Dranove, David, 2012 "Recommendations for Improving the Health System: Academics Speak Out", Health Management, Policy and Innovation., 1(1):44-59

Recommendations for Improving the Health System: Academics Speak Out

David Dranove

To help launch our new journal, the *HMPI* editorial board invited leading academics (mostly health economists) to make one or two recommendations for improving the health system in either the public or private sector. Twenty of our colleagues submitted their suggestions, which are included below. I have made minor revisions to achieve a consistent format and I have I have also highlighted specific text to bring out the main proposals in each essay. Otherwise, these are our colleagues' own words.

As I read the responses I was struck by the wide range of proposals. This is not surprising – many of our colleagues have devoted years of research and policy analysis to specific issues and they used this opportunity to emphasize them. Just as a cardiologist focuses on diseases of the heart and a nephrologist focuses on diseases of the kidneys, Martin Gaynor worries about market competition and Richard Frank emphasizes the need for payment reform. Still, certain consistent themes emerge:

· Five contributors are concerned about market competitiveness. Four would like to see steps taken to improve competition. One (Reinhardt) wonders if a market-based approach to healthcare is doomed to fall victim to price discrimination and market power.

· Five contributors specifically call for limiting or ending the tax deduction for employer sponsored health insurance. I was surprised this wasn't mentioned more often; perhaps it is taken as a given by most health economists.

· Four contributors stress the need for evidence-based medicine and, possibly, formal cost-benefit analysis.

· Several other ideas received multiple mentions, including payment reform, finding a way to cope with vulnerable populations and moving to a voucher/exchange system that emphasizes integrated delivery systems. Two contributors specifically mentioned improving the management of healthcare organizations and two others addressed issues associated with medical innovation.

The range of proposals reflects the title of the journal. Several proposals address the management of healthcare delivery and several more address innovation, including technology evaluation and electronic medical records. Not surprisingly, there are many proposals directed a

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public policy. Several contributors take dead aim at Medicare spending, recommending ways to promote innovation in care delivery. No one called for a single payer system.

Perhaps the biggest take away from this exercise is that there is no magic bullet that will save the health economy. The closest thing may be Martin Gaynor's call to "give the participants the right incentives." But that will only get us so far. Payers, providers, technology developers, patients, and regulators will still have to make difficult choices. They would do well to heed the advice of our contributors.

Michael Chernew
Harvard University

Building a sustainable health care system requires innovation in both payment and benefit design. The Alternative Quality Contract (AQC), developed by Blue Cross Blue Shield of Massachusetts, represents one approach to payment reform that appears promising. Like Medicare's Pioneer ACO model, it is based on a global budget, in which provider organizations are accountable for spending that exceeds a target (i.e., budget) and share in savings if spending falls below the target. The AQC also holds providers accountable for quality by incorporating a robust pay for performance system and technical support that BCBS provides to provider groups.

Evaluation of the first two years of experience suggests that physicians shifted referrals to lower priced providers and reduced use of some services. Estimates suggest that by the second year the AQC groups had reduced spending by 9.9 percent relative to what they would have spent if they experienced the trends exhibited by comparable groups in the BCBS network. Measures of quality also improved. The contract was designed such that these savings would be offset by the shared savings and quality bonuses, but over time the changes in physician behaviors provide encouragement that they may be able to succeed with slower rates of growth in the budget.

Demand side innovations, such as Value Based Insurance Design (VBID), which aligns copays with the value of services, and tiered networks, which charge patients more if they go to high cost providers (in some cases cost is adjusted for quality) represent the growing innovation in insurance design. VBID programs recognize the tendency of individuals to reduce utilization of high value services if out of pocket cost sharing is significant. Yet unless very well targeted, VBID programs will only save money if the reductions in copays for high value services are coupled with increases in copays for low value services (or with other strategies to lower spending). Tiered network programs can reduce spending, but evaluations of their impact are limited and design issues are complex. Ideally they could be coupled with payment reforms, allowing the organizations that are accountable for outcomes to influence benefit designs in ways that will support their goals.

Because of the potential for unintended consequences and potential reductions in quality, both supply and demand side interventions must be monitored and better, more robust quality measures must be developed. But one way or another spending growth must be slowed and these innovations are the type of tools that will be needed. While striving to maintain quality is

important, we must not pretend that existing care is ideal. As the AQC demonstrates, there is ample room for these types of innovations to both slow spending and improve quality if we execute these programs successfully.

David Cutler
Harvard University

Economists like to assume things, so let me grant myself a genie with two wishes, restricted to improving the health care system. What do I wish for? Actually, it is not that hard. First, I wish for everyone to have insurance coverage. How could one not want this? Second, I wish for a payment system that focuses on high value care, not more care or less care. In this payment system, groups of physicians are given a lump sum amount, equal to the cost of caring for a patient with a particular set of conditions. Physicians who do better will keep the savings; physicians who do worse will lose. In such a system, we could legitimately go to physicians and tell them: doing well means doing good. Patients would know that the system was on their side. Thus, the service aspect of medicine would improve along with the technical aspect. And we would spend less. If you take away my genie, I have to push for legislation to accomplish these two goals.

Bryan Dowd
University of Minnesota

While the Patient Protection and Affordable Care Act created a host of new government activities, the most pressing needs involve *activities that the government needs to terminate*. Solutions to the cost problem (inefficiency) should be guided by the adage, "If you think you're spending too much on something, stop subsidizing it." Thus, the top priorities should be ending the tax deductibility of health insurance premiums and out-of-pocket spending and bringing Medicare premiums closer to their actuarial value for beneficiaries who are not poor. Consumers need to face the marginal cost of more expensive health plans, providers, and treatment options at every point in the system. That means replacing the open-ended subsidy of fee-for-service Medicare with "premium support", installing level-dollar contributions to premiums in all public and private health plans and tiered copayments that penalize high cost providers and consumers who fail to utilize appropriate step-therapy, i.e., use of less costly treatment before moving to more costly treatments.

Antitrust laws need more vigorous enforcement and licensure laws and reimbursement rules need to be reviewed to ensure that they do not pose unjustified barriers to entry.

Because waste in the health care services market is dangerous to consumers, the cost problem can be attacked by improving quality, particularly the problem of medically ineffective care. Bundled payments, including capitation, may help, but elimination of medically ineffective care

likely will require not only the right type of provider payment and health insurance coverage, but also the right providers, and most importantly, the right consumers.

Evaluation of treatment approaches in different delivery systems, e.g., staff model HMOs, and demonstration projects are needed to assess the potential savings.

The problem of long-term risk protection in the individual insurance market must be addressed through encouraged maintenance of continuous coverage, insurance pools with limited open enrollment periods and late enrollment penalties, and high-risk pools.

Reducing waste in the markets for health insurance and health care coverage will improve affordability and thus address problems of both efficiency and fairness.

Alain Enthoven
Stanford University

A 2005 report by the Institute of Medicine and the National Academy of Engineering "estimated thirty to forty cents of every dollar spent on health care…is spent on costs associated with 'overuse, underuse, misuse, duplication, system failures, unnecessary repetition, poor communication, and inefficiency.'"To cure this, we must make it in the interest of everyone concerned to reduce waste—for consumers to choose efficient delivery systems, and for providers to form, offer and improve such systems through a continuous process of redesign that reduces waste.

To move decisively in that direction, Government must (1) transform Medicare into a "premium support" or "managed competition" model in which informed, cost-conscious consumers can keep the savings by choosing wisely, (2) cap the exclusion of employer contributions to employee health care from the taxable incomes of employers at the price of an efficient plan, with or without adjustment for regional costs, and (3) greatly expand the population buying health insurance through exchanges so that all employers up to size 100 or 200 or more employees are required to buy through exchanges as a condition for their employees to continue to receive the exclusion. (There needs to be powerful incentives for all in a large class of employers to join the exchanges lest the exchanges suffer adverse selection.) The cap on the tax exclusion is needed to increase employees' incentives to seek value for money in choice of plan, as well as to save the federal budget hundreds of billions of dollars. These changes would greatly expand the market for efficient integrated delivery systems.

Richard G. Frank
Harvard University

It is clear that much of the long-run budget problem in the U.S. is driven by rising health care costs and spending. One important approach to addressing the health care spending growth is to

bring more of public health care under budgets and create more tightly organized networks of providers to deliver care. As such to the extent they use budgets, Accountable Care Organizations (ACOs), Medicaid Health Homes, and Patient Centered Medical Homes (PCMHs) are promising developments. Nevertheless, all indications suggest that the economic payoff to more integrated health care organizations operating under gain sharing (a euphemism for profit sharing) or full risk sharing arrangements will come from aggressively managing the care of high cost participants in public health care programs (Medicare and Medicaid). Persistently high cost cases are most commonly people with Multiple Chronic Conditions and functional impairments. For example, among adults in the top 5% of spending in the U.S., roughly 60% have chronic conditions and functional impairments.[1] (Lewin, 2010) That is, frail older adults, people with disabilities and those with severe and persistent mental disorders. Saving money therefore depends on restructuring the care for vulnerable populations.

Saving money and improving care or at least not creating new harms requires a delicate balance of policies that will result in significant reorganization of care (away from high cost institutional care) in ways that protect the very sick people upon who large sums are spent. The landscape is littered with noble failed attempts. This will require judicious use of high powered financial incentives, more focused monitoring and efforts that enlist the active participation of consumers in the efforts. This means undertaking focused efforts to hold organizations such as ACOs, Health Homes and PCMHs accountable for the well-being of the most vulnerable, and extending public policies that have been successful in promoting better quality and consumer autonomy in similar circumstances. First, we must put into place new quality of care indicators for high-cost-vulnerable populations that recognize their complex needs. Current measures are not oriented that way and tend to assume that chronic illnesses are managed one at a time. Second, evidence suggests that neither exit nor voice impose strong discipline on the quality of care for vulnerable populations. Therefore it will be important to put into place strong consumer protections like those that have been developed under Part C of Medicare and in some state Medicaid programs. Finally, incentives for both providers and beneficiaries that attenuate supply side moral hazard to stint on quality and allow beneficiaries to benefit directly from efficiency gains would promote quality and more active consumer involvement in care. Two sided risk sharing (risk corridors) that are linked to quality measures and provisions allowing consumers to direct a share of any savings for their benefit (to purchase home modifications, additional support services, transportation) are example of how to engage consumers.

Roger Feldman
University of Minnesota

The Medicare program faces a fiscal crisis, largely because it pays too much for basic benefits. But chronic overpayment can be cured by harnessing competition in the form of competitive bidding. My research shows that Medicare could save $339 billion over 10 years if it took bids

[1] Lewin Group (2010) "Individuals Living in the Community with Chronic Conditions and Functional Impairments: A Closer Look" Washington D.C.: USDHHS ASPE

from private plans and the traditional fee-for service plan, and it paid all plans at the 25th percentile of those bids. This payment reform could be accomplished while guaranteeing the elderly that at least one Medicare plan would be available in every area of the country for no out-of-pocket cost beyond their Part B premium.

Victor R. Fuchs
Stanford University

Recognize that there are two necessary and sufficient conditions for universal coverage:

1) Subsidies for those too poor or too sick to obtain insurance at market prices
2) Compulsion for those who prefer not to buy insurance.

Recognize that risk-adjusted capitation payment for defined populations appears to be the most effective and efficient form of paying for care.

Recognize that a team approach based on group decision-making, standardization of procedures and protocols, outcome measurement, and peer review is the most effective, efficient way of improving the quality of care.

The "universal voucher" approach funded by a dedicated value-added tax paying a risk-adjusted capitation fee to accountable care organizations that compete on service and quality of care seems to be the best solution to a problem that has no perfect solution.[2]

Martin Gaynor
Carnegie Mellon University

If I were Health Reform Tsar (i.e., I had absolute power to reform the health care system), my overarching goal would be to *create basic ground rules for the system and then let the system run, avoiding heavy handed regulation or micro management*. The key objective of these ground rules is to give participants the right incentives insofar as possible. With that in mind, I would do the following.

I. Health Insurance Reform

· Eliminate the tax exclusion of employer sponsored health insurance. This will eliminate a major distortion in health insurance (and ultimately health care) and in labor markets, and generate tax revenues, while allowing for lower income tax rates.

[2] See E.J. Emanuel and V. R. Fuchs, A Comprehensive Cure: Universal Health Care Vouchers, Brookings titution Hamilton Project, July 2007

· Automatically enroll every U.S. citizen in a standard health insurance plan. The plan will provide insurance, and will therefore have a high deductible, and fairly high coinsurance or co-pays, but will have a stop-loss to prevent financial ruin. The cost-sharing features will be on a sliding scale according to income, so individuals only face risk that they can reasonably bear. Likewise, premiums will be subsidized on a sliding scale according to income.

· Individuals can opt out of this plan if they have proof of insurance coverage that is at least equivalent to the standard plan. Individuals can choose among insurers offering this plan. If they fail to choose, they will be randomly assigned to an insurer. Insurer premiums will be risk-adjusted, and there will be a high risk pool. No denials of coverage or coverage rescissions will be allowed.

· Medicare and Medicaid will be phased out; everyone will obtain coverage as indicated above.

II. Financing

· The subsidies for insurance coverage will be entirely financed via a dedicated consumption (sales or VAT) tax, e.g., a la Fuchs and Shoven[3], with as few loopholes as possible. All government funding must only be from this source – no other sources of revenues may be applied. This way the cost and financing of government spending on health care will be as clear and transparent as possible. All other funds will be privately financed.

III. Supply Side Reform

· Eliminate barriers to entry to providing health services. Lack of competition leads to poor service, poor quality, and high prices, and impedes innovation (especially organizational innovation). We should free up entry into the medical profession and into the specialties. Twice as many people apply to medical school as get accepted, and this has been true for many years. Quite a few more applicants can be accepted without diminishing the quality of medical students. Therefore, artificial barriers to creating new medical schools or expanding the number of slots in existing medical schools need to be eliminated. Entry into specialties is controlled by incumbents. Artificial barriers to entry into residency training programs should be eliminated. Along the same lines, allow non-physician medical personnel, such as nurses, nurse practitioners, psychologists, pharmacists, etc. much greater freedom to treat patients independent of physicians. Finally, ease barriers on new forms of health care organizations entering the market, such as retail clinics, freestanding surgery centers, specialty hospitals, etc.

[3] Fuchs, V.R. and J.B. Shoven (2010). "The Dedicated VAT Solution, SIEPR Policy Brief, http://siepr.stanford.edu/www.stanford.edu/group/siepr/cgi-bin/siepr/?q=system/files/shared/pubs/papers/briefs/PolicyBrief08_2010v2.pdf.

· Eliminate public subsidies to medical education. These only add to the crazy quilt of distortions in this area. With twice as many applicants as accepted students, there is clearly excess demand for medical education. Public subsidies are not only unnecessary, they overwhelmingly go to children from upper middle class or upper class families.

· Remove barriers to insurers operating (underwriting) across state lines.

· Aggressively enforce the antitrust laws in health care. There has been a great deal of consolidation in health care markets in recent years, especially in hospital and insurance markets, but also in physician markets and between the different kinds of market participants (e.g., insurers-hospitals, hospitals-physicians, etc.). Consolidation has resulted if few, if any benefits, and has harmed competition and led to increased prices, reduced quality, and impeded the emergence of new, innovative forms of health care delivery. Aggressive antitrust enforcement can help solve problems in specific markets. It can also have a deterrent effect on those considering anticompetitive actions.

These ground rules are intended to provide a general framework for the health care system. They are deliberately intended to be general, not specific, in particular so there are incentives for innovative and efficient new arrangements and so such arrangements can spontaneously emerge.

Robert S. Huckman
Harvard University

The past two decades have been marked by a substantial increase in the amount of information that is publicly available to American consumers about the quality and cost of care provided by specific physicians and hospitals. In many states, patients considering a surgical procedure, such as cardiac bypass or knee replacement, can learn about the risk-adjusted outcomes of particular providers in their area. Further, they can also obtain information about other measures of process conformance or patient satisfaction at specific hospitals. Yet despite this seeming wealth of information, there remains a lingering sense that patients still fall well short of being informed consumers. As a system, we are left wondering why this is the case and what the private and public sector can do about it.

Though certainly not a complete solution for closing this information gap, one step in the right direction would be to complement existing efforts to disseminate information about the relative performance of competing providers with analogous efforts to report the relative performance of competing modes of treatment. Much of the current approach to information dissemination implicitly assumes that a consumer has decided on a course of treatment and is searching for a provider of that specific type of care. Such a view, however, ignores the possibility that a patient's primary concern may not be whether to receive care from surgeon A or surgeon B but rather whether to have the surgery in the first place. For example, the Center for Shared Decision Making at Dartmouth-Hitchcock Medical Center offers patients contemplating surgery access to information—including results from academic studies as well as videotaped

testimonials from patients—about specific modes of treatment. Such information offers patients a sense not only of clinical outcomes, such as mortality or infection, but also of how they might experience aspects of treatment such as pain management, recovery, and loss of time from work.

The Affordable Care Act (ACA) created the Patient-Centered Outcomes Research Institute (PCORI), which is charged with supporting research on the cost-effectiveness of various forms of medical treatment. PCORI represents an important step toward improving the base of information about competing modes of treatment. As PCORI refines its funding priorities, it should take into account the broad range of factors that might impact outcomes from the perspective of the patient. Further, PCORI needs to ensure that the findings of the research it supports are efficiently communicated to patients, not just clinicians. By doing so, it will help the system move closer to reaching the goal of informed consumption.

John Mullahy
University of Wisconsin

The delivery of evidence-based healthcare (EBH) is heralded as an important element of strategies to enhance healthcare quality and -- if delivered in settings wherein the costs of such care can be considered -- simultaneously restrain healthcare costs. The evidence base supporting EBH ultimately has as its foundation controlled trials, observational studies, electronic medical records, and other data systems. Considerations of the linkages between interventions and patient health are the core concerns of what has come to be known as patient-centered outcomes research.

For such outcomes research to fulfill its promise, many well recognized challenges must be confronted and surmounted. Not least of these challenges is that for EBH to succeed, the health outcomes measured in such work must correspond to outcomes that are relevant in patient-provider decisions and, ultimately, to patients' welfare. Readily measured surrogate outcomes (e.g. biomarkers) or statistical summaries of outcome distributions that fail to describe parameters of concern to patients at the time of treatment decisions are typically no substitute for relevant statistical measures of how interventions affect how patients "feel, function, or survive." Recent initiatives to incorporate patient-reported outcomes (PROs) in regulatory and other decisionmaking contexts are to be lauded, but are only a beginning. The proponents of EBH must strive to better understand patients' preferences in different decisionmaking contexts, and to undertake measurement strategies to generate the specific data and evidence that can guide decisions in accordance with such preferences and thus offer prospects for welfare-enhancing healthcare.

Stephen Parente
University of Minnesota

One of the most common statements about the state of the US health economy is ‘the system is broken’. Whether it is the President of the Mayo Clinic or the CEO of United Health Group, it is

a common refrain. And just when the doom and gloom of our current state of affairs is articulated a shaft of brilliant, bright wonderful light is proposed to lead the healthcare system to salvation. It is the salvation of tomorrow made available through health information technology (IT).

Since 2004, the US government has invested tens of billions to spur the growth of health IT. The largest outlay of expenditure occurred in 2009 with the federal stimulus Bill. Federal resources have created a new agency, the Office of the National Coordinator of Health Information Technology (ONC) to further advance the direction of the nascent health IT industry.
The good news is that the industry has responded. American hospitals and clinics are adopting Electronic Health Record (EHR) systems very rapidly. One reason is that, as part of the American Recovery and Reinvestment Act (ARRA) of 2009, the U.S. government has tied financial incentives to "Meaningful Use". The 2010 Patient Protection and Affordable Care Act is likely to further pressure healthcare care providers to adopt EHR systems with the intention of improving quality and patient outcomes.

The bad news is the current trajectory of the industry and the weak enforcement mechanism of meaningful use could lead billions being spent with little for the US citizen to gain in terms of improved outcomes. It is likely the Meaningful Use guidelines are not assertive enough in advancing evidence-based care through proven features like computer assisted support for the right technology for a patient. The Center for Medicare and Medicaid Services (CMS) appears to have taken a slow, incremental approach by focusing on the broad acceptance of basic systems with a long time line (extending until 2015). While this may certainly leave time to allow for widespread adoption, it is unclear what incentive healthcare providers would have to adopt advanced systems in the later years of implementation, especially in an industry known to resist change. Furthermore, the fact that most Medicare incentive payments are tied to early stages IT adoption does not help this situation. The stated primary goal of "Improved Outcomes" for is certainly promising, but it as ill-defined as 'World Peace'. There is not enough information is available to determine how well those guidelines will be received and adopted by the healthcare providers when they are rolled out.

My challenge to prospective authors of this journal is to complete a set of analyses to inform the value of health information technology for the US health economy using rigorous methods and robust databases. The age of small sample and weak methods is over. Peoples' lives will literally depend on the proving the value of these innovations not just on the balance sheets of investors but in the lives saved, extended and improved by health IT. Let's get it done.

Mark Pauly
University of Pennsylvania

For the poor and low income population, I favor predetermined credits or subsidies for the purchase of basic catastrophic coverage whose maximum permitted out of pocket payment increases with income.

For the rest of the under-65 population, I favor canceling or capping and gradually phasing out the exclusion of employment based benefits from taxation. I favor permitting risk rating of private insurance premiums, and permitting employers to choose whether or not to offer unsubsidized group insurance. Individual insurance would be required to have provisions for guaranteed renewability at class average rates, and there would be group-to-individual conversion.

Credits or subsidies for insurance would vary with risk as well as with income. High risk pools offering basic coverage funded with general revenues would be available as a backstop. An individual mandate for basic catastrophic coverage would apply to all citizens, enforced by a penalty equal to the net-of-subsidy premium for the lowest cost basic coverage for that person at their income level.

The rate of growth of medical spending which results from individual choices of insurance and medical care under this system of undistorted prices would be defined as the right rate of growth in spending regardless of its amount (in absolute dollars or relative to GDP).

Tomas J. Philipson
University of Chicago

Many analysts stress that medical R&D and innovation are central to the expansion of the US health care sector. However, there is no explicit analysis relating financial markets, determining the returns for those investing in medical R&D, and the real health care sector, expanding as a result of such investments.

In recent work with Ralph Koijen and Harald Uhlig at Chicago, we examined how the financial returns of investing in medical R&D are related to the growth of health care spending. We documented evidence of a "medical innovation premium" - a significant risk-premium of about 3-5 % a year- for firms engaged in medical R&D in the US the last four decades. This finding needs to be incorporated into future projections of the size of the health care sector as this premium affects the cost of capital and medical R&D investments underlying the spending growth of the sector. In our analysis, we interpreted this premium as compensating investors for bearing government-related risk to markups on developed innovations and analyzed its quantitative on sector growth. This may be exemplified by the current risk associated with ACA and its negative impact on the investment climate. Our calibration implied large effects of the premium on health care spending; removing government risk would almost triple medical R&D spending and thereby increase health spending further by 4% of GDP.

A better understanding of why investors in medical RD need to be compensated by the he medical innovation premium is needed, and how reforms affect the premium. Such an understanding will greatly affect how reforms are assessed in terms of future spending growth. In addition, it implies revaluing future US Medicare and Medicaid liabilities that is currently discounted by risk-free Treasury rates by public agencies such as CBO but discounted by the medical innovation premium by market participants.

Carol Propper
University of Bristol and Imperial College London Business School

Until recently, most evidence on the relationship between competition and quality in healthcare was from the USA. This may not be terribly helpful to those interested in healthcare reform worldwide as the US system remains very much an outlier in terms of size and complexity. Further, inference from US studies is difficult because market structure in the US system is likely to be endogenous.

What can be learnt from a very different system: the tax financed British National Health Service? The advantages of examining the NHS are that we can exploit centrally mandated policy changes to try and get identification. The emerging evidence suggests:

· Patients have responded to being allowed greater choice, facilitated by greater availability of information and regulated per case prices. Hospitals rated as better both in terms of some measures of clinical quality and in terms of having lower waiting times - before the policy reform attracted more patients and patient from further away after the reform (Gaynor et al 2010).
· Hospitals located in areas where patients had more choice had greater improvements in clinical quality (measured by lower death rates following admissions) and greater reductions in lengths of stay post policy than hospitals located in less competitive areas. What's more, the hospitals in competitive markets increased their quality without increasing total operating costs or shedding staff.[4]
· Hospital consolidation and mergers did not improve outcomes for patients, echoing similar findings from the very different US market.[5]
· Better management in NHS hospitals is associated with better clinical and financial outcomes and management is better where local hospital market competition is higher.[6]

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[4]Martin Gaynor, Rodrigo Moreno-Serra and Carol Propper Death by Market Power. Reform, Competition and Patient Outcomes in the National Health Service NBER Working Paper number 16164 (July 2010) http://www.bristol.ac.uk/cmpo/publications/papers/2010/wp242.pdf. Cooper, Zack., Steve Gibbons, Steve Jones, Alistair McGuire (2011), Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms" Economic Journal. 121(554): F228–F260

[5] Martin Gaynor, Mauro Laudicella and Carol Propper Can Governments do it better? Merger Mania and the Outcomes of Mergers in the NHS Journal of Health Economics 31(3): 528-543 (May 2012)

[6] Nicholas Bloom, Carol Propper, Stephan Seiler and John van Reenan
The Impact of Competition on Management Quality: Evidence from Public Hospitals NBER Working Paper Series number 16032 (May 2010) http://www.bristol.ac.uk/cmpo/publications/papers/2010/wp237.pdf

(Bloom et al 2010).

The arguments may be more nuanced than many politicians (and perhaps health commentators) would like. But there is no evidence from recent experiments in the UK that allowing patients more choice and exposing poorly performing hospitals to the threat of their patients choosing another provider has led to poorer outcomes for patients or clear reductions in equity of access to treatment.

Jim Rebitzer
Boston University

It is no secret that the health care system in the United States is in bad shape. Much current discussion focuses on failures in health insurance markets or dysfunctions in public policy. Over the long-haul, however, the imperative is to reduce costs and improve quality. This will require innovation in processes and products and business models. Sustaining innovation is hard and it is especially hard in health care. The economics of the delivery system are such that we cannot rely on market competition to uncover effective practices in an efficient or timely manner. Thus my suggestion for improving the health-care system is to invest in numerous, well-designed studies of the effect of management practices on innovation and organizational performance.

We need answers to basic questions. Are there persistent performance differentials across health care organizations? If so, which management practices enable these? Are disruptive innovations feasible or desirable in health care? Are efficiency and innovation favored when physicians operate as employees in integrated delivery systems or as entrepreneurs in smaller practices delivering more fragmented care? If the former, how can capitation or other incentives applied to large organizations translate into effective motivators for individual health care providers?

Academic research can inform and even transform managerial practice - provided the results are communicated in a usable manner to the right people at the right time. In the case of health care, this requires that medical schools and nursing schools integrate these new research findings into their curriculum. Over time the study of management and innovation may become as central to medical education as physiology or anatomy.

Uwe Reinhardt
Princeton University

Of the pervasive price discrimination in our health-care system, management gurus Michael A. Porter and his colleague Elizabeth Olmsted Teisberg wrote in their *Redefining Health Care* (2006)[7]:

"Finally, the current system has resulted in pervasive price discrimination, in which different patients pay widely different charges for the same treatment, with no economic justification in terms of cost.… The administrative complexity of dealing with multiple prices adds costs with no value benefit. The dysfunctional competition that has been created by price discrimination far outweighs any short-term advantage that individual system participants gain from it."

I agree with the authors. The challenge is upon American health economists is to demonstrate convincingly why our price discriminatory system in health care, begotten by a system in which a highly fragmented payer side "negotiates" with an ever more consolidated supply side, is economically superior to, say, the Swiss or German health systems in which prices for regional (state or canton) all-payer system are negotiated in a quasi-market between associations of health insurers and associations of doctors, of hospitals, etc.

Christopher Ruhm
University of Virginia

The most important challenge of the U.S. health system today to maintain or improve the quality of care while simultaneously reducing the rate of cost increases. The latter will require comprehensive approaches to reduce expenses throughout the entire system. Many of these efforts will require government policies or direct government intervention. For example, legal obstacles to negotiating lower Medicare costs need to be eliminated (e.g. those related to pharmaceutical prices), and alternatives to expensive emergency department treatments should be promoted. The United States should follow most other industrialized countries in developing systemic approaches to reducing administrative costs and the prices of all aspects of medical care. This will involve more comprehensive use of cost-effectiveness and benefit-cost analysis, as well as difficult decisions regarding what types of care to provide and when to choose not to supply certain types of care. It is unclear to what extent politicians and the public are willing to make these complicated and controversial decisions.

Robert Town
University of Pennsylvania

The approval, coverage and payment policies for new technologies in the US provide incentives that significantly deviate from the ideal ones. First, the criteria by which the Federal Drug Administration (FDA) should be changed from "safe and effective" to simply "safe." This is

[7] Porter, M. and E Teisberg (2006), *Redefining Health Care: Creating Value-Based Competition on Results* Cambridge: Harvard Business Review Press

similar to the standard that is generally used in Europe for medical devices. The FDA approval process is currently too long and too unpredictable and sends a muted a message to pharmaceutical manufacturers, biotech firms, entrepreneurs and venture capitalists regarding the likely approval of their product given performance benchmarks. Second, technology coverage decisions should rely, in part, on cost-effectiveness analysis but should also recognize the value of having multiple treatment options in the market. Third, administrative payments for these technologies should reflect value not costs. Importantly, approval, coverage and payment policies should be harmonized in order to provide consistent and appropriate price and cost signals to the market.

R. Lawrence Van Horn
Vanderbilt University

The US healthcare "system" has been on an unsustainable fiscal trajectory for the last 30 years. Characterized by declining patient financial obligations and unlimited demand , the system has relied unsuccessfully on self-limiting supply mechanisms to reduce and appropriately deliver care. These have failed. Time for experimentation has passed and in equilibrium we will be forced to return to the fundamentals of 40 years ago. The tax-exempt treatment of health benefits must end. Prepaid health care consumption will wane and return to true insurance in the growth of CDHP plans. Greater patient cost sharing will naturally result, putting downward pressure on demand. The greater patient fiscal stake will change incentives around both consumption as well as lifestyle choices which are the primary determinant of health.

At the same time our country will finally be faced with the uncomfortable conversation regarding the extent of the social contract between the government and our citizenry around publically funded health care programs. The existing level of service provision, funded by Medicare and Medicaid will have to be balanced against our ability to raise funds. The result will necessarily be a reduction in the scope of services afforded those who rely on government programs. A more clearly demarcated public and private system will emerge and the US "system" will look indistinguishable from those in other countries around the world.

William White
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Fragmentation and poor coordination of care have been widely identified as major sources of inefficiency in the U.S. health care system. Most would agree that improved Health IT (HIT) systems can help improve coordination by facilitating information flows among providers, patients and payers. The issue is how to get there. Federal policies have focused on promoting private investments in HIT. This is well and good. However, there is a critical public goods problem which markets have not been very successful in addressing. To fully realize the benefits of HIT, there need to be common platforms that allow systems in different organizations

(and indeed, often within organizations) to readily talk to each other. So far, we are a long way from achieving interoperability. It is probably neither practical nor wise for the Federal government to attempt to accomplish this through encompassing regulation. However, requiring a minimum standardized electronic medical record for payment under Medicare could go a long way.