "supply-sensitive care".

> Supply-sensitive care refers to services where the supply of a specific resource (e.g., the number of specialists per capita) has a major influence on utilization rates. Physician visits, hospitalizations, stays in intensive care units, and imaging services are all examples of care where the local supply influences the frequency of use. Variations in supply-sensitive care are largely due to differences in local capacity and a payment system that ensures current capacity remains fully deployed [6].

Providers paid on a fee-for-service basis have financial incentives to deliver additional care. The problem is exacerbated by moral hazard: the indifference that patients have to costs that are mostly or fully covered by third-party insurers. These problems are perhaps unique to countries that do not capitate payment or have global budgets for healthcare.

Related concepts that help explain the dynamics underlying supply-sensitive care are Roemer's Law and the Medical Arms Race. Roemer's Law "famously and simply states, hospital beds that are built tend to be used" [7]. The name is an allusion to research conducted by Dr. Milton Roemer in the 1950s finding that an increase in capacity correlated with an increase in utilization [8]. This finding has been replicated by other researchers [9] and remains the foundation upon which health planning stands.

The Medical Arms Race concept is premised on the idea that hospitals compete for physicians and patients not on overall value, as in most types of markets, but rather by providing services considered desirable and of high quality, in particular "highly specialized, inpatient clinical services that utilize latest technology" [10]. The result is "service duplication and excess hospital capacity, particularly in markets with many competitors. Contrary to neoclassical economic theory, hospitals in more competitive environments [have] exhibited higher costs per case and day than less competitive environments, controlling for other factors" [10].

Surveying the US hospital environment in 2003, as the managed care heyday had come to a close, researchers from the Center for Health Systems Change found

> hospitals using a variety of techniques to increase inpatient specialty service volume, particularly in cardiology, oncology, and orthopedics. They also were adding outpatient centers that can substitute for hospital care or generate additional diagnostic testing and inpatient care.
> Many of these inpatient and outpatient specialty care programs were designed to increase revenue and margins and stem specialists' competitive instincts. Higher total revenues and margins might be achieved by focusing on a more limited set of services for which prices were higher. Hospitals also refocused their attention on strengthening their relationships with specialists who still generate the majority of hospital revenues. As one respondent noted, "cement specialists to your hospital or they will become your competitors". Finally, efforts to improve specialty care were also designed to attract consumers who have increased choice due to changes in health plan products and provider networks [10].

The foregoing factors contribute to a "market failure" usually described as information asymmetry: the provider has more knowledge of the true medical necessity of a recommended treatment than does the patient or insurer, permitting the provider to offer a treatment that is higher-intensity or higher-cost than an alternative.

Until the day arrives when fee-for-service medicine has been supplanted in the U.S. by payment models that make some form of integrator—be it an integrated delivery system like Kaiser-Permanente or a virtual equivalent such as an accountable care organization—responsible for the total cost of care for a patient population, payers and purchasers