A conversation with David Cutler on October 17, 2014

Participants

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Note: These notes were compiled by the Open Philanthropy Project and give an overview of the major points made by Professor Cutler.

Summary

The Open Philanthropy Project spoke with Professor Cutler as part of its investigation into health care reform in the United States. Conversation topics included the importance of increasing coverage and addressing public health concerns, as well as the obstacles to lowering costs while improving quality of care.

The current state of health care reform

There is currently a lot of attention directed towards health care reform, particularly around new models of care delivery and compensation. There will likely be increasing reform as the broader economy continues to recover from the 2008 crisis, but reform may stall out before the health care system is truly changed. Many institutions still use fee-for-service models. Considerable effort will be required to change the incentive structures in health care.

The three largest issues facing the U.S. health care system are:

1. Increasing the proportion of people with coverage
2. Addressing public health issues
3. Improving the trade-off between cost and quality

Increasing coverage

A significant portion of the 2010 Affordable Care Act is concerned with getting more Americans covered by health insurance. There needs to further experimentation at the local level in order to discover the most efficient ways to do this. Replicating and expanding effective methods could have an immediate impact on coverage rates.

When trying to increase coverage, the nature of the message matters. People respond better to telling them that 75% of their neighbors have already acquired health insurance than to warning them that they will be fined if they are not covered. Other insights from behavioral economics could also be applied usefully.

Addressing public health issues

Obesity, smoking, alcohol, and gun safety are significant public health concerns. Smoking is estimated to kill 435,000 people per year, obesity 400,000 and alcohol 85,000. In these areas, the main obstacle is not lack of knowledge, but behavioral questions of when and how people make decisions.

Accidental drug deaths are an overlooked public health issue, though attention is increasing. Most of these deaths involve legal drugs. City and state governments are starting to work to lower rates of accidental overdoses. Public policy that regulated how doctors prescribe drugs, particularly narcotic painkillers, could have a significant effect on overall overdose rates.

Improving the trade-off between cost and quality

Nearly everyone thinks that the U.S. spends more on health care than it should and that this excess spending does not contribute to increased quality of care. There is considerable traditional social science research on this dilemma, as well as more experimental work. For example, the Massachusetts Health Policy Commission, on which Professor Cutler serves, was given $120 million to help improve the hospital industry. It received proposals for a wide range of projects, from reconfiguring emergency departments in order to better address behavioral health problems to experimenting with telehealth approaches. While not all of these novel approaches are likely to improve quality while reducing spending, some will have significant positive effects.

Many obstacles have impeded progress in improving the cost and quality trade-off. A few examples include:

- lack of information sharing
- lack of coordination
- lack of competition
- issues with price transparency
- misaligned incentives in hospital-insurer contracts.

Lack of information sharing

Little is known about how health care quality differs across areas and what the most successful health care policies are. While there is considerable research on measuring and improving quality of care, there is little consolidation of the findings from various projects and initiatives. For example:

- 25 states (from across the entire political spectrum) have State Innovation Model grants. There is no single source that summarizes what is going on in all 25 states.

- Around 15 states sponsor groups that analyze health care delivery to study the relationship between quality and price. These groups do not sufficiently collaborate with each other and their data has not been aggregated.
- According to Leavitt Partners, there are now over 650 Affordable Care Organizations (ACOs). There is little evidence on how ACOs are performing and no consensus on what the best practices are.

Some groups are attempting to fill these knowledge gaps. For example:

- The Laura and John Arnold Foundation has funded the Center for Healthcare Transparency, which is trying to consolidate data from state systems and disseminate their findings. This project will take a couple of years.
- The High Value Healthcare Collaborative at Dartmouth University is gathering electronic medical record data to compare high-performing health care systems.
- The Commonwealth Fund has published reports on the practices of high-performing health care systems.

It would be useful if a group catalogued successful public policies in the way the Commonwealth Fund has compared health care systems. A project like this would be best placed at a group like the Commonwealth Fund or the Kaiser Family Foundation, which has the existing infrastructure to help distribute the findings.

Most work measuring, assessing, and comparing quality of care across different health systems has occurred with the urging and funding of private foundations. This is in part because medical professionals have never been challenged to collect data on their own performance.

Currently, there is no systematic rating or ranking system. U.S. News & World Report ranks doctors and hospitals, but its rankings are mostly based on reputation. If Medicare announced that it was going to rate all physicians, there would be more of an incentive for physicians to monitor their own performance. A large clinical team would be needed to design a systematic rating methodology. There has not been the foresight to organize such an effort. Comparative research on quality of care is also slow because hospital administrators and health care bureaucrats are generally not connected to academic networks. Most work with small budgets and are not in the practice of writing grants or rigorously evaluating programs. There may also be a lack of funding for this sort of research.

Patients also often do not understand quality of care issues very well. Most health care is very local. Patients will usually choose the hospital closest to their home, even if one five miles away has a significantly lower mortality rate for an operation they need.

Lack of coordination

Lack of harmonization between Medicare, Medicaid and private insurance is another obstacle. In Massachusetts the incentives between these three programs are not aligned.

Effective service delivery requires coordination and clinical integration between hospitals, their doctors and nurses, and other institutions that provide care, such as nursing homes. The benefits of this clinical integration can be achieved without full corporate integration. ACOs are a middle ground because they require financial integration but not corporate integration.

Price transparency

Insurance cost sharing practices are rarely transparent to consumers. Massachusetts passed a payment reform law that required all insurers to post their cost sharing policies online by October 1, 2014. Cost sharing is very common and disseminating that information is vital because 20% of people have high deductible plans and likely have little means to pay for additional services. Insurers had no conceptual problem with this regulation; the new law just required them to provide the information faster than they would have otherwise.

Incentives in hospital-insurer contracts

There are currently few incentives for hospitals to cut down on unnecessary procedures. Every hospital knows its physicians use tests and procedures differently. However, reducing this variation by promoting the most cost-effective practices would ultimately lower the number of procedures and therefore cut into the hospital's profits (assuming it operates on a fee-for-service basis).

Current alternative contracts made between insurance companies and hospitals are one-time deals. Ideally, alternative contract models would be developed. Depending on the characteristics of the hospital and the insurer, a certain alternative model would be selected as the best fit. To implement this system, a number of technical issues would have to be resolved (e.g. how to attribute patients to doctors), but this is doable.

ACOs are another way to reshape the incentives within insurance contracts.

Lack of competition

There is a high barrier to entering the health insurance industry. New insurance companies struggle to get good rates from providers.

However, state and federal regulation do not account for much of the high barriers to entry. In 2011, Georgia passed a law that allowed people to purchase insurance from out-of-state carriers, but no out-of-state carriers even attempted to sell

coverage in Georgia. According to some venture capitalists, the profit margins in insurance are too small to make it an attractive business venture.

A lack of competition among hospitals, often due to consolidation, is also a real issue.

Poor management

Poor management is a serious barrier to reform. When hospitals have pricing power over doctors, they can enforce reform in clinical practices, but only if the management is sophisticated enough to do so.

Hospitals administrators often have a Master of Public Health or a Master of Public Administration and no business degree. These administrators may lack the sophistication to manage such complicated businesses.

The administrative costs in health care are too high. A rough estimate is that twice as much is spent on administration as is spent on treating cardiovascular disease and three times as much in spent on administration as is spent on cancer care. The health care system lacks the incentives that would encourage a systematic change in administrative practice. Templates on how to run and improve administrative systems would be helpful.

Private equity firms have started to buy hospitals in an attempt to restructure and reform them, but the process is more difficult than they anticipated. A more common practice to save money and increase efficiency is to consolidate several hospitals into one system.

Poor management, rather than the misalignment of incentives or concern for profit margins, is also preventing progress on reforming end-of-life care policy. The Gundersen Health System in Wisconsin provides some of best end-of-life care in the country. Researchers there had conversations with some patients about end-of-life decisions and end-of-life care soon became a standard part of patient care. It would be great if larger health care organizations started following Gundersen's model.

If more organizations completed the World Management Survey and grappled with the results it would improve management. Professor Cutler would be very interested in a project where 500 hospitals completed the survey and their boards were required to produce a response after reviewing the results. A simple response, such as talking to organizations with high management ratings, could spur significant change.

Lack of technical ability

Another obstacle is the lack of technical sophistication in the health care industry. Many hospital information systems are terribly antiquated: they must be updated

after every new edition of the International Classification of Diseases and there are never enough COBOL programmers to meet the immediate demand. New code is also required to allow practice management to communicate with insurance companies and access electronic medical records. Hospitals and insurance companies lack the sophistication and incentives to invest in this technical work.

Scope of practice issues

Doctors and dentists are afraid they will lose business as the industry changes. However, there is not a sound argument for these worries. Doctors are unlikely to miss the work that will be covered by nurse practitioners, physician assistants, or other professionals. If there were a model piece of legislation on scope of practice, it would be easier to encourage states to pass it.

While there have been several reports on what nurses practitioners can do relative to doctors, scope of practice issues have not received enough attention. This is in part because they do not directly depend on payment system reform or quality of care improvements.

Funding needs

It is currently difficult to get funding for on-the-ground research projects that examine individual health systems to understand which practices and policies work and which do not. Critics comment that findings from these single case studies are not generalizable. However, learning by example may be an important to step in understanding high-performing health systems.

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