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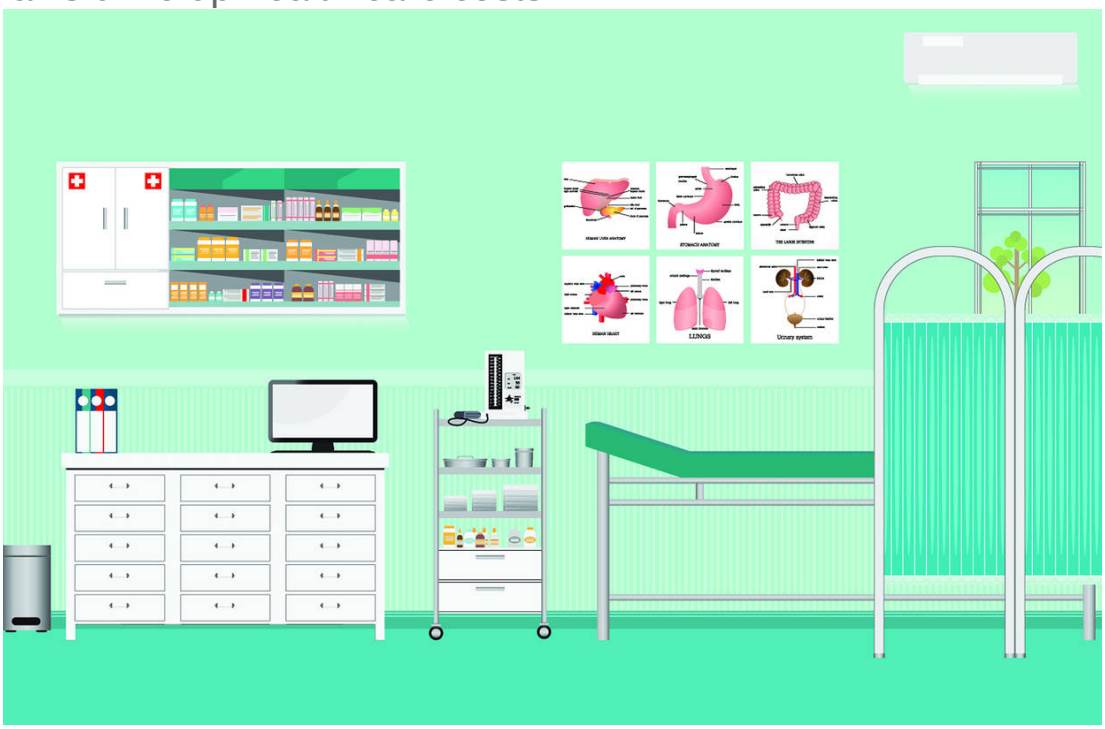
A Regulation That Protects Big-Hospital Monopolies

By restricting construction of new medical facilities, certificate-of-need laws drive up health-care costs.



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By
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In Cartersville, Ga., two highly regarded obstetricians, Hugo Ribot and Malcolm Barfield, hoped to add a second room to their one-room surgery center. But the plan hit a snag. They needed to obtain a "certificate of need" from Georgia's Department of Community Health. Three large hospitals in the area—which provide similar services at far higher cost—blocked their application. Dr. Ribot and Dr. Barfield are now suing the state for restraint of trade.

Thirty-five states and the District of Columbia have certificate-of-need laws governing the construction of new medical facilities. These laws give favorable treatment to major medical centers and other existing hospitals by limiting competition. Result: higher prices for patients.

In the 1960s, when the certificate-of-need concept appeared, health-care delivery was different than it is today. Indigent patients were often treated in charity and teaching hospitals, which relied on paying patients to keep them viable. That changed in 1964. Thanks to Medicare and Medicaid, hospitals got paid for taking care of the poor.

Health costs were escalating, but policy makers and economists misdiagnosed the cause, pinning the blame for price inflation on excess capacity. In New York, the hospital industry petitioned the state for protection. Without a certificate-of-need law, they claimed, competitors would lure away established hospitals' paying patients, leaving them to act only as a safety net for the destitute. The result, they said, would be financial ruin. Other states soon followed suit.

So did Congress. The National Health Planning and Resource Development Act of 1974 gave states with certificate-of-need programs additional federal health-care dollars. By 1982 every state except Louisiana was on board. Certificate-of-need laws eventually expanded to cover not only hospitals but a wide range of facilities, including imaging centers and outpatient surgery centers.

It didn't take long for Washington to realize that certificate-of-need laws weren't bringing prices down. The federal program was abolished in 1986, and 14 states subsequently scrapped their certificate-of-need programs. But hospital associations across the country work hard to maintain the market advantage that certificate-of-need laws provide, spending millions of dollars to lobby state legislators to block reform.

Their claims don't add up. The Mercatus Center at George Mason University has shown that Virginia, which has a certificate-of-need law, has 131 fewer hospital beds per 100,000 people than those without such laws. Certificate-of-need states also have 30% fewer rural hospitals and 13% fewer rural ambulatory surgery centers.

Big hospital associations in certificate-of-need states falsely claim that limiting competition improves access to care. In fact, according to Mercatus the quality of care in these states is worse. In particular, deaths from treatable complications following surgery, as well as mortality from heart failure, pneumonia and heart attacks are higher in certificate-of-need states. Certificate-of-need programs also fail to constrain hospital costs, which are higher in states with such laws on the books.

Finally, the claim that hospitals will be financially ruined by their obligations to charity without the protections afforded by certificate-of-need laws is unsupportable. There is no difference in the provision of charity care between states with and without such programs.

Certificate-of-need laws are a remnant of a failed theory of government health-care planning. Their only purpose today is to restrict competition and protect the big hospitals' local monopolies. The federal government, which played a central role in creating this problem, could help solve it by making Medicaid block grants contingent on repeal of certificate-of-need laws.

So long as these harmful laws continue to prevent health-care providers like Dr. Ribot and Dr. Barfield from expanding the services they offer, health-care costs will continue to rise. Ultimately, it is patients who pay the price.

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