Correspondence

Reaction to Kinzer and Norris letters on health care regulation

To the Editors:

I enjoyed reading the *Journal* letters by David Kinzer and John Norris on the rapid growth of government regulation of health care services and on the increasing demand for the services of health lawyers (*Correspondence,* Winter 1979). While I agreed with much of what they had to say, I would like to add a few observations from the vantage point of a regulator.

I am optimistic about the increasing involvement of lawyers—particularly those who specialize in health law—in the management and regulation of the health industry. In my experience, the participation of lawyers counselling regulators and the regulated brings clarity and specificity to the discussion, drafting, interpretation, and enforcement of regulations. While their insistence on clarity and specificity may occasionally protract the process, more often it serves to prevent problems, for the questions asked by lawyers expose vagueness, misunderstandings, and confusion among regulators and regulated alike.

On the other hand, there can be no question that the growing participation of lawyers has contributed substantially to the phenomenon which Kinzer, Norris, and I call over-regulation. Before lawyers were involved, health care regulation was a matter for negotiation between health care professionals: a physician regulator on one side and a physician or health care facility administrator on the other. Regulations took the form of commandments to do right or lose your license.

In recent years, regulations have grown more complex, more detailed, and more subtle. We can trace that growth to the concomitant growth in government purchases (Medicaid and Medicare) of health care services, but I think it is attributable also to the demands of the regulated—frequently formulated and expressed by their attorneys—that they be regulated consistently, fairly, and equally.

Faced with such demands, health care professionals responsible for regulating, for example, the quality of care, have been forced to "be more

specific." Their response has been to be elaborate. Rather than omit something which someone might think important, the regulator will specify everything, including the elevation of the night-light above the baseboard. To give you some idea of the result: when the Long Term Care Division of the Massachusetts Department of Public Health translated state licensure and federal certification requirements into a survey instrument to be used to determine compliance with those requirements, the resulting form contained 602 items, *after* all duplicate items were eliminated. Regulations governing the cost and distribution of health care services have proliferated in similar fashion. And they will continue to proliferate.

To reverse this trend will take years. The approaches suggested by Norris—pressure-point regulation and regular assessments of the value and efficacy of regulations—are very promising, but their implementation will entail the rethinking and redrawing of federal and state law and regulation.

Even so, there are things which states can do to reduce the burden of their own regulations. In Massachusetts we are initiating three efforts worth noting: (1) consolidation of the licensure inspections of hospitals with the reviews conducted by the Joint Commission on Accreditation of Hospitals in a co-survey arrangement similar to that recently and successfully instituted in New York; (2) development of survey-by-exception and other devices whose use will allow us to reduce the frequency and scope of routine inspections of well-run long term care facilities; and (3) amendment of the clinic licensure law to eliminate redundant (and conflicting) regulation of ambulatory care providers.

The success of these efforts will sharpen the focus and increase the sensitivity of our regulations while reducing their burden. It will also prepare us to participate in more comprehensive efforts of the kind envisioned by Norris and Kinzer. I look forward to them.

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