

Comments on paper by Steve Shortell and Larry Casalino and paper by Hal Luft for the Focused Research on Efficient, Secure Healthcare (FRESH) Thinking Conference session on The Organization and Delivery of Care and Payment to Providers

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The papers by Casalino/Shortell and Luft explore different but overlapping aspects of the organization and delivery of health care and payments to providers. One thing common to both papers is a high degree of attention to the optimal design of incentives for providers and patients and an interest in creative approaches to improving these incentives. This attention to incentives is appropriate given how the U.S. health care system has traditionally been organized. Indeed, in broad strokes, the discussion of these issues in these papers mirrors the discussion of these issues in policy that has shaped the health care debate in the US for the past 30 years or more.

Nevertheless, the papers do offer “fresh” thinking in the sense that they propose relatively untried ideas as potential strategies to address the health care problem in the US.

I will address these fresh ideas in turn, beginning first with the Casalino/Shortell paper and then the Luft paper. However, I think it is worth first considering whether the very freshness of some of the ideas discussed in each paper may suggest that they do not uniquely address the essential problems of designing an efficient health care system. In particular, to the extent the “fresh” ideas proposed here are not already in use in other countries that seem able to produce health care systems with benefits that rival those of the US but at far lower cost, it would seem that these fresh ideas are not essential to achieving those goals. This is not to say that these fresh ideas may not be successful at generating the desired results, but only that, to the extent these

ideas are fresh, they may not necessarily be essential to achieving the goal of a more effective and efficient health care system.

The Shortell/Casalino paper discusses a series of key challenges for health care delivery systems and associated core capabilities, and explores the implications of these for the best strategies to create an accountable health system. The challenges are insurance coverage, financing, payment technology assessment, and public reporting. The core capabilities are: redesign of core processes of care delivery ability to work in teams, ability to coordinate care and manage patients across sites over time, ability to generate performance data for accountability and improvement purposes, use of information technology, clinical knowledge management, and the ability to adapt to and manage change. The authors note some benefits of a variety of different approaches to organizing hospital-physician relations, but the multi-specialty group practice seems to perform as well or better in their analysis than all the other alternatives considered. This may not be surprising given its approximation to what presumably would be the most aligned health system imaginable, a fully integrated one. The paper also considers a variety of barriers and facilitators to changes in the delivery systems. These include performance measurement, extent of adoption of EMRs/EHRs, use of knowledge to improve care, incentive alignment, and individual physician autonomy.

I am very sympathetic to much of what is said in the paper, and appreciate that the authors do not merely discuss incentives, but demonstrate a deeper appreciation of the brick and mortar and cultural aspects of health care system management. Many parts of the paper are not fresh in the sense that the ideas are wholly new, but the discussion of each issue is well executed in my

opinion and the ideas are nicely integrated with each other. One aspect of the discussion I was particularly pleased to see was the discussion of need for sophisticated managers of health care organizations, and the importance of economies of scale in ensuring effective health care management. I think these issues have been profoundly neglected in the literature, on the ground in health care organizations, and the design of health care policy. Many of the most important strategies for reforming health care systems processes, such as medical informatics investments, have absolutely huge fixed costs, and smaller organizations are inherently disadvantaged by such cost structures. Moreover, the scale of many health care organizations is such that top managerial talent is less likely to be drawn to such jobs than they would be if those organizations were far larger. Some of the smaller scale of health care organizations may have to do with the importance that they be locally available and the fact that they are highly capital intensive, so that they are hard to quickly displace through market competition. But issues such as the ongoing subsidies of hospitals as non-for profit institutions seem also to be very important. I think that better understanding the supply, demand, and consequences of managerial expertise in health care is a very exciting area for future work. As the authors point out, the need for more effective health care management also has implications for medical education, and this is also an exciting area for future work. The authors also comment that this issue of workforce training may be one “beyond the scope of comprehensive health care reform”. However, I wonder whether we might be more successful were we to instead to consider it a prerequisite for the wide application throughout the healthcare system of the steps that Shortell and Casalino outline for improved management of health care organizations.

One area where I think the paper could be improved is by a more careful discussion of the theoretical concerns that might provide guidance as to when transactions are best organized with a firm and when they are best organized through a market^{1,2,3} One particular aspect of health care markets that seems important is that of reputation and the associated issues of agency. What does this mean for firm size? How will different types of patients (e.g., savvy versus vulnerable), organizations (e.g. small vs. large firms), and even markets (e.g. big cities with multiple providers vs. smaller cities, or care for common versus rare conditions) be differentially served by alternative contracting systems that vary in how decisions are made? Greater attention to these concerns might help sharpen some of the findings of the paper.

The Luft paper places a great degree of emphasis on the idea of paying for episodes of care. I think this is an idea with some promise, but find it hard to see it as a transformative one across a broad number of conditions. One reason for this is that I think there are other systems that can generate many of the same benefits. For example, the idea of treating a care episode as the unit of payment combining both physician and hospital fees has some appeal for aligning incentives, but it is not clear that such an arrangement would clearly dominate the sort of incentives created by the greater alignment of hospital and physician incentives created by the growth of the hospitalist movement. That such a system would offer benefits over a fully capitated system seems even harder to argue, since such a capitated system could always organize itself to establish such an arrangement. Analogously, one has to wonder why, if such a system would indeed be preferred, we do not see more examples of its use within managed care systems. As I look at the proposal, I think one problem might be the pure complexity of the proposed system involving both an episode-specific payment and then perhaps a secondary form of insurance that

would intercalate with it. I worry about how providers, no less consumers, would learn to function in such a complex system. Perhaps even more fundamentally, any episode-based system is at risk of the problems that can plague any form of prospective payment:

- 1) inappropriate incentives to trigger the “episode” (requiring auditing of eligibility when the provider has the potential to benefit (think DRG creep and Medicare PROs) or auditing of appropriateness of testing when the patient has the potential to benefit (e.g., very ill patient gets tested for prostate cancer to get a payment provided for forgoing care in the presence of known prostate cancer).
- 2) Cherry picking – incentives to select for health patients or skimp on care for sicker ones.
- 3) Tendency for high-powered incentives under prospective payment to be reduced over time as both 1 and 2 above lead to the construction of ever-finer categories that effectively undermine incentive to contain resource use under prospective payment (example, AMI with or without bypass)

Another major concern would be how much should episodes would really differ from the current prospective payment system. When the episode involved hospitalization, the high cost of hospitalization relative to ambulatory care may cause the establishment of episode based approaches to have relatively minor overall effects on the alignment of incentives relative to current hospital prospective payment systems. For ambulatory care, the strong tendency to address more than one problem in a visit makes it hard to see how carving out episodes for specific illnesses would be easily accomplished.

Together, the Shortell/Casalino and Luft papers provide a good starting point for a discussion of relationship between the organization and delivery of care and payments to providers. In addition

to the direct responses above to the individual papers, there are some additional comments I would like to add. First, the relationship of these issues to technology assessment is so crucial as to warrant even more attention. If technology is a main driver of costs and better use of evidence-based decision making can successfully improve the cost and effectiveness of care almost independent of how care is organized. Second, broad issues in the public finance of insurance, such as the tax deductibility of employer contributions for health care, also may have pervasive effects on efficiency that allows inefficient systems to persist. Third, the potential effects of, and reasons for the lack of, fully integrated systems, receives less attention than I might have expected given what would seem to be their potential to transform so many elements of the system. For example, highly meaningful physician payment reform has proven politically impossible to enact in the US, but widespread managed care has the theoretical potential to rapidly alter this landscape if the demand for specialists changes suddenly if the market share of managed care grows rapidly. More generally, the whole political context of alternative reform strategies may alter the likely effects of the strategies for the potential changes in health care organization, delivery, and provider payments that are discussed here. In an area as heavily dominated by regulation as health care is in the United States, it would seem that any detailed economic analysis of incentives should be matched by an equally detailed political analysis of how such incentives are likely to evolve over time.

References

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