

MAGAZINE DESK

## The Quality Cure?

By **ROGER LOWENSTEIN (NYT)** 5159 words

Published: March 13, 2005

David Cutler hit what seemed to be the peak of his career at 28, when as a junior faculty member at Harvard he was whisked down to Washington to help draft a health-care bill under the tutelage of Ira Magaziner and, of course, Hillary Clinton. The project produced a dispiriting result: nothing.

Corporations, consumers, the uninsured and doctors had all been clamoring for reform, and the question of why the project failed has nagged at Cutler ever since, especially as the problems have continued to worsen. In the years since he left Washington, which was in 1994, the ranks of the uninsured have surged, from 35 million people to 45 million. There are also serious gaps in the quality of care, and there is a deep dissatisfaction with the way the system functions -- in how it seems to make adversaries of patients, doctors and insurers, for instance. Arguably, Americans want health-care reform more urgently than anything else.

Yet designing a national health-care policy has become a kind of taboo. Congress provided prescription drugs for seniors, and President Bush, not normally thought of as timid, has backed some modest initiatives: legislation to limit malpractice suits, individual health savings accounts. But Washington has done nothing on the scale that a social engineer -- a Robert Moses or a Daniel Patrick Moynihan -- might to reinvent the system. Cutler has thought about this ever since his failed experience in Washington, and his diagnosis has shaken up the health-care-policy world. "The real reason health-care reform has not succeeded," he has written, "is that it is rooted in a misconception of what health-care reform should accomplish."

Virtually every would-be reformer, Democrat and Republican alike, starts with the presumption that the major problem in health care is high costs. This is understandable: America now spends 15 percent of its gross domestic product on health care. That's a higher percentage than any country has ever spent in the history of the planet, and the figure is increasing. The United States spends more on health care than on automobiles; we spend more on health care than China spends on tea; in fact, as Cutler likes to point out, we spend more on health than the Chinese spend, per capita, on everything. And health care threatens (far more than Social Security) to consume the federal government. Medicare, the health-care program for retirees, and Medicaid, which provides basic services for the poor, already account for one-fifth of the federal budget, and their share could double in a generation.

Curbing such growth has been the aim of every reformer, and according to Cutler, it is the reason reform has failed. The Clinton team proposed to pay for universal coverage by limiting increases in spending (partly through mandatory caps). But limiting spending also meant limiting service. The proposed legislation was never put to a vote.

Managed care was next at trying to contain costs. It succeeded for a while, until it became clear that Americans did not want health-maintenance organizations to limit their choices any more than they wanted the government to. Since then, reform has languished. The Medicare drug bill is suggestive of why. The Republican Congress promised restraint but then passed a hugely expensive law that barred Medicare from using its clout to negotiate prices with drug companies. The pattern has been failed efforts to control costs, followed by a void of new ideas.

Cutler's approach is radically different. He says that most health-care spending is actually good. Spending has been rising, he says, because it delivers positive, and measurable, economic value, and because it can do more things that Americans want. Therefore, Cutler says, we should focus on improving the quality of care rather than on reducing our consumption of it. Rather than pay less, he wants to pay more wisely -- to encourage health-care providers to do more of what they should and less of what is wasteful.

This, as it turns out, is exactly what some of the most innovative health-plan sponsors -- from Kaiser Permanente to General Electric -- are doing. To them, the Cutler approach of focusing on quality offers a way out of the void and possibly, over the longer term, an acceptable route to restraining costs.

To understand how Cutler has upended conventional thinking, you first have to understand the political straitjacket in which health care has found itself. Health care "lefties," as Cutler refers to some of his colleagues, favor a European system -- universal insurance financed by a single payer (the government) and some sort of rationing to hold down the screaming increase in high-tech procedures. Canada rations by limiting access: Ontario, with one-third the population of California, has one-tenth the number of open-heart-surgery facilities.

While Cutler acknowledges the merits of such an approach, he also sees its problems. The British may be accustomed to waiting for hip replacements, but Americans do not like rationing. Also, systems with just one payer do not encourage innovation and experimentation. Imagine America if everyone were on Medicare. Doctors and hospitals would do whatever Medicare approved and nothing more.

Right-wingers go for a market approach -- it's not the technology they object to, but people's cheap access to it. If people paid for their own angioplasties, so the theory goes, they would have fewer of them. This is the theory behind Bush's health savings accounts, initiated during his first term: let people buy insurance from their own (tax-sheltered) pockets.

Apart from the obvious objection that low-income people find it hard to save for those accounts, Cutler points out another shortcoming: Most of the dollars spent on health care are spent on people with serious illnesses or conditions. Those with coverage quickly move into the territory covered by insurance. Few people really pay for their own angioplasties, so few care what they cost.

Moreover, it's not clear that we want people to be too price-sensitive, especially people with chronic conditions, lest they try to starve themselves of care. "My grandmother used to say, 'Why should I take the blue pill -- I'm feeling better,'" Cutler recounts. "The blue pill was why she was feeling better." As Cutler told me in the first of our many conversations, "Ultimately, every discussion of health care turns personal."

A tweedy, self-effacing 39-year-old, Cutler is a seriously modified lefty. He envisions a system in which everyone could get insurance while free-market incentives would motivate health-care providers to be more effective as well as more efficient. Instead of suppressing

the market by rationing care, restraining prices or regulating doctors, he wants to liberate it. It is neither Clinton nor Bush -- but closer to Bill Bradley, whose 2000 campaign Cutler advised. Dr. Robert Galvin, head of global health care at General Electric, says, "David has showed everyone that the way to rein in costs is not to squash innovation."

The soft-spoken Cutler was a star even as a Harvard undergraduate, when he assisted an up-and-coming economics professor named Larry Summers. Finance -- not health care -- was the hot field among economists, but as a graduate student, Cutler wrote a still cited dissertation on how changes in Medicare's compensation scheme caused hospitals to release patients after shorter stays. It proved, Cutler says, that doctors were incredibly and, in some cases, "horribly," responsive to incentives.

Hired onto the economics faculty at Harvard, he was urged by Summers to continue in health care. After his stint in Washington, Cutler continued to think of ways of rationing care until, at lunch one day, an economist named Zvi Griliches asked him, "Why is it you think I get too much health care?" He said it in a thick Polish accent -- "Vy is it?" Cutler immediately saw his point. He was looking at the wrong side of the ledger; instead of worrying about the cost of health care, he should think about the benefits.

This sounds obvious, but almost no one was looking at it this way. Thinking of people he knew -- "all health care is personal" -- Cutler wondered if Americans might be spending more because they were getting more and better treatment. Joining with Dr. Mark McClellan, another economist, he zeroed in on heart disease. The pair discovered a curious fact: heart attacks were occurring less frequently, thanks to drugs for treating high blood pressure and to reductions in smoking, but spending on heart attacks was rising. Surgery rates -- \$25,000 for an angioplasty, \$40,000 for a bypass -- had been relatively stable. But as the technology improved, the operation was being performed far more often. Was that an example of waste?

Looking at the data, they discovered that, on average, heart attack victims were surviving eight months longer than in the 1980's. In economic terms, they argued, the increased spending was "worth it." Subsequently, Cutler concluded that a 45-year-old American could expect to spend \$30,000 over the course of his life on all forms of cardiac care and that, thanks to improvements in cardiac technology alone, he could expect to live three years longer. That worked out to \$10,000 a year of added life. Cutler can rattle off figures to prove that Americans value life even more. (Air bags cost something like \$100,000 per year of life saved, for instance.) But you don't need to be an economist to believe that \$30,000 for three extra years is a pretty good deal.

McClellan now runs Medicare, where he is experimenting with paying doctors for better results -- a Cutler-like departure from the old policy of simply trying to restrain costs. But it is Cutler, now the dean of social sciences at Harvard College, who has plainly broken from the health-care establishment. In a book published last year, "Your Money or Your Life," Cutler summarized his research as follows: "The evidence shows clearly that spending more has been good; we get a lot more out of the medical system than we put in."

The book won praise from The New England Journal of Medicine and other publications. "It's good to see in Cutler's study an analysis of some of what has gone right," a reviewer in The Los Angeles Times commented.

Critics responded that good health care could be much less expensive. Canada spends only 10 percent of its G.D.P. on health care, but according to common yardsticks like longevity and infant mortality, Canadians are just as healthy. Dr. John Wennberg, a health-care expert at Dartmouth, and his colleague Jonathan Skinner point out that some areas of the United States, like Boston and Miami, spend far more than others, like Minneapolis, without any

noticeable improvement in mortality. This leads them to conclude that the additional spending is fruitless.

Ira Magaziner, who ran the Clinton effort, says that project was meant to eliminate just such redundancy and also to make a serious dent in administrative costs. "There is a lot of waste you can take out of the system before you get to questions of rationing," he says. In any case, the Clinton plan's complexity, as well as the secretive style in which it was developed, probably did as much to torpedo it as rationing, which is what Cutler has focused on.

Cutler, who reads as many medical journals as economics ones, does not dispute that America buys more health care than it needs. He estimates that 20 percent of spending (such estimates are all over the map) is unnecessary, much of it for tests and specialist consultations. Indulgent Boston, for instance, has 1.7 times as many specialists per capita as frugal Minneapolis. But it is extremely difficult to weed out only the "bad stuff," Cutler says. Oregon, he notes, tried to proscribe "unnecessary" procedures for Medicaid patients. It ended up relenting on almost everything.

In any case, the idea that America could trim spending to Canadian levels is probably unrealistic. American doctors earn more than those in Canada. Our culture tolerates, even approves of, greater disparities in income; Congress is not likely to legislate a change. Canada also enjoys a "free rider" benefit. Drug makers earn a return on their investment in the United States, and so are willing to accept price caps in the smaller Canadian market. And since Canada has just one insurer (the government), its doctors spend less on administration.

However, health-care costs in Canada have increased at nearly the same rate as in the United States. In fact, spending growth in most developed nations -- regardless of how they finance and organize care -- has been moving ahead at similar rates. Since 1960, costs in six of the G-7 countries have risen, on average, by 4.9 percent a year. The rise in costs in the United States, at 5.1 percent annually, is close to the middle of the pack. Sherry Glied, of Columbia's School of Public Health, concludes that "no particular characteristic of any health-care regime is the main determinant of growth in costs." Technology is.

Critics of America's profligate ways fret about the relentless character of spending increases, and they have a point. Even when technologies lower costs, they increase spending by broadening the market. More people have gallbladders removed because laparoscopic surgery is less invasive. More people take medication for depression because the Prozac-era drugs have fewer side effects than earlier drugs. In fact, doctors diagnose depression more often. Better treatments lead to higher use.

Contrary to the fears of many on the left, higher prices are not the chief culprit. Thanks to continued pressure from H.M.O.'s, doctors' rates have been held in check. So have the prices of pharmaceuticals already on the market. But because new drugs are more expensive, and because people take more pills, total spending on drugs since 1990 has quadrupled.

As Cutler says, medical spending isn't increasing because of inflation so much as because of people consuming more "good stuff." This view is beginning to course through the health-care world. Scanning the literature, you now happen upon sentences like, "We believe that some of the concern about the growth in spending may be misplaced" (Health Affairs) and "On average . . . society is better off exchanging more money for better health" (The Journal of Economic Perspectives). No one disputes that spending will continue to increase; limiting the rate of growth is the most we can hope for.

Since he reckons that most of what we get is beneficial, Cutler puts primary emphasis on improving the quality of care. "Most of economics is about the cost of things," he notes.

"There has been little effort to figure out what the benefits are. That's often more difficult. How do you value clean air, lower crime or improved health?"

What Cutler has in mind is a twofold plan. First, he proposes a variant of the voucher system. Let the government finance people's -- everyone's -- health care, with tax credits to be spent on private providers or insurers. But vouchers would only broaden the system, not improve it. To accomplish the latter, Cutler wants insurers, both public and private, to redesign the way doctors and hospitals are compensated, to give them an incentive to compete on quality.

At first blush, this struck me as pretty naïve -- the sort of mushy academic theory that could lead, ultimately, to higher bills. Cutler's former mentor Summers, now Harvard's president, shares that skepticism. How, after all, do you measure performance in health care? It turns out that there are lots of ways.

People (like me) often assume that the American system, while expensive, is about as effective as possible. That turns out to be wrong. People are prescribed pills for hypertension and don't take them. Diabetics are supposed to monitor their blood sugar and don't. According to a study by the RAND Corporation, people get only 55 percent of the care recommended for them. Doctors themselves are surprisingly inconsistent. Alarming, many heart attack patients do not receive beta blockers, inexpensive pills that significantly reduce mortality.

Dr. Donald Berwick, a pediatrician obsessed with the shortcomings in health-care quality, has shown that it is possible to improve care rather significantly. Berwick, who runs the Cambridge-based Institute for Healthcare, teamed with the Robert Wood Johnson Foundation for a trial in which six hospitals and one H.M.O. focused on improving overall performance. The results were stunning. Tallahassee Memorial Hospital reduced mortality after heart attacks from 12 percent to 6 percent in two years. It also lowered mortality for strokes by 41 percent and for pneumonia by 32 percent. The improved cardiac performance was a result of systematically administering beta blockers and aspirin, making sure EKG's arrived promptly and prodding the emergency-room doctor and the cardiologist to be in closer touch. These procedures "were being done" before the project began, says Winnie Schmeling, an administrator at Tallahassee Memorial. "They just weren't being done every time."

According to Berwick, Tallahassee's experience is common. "Hospitals are out to save lives, but they won't necessarily track survival rates, or compare themselves to others, or think about what they could be doing better," he says.

There is an aphorism for such behavior in the business world: "You manage what you measure." If doctors measure how long it takes to deliver an EKG, then EKG's are delivered faster.

America's fee-for-service system does not require doctors to measure. It rewards them for each instance of delivered "care," Cutler notes, but not necessarily for the end result -- for "health." This is especially true for chronic patients, whose well-being depends on following a long-term regimen of care. Diabetics, for instance, should receive yearly eye exams, regularly monitor blood sugar and cholesterol and take other steps to avoid problematic (and expensive) complications. "Doctors say, 'You really should get your eyes examined,'" Cutler notes. "There is no follow-up. Every doctor you talk to says: 'I know we don't do a good job on that. We don't get paid for it.' My way, we would pay them."

How would "paying for performance" work? In the late 90's, HealthPartners, a not-for-profit health plan in Minneapolis with 630,000 members, instituted a bonus system to providers. It paid doctors extra if their diabetic patients got blood sugar and cholesterol below certain

levels, ceased smoking and took aspirin daily. In 1996, 5 percent of patients met all criteria. By 2003, 17 percent did. Similar gains were registered with heart patients. "These clinics are trying to provide quality care," says Dr. George Isham, the plan's medical director. "What we're doing is putting a measurement on it." In 2003, the plan awarded a total of \$9 million to doctors on merit. But was it worth it?

At Isham's request, Cutler and a team of colleagues analyzed the economic payoff. They found that the program reaped huge rewards. It cost \$330 a patient and was expected to save roughly \$30,000 over each patient's life. While the analysis is not precise, Cutler wrote, it "illustrates a general point that professionals in health care have known intuitively for some time: . . . comprehensive disease-management programs are clearly worth the investment."

The rub is that the investment was only marginally worth it for HealthPartners. The gains went to the patients, in the form of better health, and to their employers, who were expected to suffer less absenteeism. HealthPartners did recoup some of its investment, as members were hospitalized less frequently. But some of those people would change jobs and change insurers, so the benefits were largely reaped by someone else. Ultimately, as patients retire, they will be reaped by Medicare.

This "exemplifies some of the problems inherent in our current system," Cutler wrote. A program with huge benefits for society (and for patients) offered only a marginal incentive to the health plan to create it. HealthPartners did not have the option of simply raising its rates, because healthy patients would have departed for a cheaper plan. This is why closed-loop systems -- systems in which patients made healthy don't leave -- tend to work best.

Kaiser Permanente, the huge health plan based in California, is something of an example. Both insurer and provider, Kaiser pays its doctors a fixed salary regardless of how much (or little) they do. Its doctors also receive a bonus tied to measures of performance. The theory is that its integrated approach will pay off both in terms of patients' health and economically. So far, the approach has shown significant improvement in health and after some missteps has been able to stay competitive (though it is hardly cheap). Other major health plans in the state recently agreed to a similar system of quality bonuses, so California could become something of a closed loop.

General Electric is another intriguing case. Despite its supposed fervor for quality, until recently G.E. had been shelling out more than \$2 billion a year in health coverage without regard to the quality of care. Robert Galvin set out to change that. In 2000, G.E. and several other companies began a program to reward doctors in certain cities on the basis of quality. Specifically, the companies split with doctors the savings that flowed from better care of diabetes and heart disease. According to G.E., the average cost of caring for diabetics who are properly treated drops by \$350 a year, even before factoring in the cost of the long-term complications of leaving the disease untreated. Maybe pay-for-performance won't work for an earache, Galvin allows, "but we have found a business case for diabetes." Clinician groups that hit their quality targets can earn up to \$20,000 a year.

Predictably, G.E. started with two conditions -- diabetes and heart disease -- that afflict large numbers and for which care guidelines are well established. G.E.'s next experiment was less predictable. Cutler and others (including President Bush) have been pushing the health industry to invest in computers. Many doctors still write prescriptions and keep records manually, and Cutler says that digitizing the health-care system would save considerable administrative expense and improve quality. It would minimize prescription errors, speed paperwork and make a patient's medical history portable. But the big kick is what information technology could do for the doctor's understanding of his own performance.

Most doctors' offices have no idea, say, what the average blood pressure is of their patients being treated for heart disease. In fact, most clinics could not tell you how many heart patients they have or how many have been prescribed a particular drug. Cutler envisions a medical world in which doctors routinely get readouts of their patients' blood-pressure levels, insulin, smoking rates -- the lot. This, of course, is how most of the business world already operates. So the G.E. program is paying doctors' offices up to \$15,000 a year for investing in, and using, computers. G.E. and other companies have asked RAND to analyze the financial payoff, but in the meantime they decided to kick-start doctors, some of whom have reacted warily to any sort of proposed changes, into the digital age.

If you look at why Americans are going to the doctor, it strengthens the economic case for performance goals. Half of the growth in spending is for chronic conditions like asthma, obesity and diabetes. With proper treatment, including preventive care, chronic patients require less intensive care and less hospitalization. In their case, particularly, Cutler argues, quality will pay.

One criticism is that pay-for-performance still rewards doctors for doing something. It doesn't motivate them to cut waste -- to not do things. Another is that doctors could game the system, just as C.E.O.'s with performance bonuses can. Nonetheless, McClellan, the Medicare administrator and former Cutler collaborator, is taking a gamble that pay-for-performance will work. Medicare has started half a dozen pilot programs to test various incentives. In one, hospitals scoring in the top 10 percent in a set of quality measures for certain conditions will be given a 2 percent bonus.

Medicare is also testing incentives that reward doctors for savings. The American Medical Association is nervous about anything that smacks of encouraging doctors to withhold care (a battle it fought with H.M.O.'s in the 90's), but it appears to be willing to look at schemes that link pay to quality.

Medicare hopes that by making providers think about both quality and efficiency, modern doctors might acquire some of the wisdom of those old-time family practitioners who, so we like to recall, had their patients' health uppermost in mind without losing all regard for their pocketbooks. "Speaking as an economist," McClellan says, "it's clear that doctors respond to incentives."

Cutler says that Medicare's willingness to experiment is hugely important. Private health plans do not have the clout to force a clinic to purchase software or adopt performance goals. But Medicare is so big that were it to adopt performance targets, it would force every doctor to adjust. "Medicare could really jump-start" pay-for-performance, Galvin says. Then H.M.O.'s would surely begin to mimic Medicare and adopt similar targets.

Reoriented to managing "health" rather than merely costs, H.M.O.'s might again become a useful part of the health-care landscape, Cutler says. Managing care, he says, was a necessary idea that went off the tracks as H.M.O.'s became remote, single-minded cost-control freaks. His models for the future are the progressive organizations (he calls them hippie places) like Kaiser that employ their own doctors, invest in computers and "engage" their patients. They manage quality as well as cost.

This does sound sort of pie-in-the-sky, but Kaiser and the other California health plans are already paying bonuses to doctors who score high on patient surveys. Just imagine: a doctor paid to make you feel better.

Cutler says that the next step is for Medicare to go beyond trials and move from a

fee-for-service model to, in part, pay-for-performance. "If Medicare has to pay more to doctors -- which it will, given current projections -- don't raise fees across the board," he explains. "Set up a bonus fund that goes to M.D.'s who follow guidelines or have the best measures of outcome." Similarly, Medicare could pay more for operations that are clearly indicated, less for procedures (or drugs) that seem discretionary. By such steps, Medicare would come to resemble a large, progressive H.M.O.

All this would ease the way to Cutler's ultimate goal, which would be to abolish the distinction between Medicare and private plans. That America has a separate plan for seniors is an accident of history: it was a compromise adopted in the 60's when business and the American Medical Association lobbied to defeat universal coverage. Many corporations, however, are now quite eager for the government to resolve the mess. And the present hodgepodge system (or nonsystem) simply has no logic to support it. As former Senator Bob Kerrey testified in 2002, "There are six main ways a resident of the United States can become eligible for insurance": wait until he is 65, demonstrate that he is disabled, "get blown up in a war," prove he is poor and "promise to remain poor," work for the federal government or find a job with an employer who offers insurance. Those who fall through the cracks get only half as much care as people with insurance.

To make coverage universal, Cutler advocates a \$6,000 credit for poor families (and less, on a sliding scale, for others, tapering off to a small credit for people earning \$50,000 and up). The credits would be redeemable as a sort of health-insurance voucher. Significantly, Cutler would extend credits to everyone -- even to people who are covered now. Many employers, for competitive reasons, would still offer coverage, but access to care would no longer depend on either employment status or age.

Vouchers are a leap for a Democrat, but the idea is popular with conservatives. Bush has also proposed tax credits, though on a smaller scale and for only the uninsured. Stuart Butler of the Heritage Foundation prefers Cutler's universal model. Butler points out that the government already subsidizes people in corporate plans, who do not have to declare their employers' contributions as income. This is a huge break: it costs the United States Treasury more than the mortgage deduction. It is also distributed, illogically, only to people whose employers provide a subsidy. As Cutler declared in his book, "Health insurance is not something that is made better by tying it to employment." Even the A.M.A. has come around and favors having the government finance universal access.

Cutler's idea is to preserve the diversity of America's system while subsidizing people's access to it -- to let the G.E.'s and the HealthPartners of the world, and also the Mercks, continue to innovate.

Cutler says that under his scheme, the government might spend an additional \$100 billion a year. Some of that would represent new spending for people who previously did not have insurance; some would represent a transfer to the government of costs now borne by others -- employers, or hospitals that provide charity care. That's a big number, but, to keep it in perspective, spending for Medicare and Medicaid currently totals just over \$500 billion.

More problematic is that Cutler's plan would seem not to brake the projected future escalation of spending. By 2040, according to various projections, that spending could rise from its present \$1.8 trillion to something like \$3 trillion -- that is, to 20 percent of G.D.P. or conceivably 25 percent. This is why so much attention is focused on cost. According to Henry Aaron of the Brookings Institution, "We can't continue to provide all care for all people."

Cutler's answer to these fears is not exactly cavalier, though some might find it so. If we institute a more results-oriented, and a more health-conscious, system, our dollars will buy us

better care and probably cheaper care. By emphasizing prevention and effective treatments for the chronically ill, we might also reduce the rate at which spending grows. We'll still consume more health care -- more "good stuff," in Cutler's trademark colloquialism. But the drive to keep spending down will forever be challenged by technology's efforts to overcome it. If it turns out that gene therapy delivers a cure for cancer, and if that turns out to be something that most Americans want, we should be prepared to pay for it and indeed to tax for it, Cutler says. Spending a fifth, even a quarter, of our resources on life-enhancing and life-prolonging miracles would not be the worst of fates.

Drawing (Drawing by Kit Hinrichs/Pentagram)

[Copyright 2005 The New York Times Company](#) | [Privacy Policy](#) | [Home](#) | [Search](#) | [Corrections](#) | [Help](#) | [Back to Top](#)