The Missing Health Care Reform: Transparency

Regina E. Herzlinger
Nancy R. McPherson Professor of Business Administration
Harvard Business School
Baker Library 171
Soldiers Field
Boston, MA 02163
rherzlinger@hbs.edu
617.495.6646 (phone)
617.495.0358 (fax)

May 4,2010

Health care transparency was surprisingly absent from the health care reforms enacted in 2010. The passage of the transparency Bills presented today will help to rectify this omission .

After all, transparency can help foster significant cost and quality improvements and improve access for the uninsured . Additionally, unlike some reform elements, the American people very much want the government to effect transparency: the number one change Americans wanted from the government in one survey "was requiring that performance ratings on hospitals and doctors be publically available."[1]

Cost control—Generally, consumers get better value as transparency increases.[2] With health care transparency that could help them answer questions like "Which insurance companies and policies offer the most medical care benefits per dollar spent? Treat sick people the best? Offer the best doctors and hospitals? Are disliked by doctors and hospitals because of their slow and low payment practices?", consumers could reward insurers who gave them the best value, encouraging competition and innovation. The health insurance industry is surprisingly entrepreneurial:[3] the firms currently dominating the high deductible insurance market were formed only nine years ago, for example.[4]

Transparency could help insurers to better control costs by constructing narrow networks of the best value doctors and hospitals. UnitedHealth estimated savings of $37 billion from 2010–2019 from incentives to use the highest quality health care providers.[5] Health insurers typically do not offer these narrow networks because the American people suspect that insurers favor low-cost providers, rather than high-quality ones. The availability of independent data through which enrollees could verify the quality of doctors and hospitals would alleviate such concerns.

Further, the mere act of obtaining data motivates positive changes among suppliers, a phenomenon known as "the audit effect."[6] The US Congressional Budget Office, for example, estimated that sharing peer profile scorecards with physicians would save Medicare $350 million from 2010–2014.[6]

Quality effects—Transparency can also spur quality improvements. For example, although researchers virtually eliminated an ICU infection in Michigan that kills up to 60,000 people annually in the U.S., their intervention has not spread rapidly, perhaps because deaths from infections are invisible.[7] If hospitals were required to publically report valid data, infection rates would likely plummet.

Evidence suggests that hospitals respond to publicly reported data with efforts to improve patient care and their standing in reports.[8] Patients respond too: in New York and Western Pennsylvania they increased the market share of higher quality providers.[9] When English patients and providers obtained information about hospital quality and waiting times, as part of a package of reform which included public performance ratings, both measures of performance improved significantly.[10]

Access impact—Currently, charges for the medical care of the uninsured are difficult to find and differ widely. One study found that the uninsured paid 75% more for one procedure than Medicare patients.[11] Public posting of charges would enable the uninsured to more readily compare competitive prices.

Yet transparency is not without risks. Some economists believe that in a concentrated market, like many in health care, transparency can lead to collusion.[12] Others may believe that some degree of price discrimination is essential for equity. Yet, a recent Congressional report which assessed all these risks concluded that transparency can help improve quality and reduce costs.[13]

We lack transparency primarily because government has not required it, failing to invest in developing robust measures, to create standards for measuring quality, and to ensure that accurate and reliable data are readily available. The available public data are limited. Hospital Compare, the Website of the U.S. Department of Health and Human Services, for example, reports on only six medical conditions and 26 surgical procedures.[14] It contains measures only of the *process* of providing medical care—did the hospital give you an antibiotic before the surgery—rather than *outcome* data—how often patients were infected in this hospital? Yet, consumers do not value such process data highly.[15] In 2008, only 6% of surveyed Americans heard of Hospital Compare.[16]

Although more than 40 states and a number of private organizations[17] provide some health care transparency, they too are not fully responsive. Moreover, they offer limited input from consumers,[18] although consumers value information obtained from people like them highly.[19] Further, none of the state sites compare their data to the best in class in the U.S. For example, Maryland's Johns Hopkins may provide best in class care for prostate surgery and the Massachusetts General Hospital for thoracic surgery but the users of transparency sites in each state will likely not know that.[20] The absence of this information also inhibits the nascent movement in inter-state medical tourism and its cost savings[21] and quality improvements.[22]

Similarly, a survey of the transparency efforts of 25 nonprofit hospital systems concluded that "none of the healthcare systems studied had information available on their Web sites that was relevant, reliable, and transparent in all .

. . categories.” Their quality transparency data earned among the lowest ratings. [23],[24]

Government Success in Transparency

The public’s desire for transparency and the failure of markets to create it warrant governmental action. The government’s efficacy as a transparency agent is exemplified by the Securities and Exchange Commission (SEC). It was created when Franklin Roosevelt overrode his advisors’ counsel that government evaluate securities and, instead, opted for transparency to cure the stock market’s collapse during the Depression. FDR fashioned the SEC—he called it the Truth Agency—to require corporations whose securities were publically traded to disclose results, using generally accepted accounting principles, audited by independent, certified public accountants and made readily available to the public. The Federal SEC superseded numerous, nonfunctional state and private transparency agencies, enabling a national capital market.

As in health care today, prior to the creation of the SEC, investors could access only the piecemeal data corporations chose to reveal. Because no generally accepted measurement standards existed, investors lacked a clear understanding of what the numbers meant and assurance that they were measured comparably across firms.[25] Businessmen argued that the costs to them of this new agency would exceed its benefits.

Although the SEC failed as a regulator, it was successful in creating transparency, which ,in turn ,lowered the cost of capital, because investors who were more certain about performance, required lower returns; helped protect against misappropriation of shareholder returns by managers, as attested to by the outcries against CEO compensation, fueled by easily accessed mandatory disclosure about executive compensation; and enabled appropriate allocation of resources: investors rewarded productive, socially responsible firms more than others.[26]

Objections to a Health Care Transparency

Why do we need government intervention for transparency?

Although the impact is uncertain, the available evidence suggests that transparency would produce a net good for consumers and health care markets, improving quality and reducing costs.[27] Governmental action is needed because, like a classic public good, the financial gains to providers from transparency are dwarfed by the public welfare it creates by increasing the quality of life.[28]

Why not leave transparency to state governments?

The best health care providers, and often the lowest cost ones, are found in many different states and may excel in different types of care[29,22] The Dartmouth Atlas and other researchers found, substantial variation in the quality of care among states.[30] While state level reporting could supplement national reporting, state transparency agencies that limit information to local providers may prevent insurers from creating multi-state networks of best value providers.[20]

Will the costs of transparency exceed its benefits?

If the budget of the new transparency commission emulated that the SEC’s billion dollar budget, estimates of the savings to be created by health care transparency easily exceed these costs. Further, by consolidating measures, transparency will likely reduce the sizeable expenses of private sector providers for collecting and reporting different measures for different insurers. The recent growth in Federal support for Health Information Technology will simplify the measurement process by automating retrieval of data now collected manually.

Health care is different. The average person will not use these data

The equilibrators of an effective market are not the *average* buyers but rather *marginal* consumers. At a high price, there are only a few buyers who are more or less price insensitive. To attract more customers, suppliers reduce their prices. The increased volume of customers more than compensates for price reduction. Suppliers continue to cut prices until they hit the last tough-minded customers who pay a price roughly equal to marginal cost.

The rest of us benefit from the relatively small last-to-buy crowd. A McKinsey study showed, for example, that only 100 investors “significantly affect the share prices of most large companies.”[31] These hard-nosed buyers are adept in finding, interpreting, and using information. The market for automobiles, a highly complex product, illustrates their impact. Automobile prices are the lowest in two decades while their quality is the highest.[32,33]

Substantial evidence indicates that today’s better-educated consumers also seek health information. In 2007, 28.7% of the population had attained a college education or more, and 85.7% were high school graduates.[34] In 1960, in contrast, fewer than half the people were high school graduates, and only 7% had a college education.[35] Higher levels of educational attainment increase not only income and ability but also self-efficacy.[36] Affluent Web surfers spend more time than others searching for information on the Net, finding good values, and improving the product for everybody.[37] A 2009 report found that 61% of American adults used the Internet for health information.[38] Millions spent an average of 20 minutes at the government's National Institutes of Health Web site, studded with arcane medical journal articles,[39] and mastered medical skills, such as CPR and the use of external defibrillators.[40]

More than 70% want online evaluations of physicians,[53(p2)] and when they obtain the information, they use it.[41] Consumers are willing to change hospitals in response to information about their quality.[42,43,44] Consumers who had made relatively poor health care choices in the past, improved them when information was available.[45]

Medical care outcomes cannot be accurately measured. Providers who treat high-risk patients or only a few patients will be unfairly penalized

More than two-thirds of surveyed physicians indicated that the general public should not have access "to information on clinical outcomes."[46] For example, one complained that the cost of collecting the data ranged from $0.59 to $2.17 per member per month. But the benefits likely far exceed these costs. For example, if quality data improve the costs of treating a diabetic by as little as 1%, the data collection costs will be repaid fiftyfold in less than one year.[47] The same report also notes that many data cannot be reliably measured for most doctors because they treat so few of the sick: “a physician would need to have more than 100 patients with diabetes . . . for a profile to have a reliability of 0.8 or better, while more than 90% of all primary care physicians at the HMO [he studied] had fewer than 60 patients with diabetes.”[59] A hospital-based study similarly concluded that “the operations for which surgical mortality has been advocated as a quality indicator are not performed frequently enough to judge hospital quality.”[48]

These challenges are real. Research is needed to mature the science of quality measurement and to minimize and account for systematic and random error, ensuring that variation in outcomes among providers represents true variation in the quality of care. In some care settings, outcomes may need to be aggregated to groups rather than individuals. To date, investments in advancing the science of quality measurement have been minimal.

But the purpose of performance measurement is to protect the patient, not the physician or the hospital. Transparency would likely cause the low-volume physicians, medical groups, and hospitals that cannot generate statistically reliable data to lose patients to those who achieve excellent outcomes, in part because of their high volume, or to consolidate practices into larger groups. Providers who see many patients of one type are more likely to develop the expertise needed to care for them effectively and efficiently.[49]

Why not restrict disclosure of the results to the providers and insurers? Why must the data also be reported to the public?

An evaluation of the impact on a Wisconsin quality improvement initiative which reported hospital performance data both publically and privately concluded that "Since quality improvement efforts among the public-report hospitals appear to be significantly greater than in hospitals given only private reports, there is added value to making performance information public."[50]

Yet, the concerns about issuing misleading outcome data are real and valid. Undoubtedly, the science of quality measurement must improve before providers will be comfortable with the public release of outcome data. It is not that scientists cannot develop measures; it is that society has not invested in developing them. Surely, if we can sequence the human genome, all 3.4 billion base pairs with 99.999% accuracy, we can develop quality measures.

Health care quality measures are currently of insufficient quality

Some providers appropriately worry about the quality of the information. Much of the language for measuring health care quality has yet to be defined; the risk adjusters that would make it possible to compare the performance of high-risk specialists to those who treat less severely ill patients are not yet fully developed;[51] raw data are often flawed; and data quality control is virtually nonexistent.[52] These are serious concerns. For example, a study that compared the rates of caesarean sections in hospitals, with and without adjustment for the fact that some hospitals might have more patients prone to caesareans, found that adjustment caused the performance of a fourth of the hospitals to change dramatically :for example, 10% of those originally classified as especially high or low users of these surgeries were reclassified as normal and some classified as normal were reclassified as having greater or lesser rates of surgery than the average.[53] Physicians may be dissuaded from caring for very sick patients if outcome measures do not correctly reflect the severity of illness.

Measurement issues like these can be resolved with investment, time ,and experience as illustrated by the continual evolution in financial measures such as *beta*, the measure of risk of different investments. *Beta* has been continually refined since it was first suggested in 1952 by people so expert that one of its developers won a Noble prize.[54]

Conclusions

Although financial performance measures are not perfect, public disclosure forced them to improve continually over time. Absent governmental oversight, we have little hope that health care will significantly improve transparency. Consumers pay the price of the failure of health care transparency, sometimes with their lives, and frequently with their pocketbooks. And providers, payors, and regulators pay the price too by lacking data to effectively and efficiently improve quality and reduce costs of care. Health Care Transparency will enable consumers to make more informed choice, reduce health care costs, and hold health care insurers and providers accountable for the results achieved.

References

[1] The American public on health care: the missing perspective. The Council for Excellence in Government; 2008.

[2] CRS Report for Congress. Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector Updated April 29, 2008.

[3] UnitedHealth Group website [cited 2009 Aug 31]. Available from: http://www.unitedhealthgroup.com/AboutUs/HistoryAndInnovation.aspx. United HealthCare Corporation. Annual report on form 10-K for period ended December 31, 2008. [cited 2009 Aug 31]:30. Available from: http://www.unitedhealthgroup.com/Investors/AnnualReports.aspx.

[4] Bruno MP. Lumenos 2nd VC round $9 mil brighter than original. Newsbytes News Network. 2000 Sept 26 [cited 2009 Aug 31]. Available from: www.factiva.com. Health care changes name to Definity Health and announces board of directors. PR Newswire. 2000 Sept 13 [cited 2009 Aug 31]. Available from: www.factiva.com.

[5] Congressional Budget Office. Budget options: health care, December 2008. UnitedHealth Center for Health Reform & Modernization. Washington, DC: CBO; May 2009. Working Paper 1.

[6] Churchill NC, Govindarajan V. Effects of audits on the behavior of medical professionals under the Bennett Amendment. Auditing J Pract Th. 1982:69-90.

[7] Pronovost P, Needham D, Berenholtz S, Sinopoli D, Chu H, Cosgrove S, et al. An intervention to decrease catheter-related bloodstream infections in the ICU. N Engl J Med. 2006;355(26):2725-32.

[8] Barr JK, Sherwin TE, Sofaer S, Duquette C, Waters WJ, Petrillo M. Using public reports of patient satisfaction for hospital quality improvement. Health Services Research. 2006;11:663-82. Hibbard JH, Stockard J, Tusler M. Does publicizing hospital performance stimulate quality improvement efforts? Health Aff. 2003;22(2):84-94.

[9] Jonathan T. Kolstad and Michael E. Chernew. Quality and Consumer Decision Making in the Market for Health Insurance and Health Care Services Med Care Res Rev 2009 66: 28S-52S; Start spreading the news: A structural estimate of the effects of New York hospital report cards Dranove, David; Sfekas, Andrew. Journal of Health Economics; Sep2008, Vol. 27 Issue 5, p1201-1207, 7p Is More Information Better? The Effects of “Report Cards” on Health Care Providers. David Dranove, Daniel Kessler, Mark McClellan, Mark Satterthwaite.

The Journal of Political Economy, Vol. 111, No. 3 (Jun., 2003), p.1207.

[10] Cooper, Z., Gibbons, S., Jones, S., McGuire, A. (2010) Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms. LSE Health Working Paper, No. 16. London, UK.

[11] Jonathan T. Kolstad and Michael E. Chernew. Quality and Consumer Decision Making in the Market for Health Insurance and Health Care Services Med Care Res Rev 2009 66: 28S-52S.

[12] CRS Report for Congress. Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector Updated April 29, 2008.

[13] CRS Report for Congress. Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector Updated April 29, 2008.

[14] This national voluntary reporting initiative is led by a consortium including CMS, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Hospital Association (AHA), and the American Medical Association (AMA). Hospital Quality Alliance. Available from: http://www.hospitalqualityalliance.org/, http://www.hospitalcompare.hhs.gov/Hospital/Search/SelectDRG.asp.

[15] Jonathan T. Kolstad and Michael E. Chernew. Quality and Consumer Decision Making in the Market for Health Insurance and Health Care Services Med Care Res Rev 2009 66: 28S-52S.

[16] The Path to Value. KPMG. September 2008.

[17] ConsumerReportsHealth.org. Available from: http://www.consumerreports.org/health/doctors-hospitals/your-doctor-relationship/overview/index.htm, and Health Grades, Inc. Available from: http://www.healthgrades.com/.

[18] Pronovost PJ, Faden RR. Setting priorities for patient safety: ethics, accountability, and public engagement. J Am Med Assoc. 2009;302(8):890-1.

[19] Jonathan T. Kolstad and Michael E. Chernew. Quality and Consumer Decision Making in the Market for Health Insurance and Health Care Services. Med Care Res Rev 2009 66: 28S-52S.

[20] The Dartmouth Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. [cited 2009 Sept 1]. Available from: http://www.dartmouthatlas.org/index.shtm.

[21] Wojcik J. Employers consider short-haul medical tourism. Business Insurance. 2009 Aug 24 [cited 2009 Sept 1]. Available from: http://www.businessinsurance.com/article/20090823/ISSUE01/308239988.

[22] Elizabeth B. Lamont, Davinder Hayreh, Kate E. Pickett, James J. Dignam, Marcy A. List, Kerstin M. Stenson, Daniel J. Haraf, Bruce E. Brockstein, Sarah A. Sellergren, Everett E. Vokes. "Is Patient Travel Distance Associated With Survival on Phase II Clinical Trials in Oncology?" Journal of the National Cancer Institute, 2003, 95(18):1370-1375.

[23] Pronovost PJ, Miller M, Wachter RM. The GAAP in quality measurement end reporting. JAMA 2007;298(15):1800-1802.

[24] The path to value. KPMG; Sept 2008.

[25] Perspective: The debate over regional variation in health care spending. 2010;362(7):569-574. Bach PB. A map to bad policy—hospitals efficiency measures in the Dartmouth Atlas. Skinner J, Staiger D, Fisher ES. Looking back, moving forward; Wachter RM, Pronovost PJ. The 100,000 lives campaign: A scientific and policy review. Jt Comm J Qual Patient Saf 2006;32(11):621-627.

[26] Baiman S, Verrecchia RE. The relation among capital markets, financial disclosure, production efficiency, and insider trading. J Acc Res. 1996;34(1):1-22. Kim O, Verrecchia RE. The relation among disclosure, returns, and trading volume information. Account Rev. 2001;76(4):633-54. Lambert R, Leuz C, Verrecchia RE. Accounting information, disclosure, and the cost of capital. J Acc Res. 2007;45(2):385-420. Leuz C,

Verrecchia RE. The economic consequences of increased disclosure. J Acc Res. 2000;38(3):91-124. Verrecchia, RE. Disclosure and the cost of capital: A discussion. J Acc Econ. 1999;26(1-3):271-83. Verrecchia RE. Essays on disclosure. J Account Econ. 2001;32(1-3):97-180.

[27] CRS Report for Congress. Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector Updated April 29, 2008.

[28] Start spreading the news: A structural estimate of the effects of New York hospital report cards Dranove, David; Sfekas, Andrew. Journal of Health Economics; Sep2008, Vol. 27 Issue 5, p1201-1207, 7p Is More Information Better? The Effects of “Report Cards” on Health Care Providers. David Dranove, Daniel Kessler, Mark McClellan, Mark Satterthwaite. The Journal of Political Economy, Vol. 111, No. 3 (Jun., 2003), pp. 555-588.

[29] Jha AK, Zhonghe L, Orav EJ, Epstein AM. Care in U.S. hospitals—the hospital quality alliance program. N Engl J Med. 2005;353(3):265-74.

[30] Jencks SF, Cuerdon T, Burwen DR, Fleming B, Houck PM, Kussmaul AE, et al. Quality of medical care delivered to Medicare beneficiaries: a profile at state and national levels. J Am

Med Assoc. 2000;284(13):1670-6. See also www.dartmouthatlas.org.

[31] Coyne KP, Witter JW. What makes your stock price go up and down. McKinsey Quarterly. 2002;(2)29-39.

[32] Auto Affordability Index. 2006 May 10. Available from: http://www.Comerica.com.

[33] J.D. Power and Associates. Initial Quality Study, 2005. [cited 2006 Jan 27]. Available from: http://consumercenter.jdpower.com/cc/rd/cc/global/content/ratingsguide.asp.

[34] U.S. Census Bureau. Statistical Abstract of the United States: 2009 (128th Edition). Washington, DC; 2009. p. 145.

[35] U.S. Census Bureau. Statistical Abstract of the United States, 2001. Washington, DC: Government Printing Office; 2002. Table 215, p. 139.

[36] Role in preventing medical errors. Med Care Res Rev. 2005;62(5):601-16.

[37] Forrester Research. The millionaire online. Cambridge (MA): Forrester Research; May 2000. p. 11.

[38] Fox S, Jones S. The social life of health information. Pew Internet & American Life Project. Social Media and Health; 2009 Jun 11. Available from:

http://www.pewinternet.org/Reports/2009/8-The-Social-Life-of-Health-Information.aspx.

[39] PricewaterhouseCoopers. HealthCast 2010. New York: PricewaterhouseCoopers; Nov 2000.

p. 22. Reents S. Impact of the Internet on the doctor-patient relationship: the rise of the Internet health consumer. New York: Cyber Dialogue; 1999. p. 4. Available from: http://www.cyberdialogue.com/pdfs/wp/wp-cch-1999-doctors.pdf.

[40] Armour S. Just another day at the office: heroes save co-workers' lives. USA TODAY. 2001 Apr 16;8 1-2b.

[41] Miller TE, Reents S. The health care industry in transition: the online mandate to change. New York: Cyber Dialogue; 1998. Available from: www.cyberdialogue.com.

[42] Sofaer S, Crofton C, Goldstein E, Hoy E, Crabb J. What do consumers want to know about the quality of care in hospitals? Health Serv Res. 2005;40(6 Pt 2):2018-36.

[43] Avery S. Net not just for wealthy, statscan says; survey finds e-mail most popular activity, medical information top search target. The Globe and Mail. 2004 Jul 9;A10.

[44] Hibbard JH, Stockard J, Tusler M. It isn't just about choice: the potential of a public performance report to affect the public image of hospitals. Med Care Res Rev. 2005 Jun;62:358-71.

[45] Jonathan T. Kolstad and Michael E. Chernew. Quality and Consumer Decision Making in the Market for Health Insurance and Health Care Services. Med Care Res Rev 2009 66: 28S-52S.

[46] Romano M. Performance anxiety: is it too late for physicians to set their own rules on pay for performance? Modern Healthcare. 2005 May 30;6.

[47] Based on costs of $10,000 per diabetic and an incidence of diabetes of 7.5%. This leads to costs per 1,000 enrollees of $750,000 for diabetics. A 1% reduction, $7,500, will pay for collecting performance data from 25 doctors at a monthly cost of $2.50 per member, per month. But because the number of doctors covering 1,000 enrollees is typically 0.5, the payback is fiftyfold.

[48] Dimick JB, Welch HG, Birkmeyer JD. Surgical mortality as an indicator of hospital quality: the problem with small sample size. J Am Med Assoc. 2004 Aug 18;292(7):847-51.

[49] Regina E. Herzlinger first suggested this focused factory concept in *Market-Driven Health Care* (Addison Wesley, 1997) and amplified it in *Consumer-Driven Health Care* (Jossey Bass, 1994) and *Who Killed Health Care*? (McGraw Hill, 2007)

[50] Hibbard, JH, Stockard J, Tusler M. Does publicizing hospital performance stimulate quality improvement efforts? Health Aff. 2003:84.

[51] Cucciare MA, O'Donohue W. Predicting future healthcare costs: how well does risk-adjustment work? J Health Organ Manag. 2006;20(2):150. Blumenthal D et al. The who, what, and why of risk adjustment: a technology on the cusp of adoption. J Health Polit Policy and Law. 2005;30(3):453. Clancy C. Quality improvement: getting to how. Health Serv Res. 2003;38(2):509-13.

[52] Perspective: The debate over regional variation in health care spending. 2010;362(7):569-574. Bach PB. A map to bad policy—hospitals efficiency measures in the Dartmouth Atlas. Skinner J, Staiger D, Fisher ES. Looking back, moving forward.

[53] Aron DC, Harper DL, Shepardson LB, Rosenthal GE. Impact of risk-adjusting caesarean delivery rates when reporting hospital performance. J Am Med Assoc. 1998 Jun 24;279(24):1968-72.

[54] Kritzman MP. What practitioners need to know: the Nobel Prize. Financ Anal J. 1991;47(1).