COMPETITION AND THE PURSUIT OF QUALITY: A CONVERSATION WITH WALTER McCLURE

by John K. Iglehart

Prologue: *Issues surrounding health care costs and quality are in many respects indistinguishable, if not always compatible. The pursuit of solutions to these issues is moving forward on a variety of fronts at the national, regional, and local levels. In this interview, Walter McClure describes his odyssey at the local level in striving to persuade interests there that unless they become active agents for constructive health care reform, government will eventually assume command of the system. McClure holds a bachelor's degree from Yale University and a doctorate from Florida State University in theoretical nuclear physics. McClure left the discipline of physics and took up health policy research in 1969, for reasons having to do with "relevance," his resume says. For twelve years (1969–1981), McClure worked at InterStudy, a Minneapolis-based think tank founded by Paul M. Ellwood, Jr., another leading advocate of the market model in health care. In 1981, McClure departed InterStudy and founded the Center for Policy Studies, which also is headquartered in the Twin Cities. Throughout much of the 1970s, McClure and Ellwood devoted considerable time to striving to influence the directions of federal health policy. After countless trips to Washington, they became persuaded that they had to widen out their pursuit of transforming health care through the broader application of market principles. Thus, they both devoted themselves to persuading private purchasers of medical care of the efficacy of the market model. McClure developed what has become known as the "buy right" strategy, an approach that seeks to convince purchasers and providers that their enlightened self-interest is best represented by encouraging the promotion of care that is reasonably priced and of high quality. To pursue this strategy, McClure has become an evangelist at the local level, deploying the resources of his organization as essentially a community organizer. Working most actively in the state of Pennsylvania, the center seeks out key members of a community's power structure in an effort to convince them that the most effective route to cost-efficient health care is through a decentralized, competitively based model.*

Competition Strategy

Q: You have been a part of the competition strategy in health care for at least a decade and are perceived nationally as one of its architects. I wonder, in your view, what you believe the status of the competition strategy is today.

A: Perhaps we can best review its current status if you think of the competition strategy as three components or a kind of three-pillared bridge. The first pillar is supply reform. The second is demand reform. And the third is access reform. The goal of the competition strategy is to assure high-quality care and coverage, efficiently delivered, to all Americans at a cost they and the nation deem acceptable. We can ask, how well is the strategy doing or likely to do that? But first we have to ask: Is it finished yet?

In a nutshell, the answer is no, it is not finished yet. Only the first pillar, supply reform, is up. But it is the hardest pillar, so maybe 50 percent of the work is done. The demand reform pillar is designed but is just barely beginning to be implemented. The access reform pillar is still in the early design stage, in my opinion. So the health care system still is performing badly with respect to the goals, as you would expect from an incomplete bridge. One encouragement is that it is behaving badly in a different way than under the old system. It is doing exactly the bad things (and the good things) one would predict at this stage of the bridge's progress. This encourages me greatly that the strategy will lead the system to perform as well as predicted (that is, achieve the goal) if the country will just get on with it and finish the bridge.

Q: Could you say a little more about what you mean by the three "pillars," supply reform, demand reform, and access reform?

A: Supply reform, now well under way, means getting the supply side into shape so that it can be efficient, effective, and soundly competitive, for example, by integrating providers and insurers into competing comprehensive health care plans, such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), independent practice associations (IPAS), and managed insurance plans. These plans are here to stay and will grow in market share, on their own, without the outside help necessary in the 1970s. Their growth rate in 1980 was 11 percent, and last year it was 22 percent. While these plans have the capacity to be good performers, they won't necessarily become so unless driven by proper incentives through the way patients and purchasers buy–in other words, demand reform.

Demand reform involves getting the patients and purchasers (employers, union trust funds, Medicare, and so forth) to buy in the right way: very specific ways that force the providers and plans to compete on quality, humaneness, and efficiency. These buying methods must be

designed using the requirements for a sound market as a guide—those boring things that economists nag us about. If purchasers ignore these guidelines and buy wrong, competition will backfire on them. The market will be necessarily unsound, and these comprehensive plans will compete on all the wrong things—creaming, image, fluff, quality-cutting, price-following, cost-raising behavior—all that bad stuff that too many providers and plans still compete over, because too few purchasers buy correctly yet. We need to get on with demand reform.

Access reform means setting up a stable mechanism for the poor and uninsured to buy into the new sound market at whatever level satisfies our society's sense of equity. Sound competition without access reform will drive out not only inefficiency but also charity care, including a lot of inefficiency hiding behind the name of charity. I have always felt charity was a poor way to finance an acknowledged societal obligation. The irresponsible are allowed to escape their share of the obligation, while the compassionate bear an undue share the more conscientious they are. A better approach is needed.

The Center for Policy Studies and other groups are working on access reform approaches consistent with a sound market. I think too many program proposals for the poor and uninsured miss the mark by worrying too much about where the financing will come from and not enough about how they will buy right once the financing is in hand. If they buy right, costs are contained and the financing holds together. But when they buy wrong, costs blow up, and the financing falls apart politically.

The "Buy Right" Approach

Q: Tell us more about demand reform and your ideas on buying right. How can purchasers and patients force providers and plans to compete on quality and efficiency, and what is the status of the implementation efforts you mentioned?

A: We call our demand reform strategy at the Center for Policy Studies the "buy right" strategy. It does represent a bit of a departure on how to handle quality from the original competition model of Kerr White, Paul Ellwood, and others. This strategy is based on the notion that if you want providers and plans to compete on quality and efficiency, then you have to reward those who have it and punish those who don't. The only way to reward a provider or plan for efficiency and quality is with more patients. This is also the right way to reward them because it propagates good performance throughout the system.

The buy right principle is: "Purchasers must reward efficient, high-quality providers with patients. (Patients, not phony diagnosis-related group, or DRG, bonuses, are the reward.) Purchasers should do this by giving their beneficiaries the two things they don't have now: (1) the means, and (2) the incentives to identify and choose the good provider

over the poor provider." This principle immediately raises two technical issues. First, how do you measure quality and efficiency? We call this the Q&E technology problem. Second, how can the purchaser help beneficiaries shift to the better providers and plans? We call this the incentive benefits technology problem.

We define quality as three components: patient satisfaction, effectiveness, and innovation. These components are best measured statistically. Patient satisfaction means what percentage felt treated humanely, responsively, and promptly. Effectiveness means what percentage of patients avoided preventable illness, were cured, had relief, or had improved functional capacity, compared with other plans and providers treating comparable patients. (For comparability there is no other way than to go in and abstract the clinical findings from the chart. Let's stop fooling ourselves that we can compare patient severity by claims. Let's start using the national chart abstracting systems now for quality assessment.) Innovation means, over time, constantly improving your batting averages on patient satisfaction and effectiveness while improving your efficiency, that is, reducing expenditure per covered person per year.

Our solution to the Q&E issue, which I think a crucial insight, is simple. Q&E assessment systems are expert systems. The good ones out there now have taken their inventors years to develop. The idea that a bunch of lay data committees, or even data commission expert committees, are going to produce a decent assessment system out of their hip-pocket meeting once a week is impossible. So the solution to expert systems is: you don't invent one, you buy one from experts. People unfamiliar with the state of the art of quality assessment systems should check out the systems of Gonnella, Gertman, Wennberg and Caper, Horn, Knaus, Jacobs and Brewster, Blumberg, Williams, and so on. You can buy many right now off the shelf. You can bring in the vendors available now, let them compare their wares for you, and choose the one or combination your committee thinks best. Our solution is to create a new industry of competing Q&E assessment vendors.

Note that a Q&E assessment industry that routinely abstracts the clinical findings and outcomes of every chart to assess quality of each provider would have many additional benefits. The benefits to research on technology efficiency are obvious. We would know the efficacy of a drug or procedure not only for the best providers but in average practice as well. Another benefit would be for constructing risk-adjusted capitations, on which little progress seems possible from claims alone.

Today, commercially available Q&E systems are Model Ts, limited to inpatient care but still adequate to start with. However, if we can get the structure started, it will become self-entrenching and improve rapidly. If purchasers demand that providers install such systems as a condition of getting patients, a large Q&E will be

created.

As a further hedge against primitive assessment systems, we should note that, even with the most sophisticated future assessment system, medical quality (or any other good or service) can never be judged solely by the numbers. There also must be a reasonably impartial expert review and appeal procedure to rectify numbers when there are errors or extenuating circumstances. However, I remind quality providers that purchasers will start selectively contracting among providers quite happily on price if no objective data on quality are available. They will not wait for a perfect system. So we had better give them as good as we have now and then help make it better, or else they may find only the cheap provider rather than the good provider.

A final crucial point about the Q&E problem is that all providers in the same market area, those who compete directly with each other, must be on the same Q&E assessment system, so that patients and purchasers can compare them on a uniform measuring stick. On the other hand, you don't want one national uniform Q&E assessment system, or even fifty statewide systems. First, there is no one best assessment system, and there may never be one. Second, it would cripple competition in the Q&E vendor industry, the competition we are counting on both to move all the wonderful assessment methods out of research journals and into use and to constantly innovate better methods. Hence, the best approach is to let each community choose its own system from among the qualified vendors. Assuming an industry of one or two dozen major vendors, enough different areas across the country will choose the same vendor's system to allow cross-area comparisons to help assess provider batting averages. National employers or Medicare can accept that their beneficiaries are getting good care in each area if they score well on cross-area comparisons with the assessment system of the vendor chosen by that community.

On incentive technology, the *quid pro quo* for providers accepting uniform rigorous quality and efficiency assessment is that the good providers are supposed to get patients. Any benefit plan design or administrative mechanism that helps beneficiaries know which providers score well on quality and efficiency and gives them incentives to choose these good providers over poor-quality or inefficient providers is part of incentive benefits technology.

The Center for Policy Studies recently canvassed companies across the country to find out what methods help employees to shift providers. The most common methods were multiple choice of plans, preferred provider plans, and case management, with many variations and combinations. It is clear that purchasers are starting to shift patients among providers, but usually on very bad information.

Unfortunately, in most instances, beneficiaries were given incentives

to shift to discount providers with whom selective contracts had been made, simply because purchasers had no objective information on quality or efficiency. But these same methods can be used to shift patients to efficient quality providers once Q&E assessment and reporting become widespread. Also, we found that purchasers were using the "managed multiple choice rules and procedures," pioneered by the Federal Employees Program but really refined by Scott Fleming and especially Alain Enthoven, half-heartedly or not at all. If purchasers do not use these rules actively, they invite creaming and cost-raising competition, not vigorous provider competition on quality and efficiency.

Implementing "Buy Right"

Q: What is your strategy to implement these technologies, and how successful have you been?

A: When we started widely advocating buy right in 1983, acceptance of the idea was enthusiastic. But nobody could get it off the dime at first. During the next two years, we assisted people in Minneapolis/St. Paul, Cleveland, and Denver; the center also went to Weirton, West Virginia, as chief consultants to implement buy right. And nobody, including us, could make it move. By 1985 we finally figured out why, and we devised a new implementation strategy, which now looks like it's working.

The new strategy was embraced in 1986 by the Pennsylvania Business Roundtable, the state medical society, the state hospital association, the state HMO association, and a couple Blue Cross/Blue Shield Associations. With some additional financial help from the Pew Charitable Trusts, demonstrations were initiated in Erie, Harrisburg, the Lehigh Valley, Pittsburgh, and Philadelphia, to convert the entire area to buy right. In three to five years we expect all providers in each area to be on that area's uniform Q&E assessment system and a sufficient number of purchasers to be using various incentive benefit methods (appropriate to the individual purchaser) to reward good plans and providers with patients. So far the new implementation strategy seems on track, but of course it always goes slower than you want.

Q: Can you briefly describe the new strategy and how it overcomes your earlier difficulties?

A: In our first efforts we emphasized purchaser action and tried to get each purchaser individually to start implementing the strategy. The purchaser was to install incentive benefits and then require providers to report their Q&E performance by an agreed-on, uniform, areawide Q&E assessment system, as a condition of getting preference from the purchaser's beneficiaries. But we also spent a lot of effort persuading the reputable providers that agreeing on a uniform system and installing it

would be in their interest. The real stake here is the survival of the quality provider. The new provider glut has produced a watershed: it has broken the provider guild. Once employers begin selective contracting, cheap care may well drive out good care, unless quality providers give purchasers the tools to identify objectively the quality provider.

What we learned with 20/20 hindsight was that you could not implement buy right by purchaser or by provider. You have to do it by town. First, no purchaser, national or local–except maybe Medicare–commands enough patients in any one town to really induce a provider to do anything as dangerous as rigorously measuring and exposing quality and efficiency. Further, a single employer does not have enough patients to create a valid statistical sample.

Second, look at the disincentives arrayed against the employer going it alone. One, the firm develops an employee relations problem if it installs incentive benefits while other employers in the labor market retain "free-lunch" benefits. Two, the firm develops a provider relations problem if it insists on rigorous Q&E reports. (And providers can retaliate with adverse publicity, boycotts, and lawsuits.) Employers simply will not go to war with providers on quality; they will just buy cheap instead of buy right. Three, the employer develops an "old boy" relations problem if the board members of distinguished providers feel their institutions are threatened. And four, the personnel people have to install and manage all this new, different incentive benefit stuff. What is the employer's reward? Not much. If only one or a few purchasers are buying right, that does not place enough market discipline on providers to improve quality and cost.

The same is true for providers who try to go it alone. No provider, by installing a rigorous Q&E assessment system and reporting its result publicly, would necessarily get a single new patient. No one would trust the report, no one would have anything to compare it to, and employers would not have installed incentive benefits to help patients switch providers. The disincentives include: incurring a cost (roughly twenty dollars per inpatient episode assessed) that competitors don't have; provoking the wrath of the great majority of professionals, providers, and plans who don't understand yet the real stakes; laying a paper trail for potential malpractice sharks; and correcting problems inevitably exposed by routine Q&E assessment. Thus, lack of Q&E technology is not holding up quality assessment, lack of incentives is. That is why we had such trouble implementing buy right with our original strategy.

Now, if in a community all the providers were reporting by a uniform Q&E system and all the purchasers were using incentive benefits to help employees choose efficient, high-quality providers, quality assessment would be self-entrenched in that community. Everyone would gain by staying with the system and would lose if they tried to escape it. Providers

who didn't report would lose patients. Purchasers who didn't use incentive benefits would find their employees incurring higher expense and more downtime. And patients, at last, would have more information on the performance of their providers and plans than on their automobiles or sports teams.

Our new community strategy for buy right involves three phases. In the first phase, which takes about a year, we educate and bring together important provider and purchaser leaders and get them to agree to collaborate and collectively implement buy right.

The second phase includes technical work, which takes one to two years. Three simultaneous committees are set up. First, a provider committee (with purchasers sitting in to keep it honest) chooses the uniform Q&E assessment system for the town by selecting the vendor(s) with the best system; they also establish a permanent review and appeal system for providers, for cases where providers think the vendor's reports misrepresent their performance. All providers then install the chosen system. Second, a purchaser committee (with providers sitting in to keep it honest) educates purchasers on all the different ways a purchaser can apply incentive benefit methods. All the purchasers then install their own incentive benefit programs. Last, a community relations committee conducts continuous education on the virtues of buy right. The idea is to get beneficiaries pressing their purchasers and providers to explain why buy right wasn't implemented two years ago instead of making them suspicious about all the changes.

The third phase, which should take about a year, is a dry run. This is crucial technically and for acceptability. We assume anything this new will have a few glitches and want to make sure that no provider is maligned by bad numbers. No providers have ever routinely kept score of their performance using rigorous modern statistical methods of quality assessment, and they are much more willing to try buy right if they get a reasonable period to correct deficiencies before the system operates for real. So during the dry run all reports from the vendor use coded provider names. Each provider knows only its own code, and no purchasers know the codes. When the committee finds the glitches are suitably minimal, probably in about a year, the codes are broken and the batting averages of each provider and plan are reported to providers, purchasers, and the public. The town has then officially graduated into a sound buy right market.

Q: How far have you gotten on this strategy in your Pennsylvania sites?

A: The key is obviously the first phase, getting providers and purchasers to collaborate instead of going to war. I am happy to say that four of the five sites appear to have achieved this first phase. Three of the sites are now into the committee work. This kind of progress would have been

impossible without the leadership and courage of people like John Russell, Bob Tyson, Jim Pasman, Dick Wardrop, Don Mazziotti, and many others who really deserve the credit, and, last but not least, my own colleague Bob Holmen of the center, who directs our fieldwork.

There are many sticky issues and technical details still open, but these seem solvable in principle. My hunch is that if only one of the sites makes it, that will crack the others. Indeed, I would like to see ten or twenty sites trying it around the country, because the odds are then better that at least one or two will make it, and that should help break the logjams in the others.

If more cities adopt the buy right approach, the consulting industry may shortly see the vast opportunity, first to help communities implement buy right, and then in perpetuity to help providers analyze and improve their performance and to help purchasers with their incentive benefit administration. Multiple demonstration sites would cross-fertilize one another and speed the implementation process, thus entrenching demand reform. At the same time, the Center for Policy Studies will be working along with others on access reform. I think ten years might be a reasonable estimate for entrenching the entire three pillars of the competition strategy, if the right clout and support were put behind it. By succeeding with the first phase in Pennsylvania, I think we have shown you can get the best of purchasers and providers to work together.

For quality providers, buy right means that good, efficient medicine drives out cheap medicine; no buy right means that cheap medicine drives out good. For purchasers, buy right means getting more health for less cost escalation; no buy right means getting less health for less cost escalation or, worse, more cost escalation. For both, no buy right probably means government will step in and take control of provider prices and utilization and stick purchasers with the bill for so important a service.

Federal Competition Strategy

Q: You have been critical, generally speaking, of federal health policies, criticizing them for being largely driven by so-called command and control regulation. In your view, what has federal policy done, and what might it best do to forward the competition strategy as you have sketched it?

A: I have been critical of federal policy in the 1980s for what it did not do, as well as for what it did do. What it didn't do was pursue the competition strategy. For the first six years of the decade, it virtually ignored it. This was a tremendous loss in momentum given the progress of the 1970s. Not until Bill Roper took over at the Health Care Financing Administration (HCFA) have we seen serious effort to get Medicare and

Medicaid to become aggressive and sound purchasers on a multiple choice of plans. HCFA's new effort to make the Medicare database available to inform consumers of individual provider performance is also a profound new step in the right direction.

What federal policy did do was the opposite of competition. It enacted price controls (DRGs) and use controls (peer review organizations, or PROS) on Medicare providers. These have, predictably, driven services out of the hospital to unregulated outpatient care. So now federal policy is waiting for Bill Hsaio's results to extend price and use controls to outpatient care.

Particularly galling is that the Reagan administration called these price controls "competition." The acid test of competition is whether purchasers have the means and incentives to shift patients from poor or inefficient providers to good, efficient providers. DRGs do not shift patients, they just beat up providers on prices. By calling price controls competition, the administration falsely told the public that sound competition was being pursued when in fact it languished. We lost six years, and that may push us toward permanent price controls.

Price controls are tempting because they do give you some cost control in the short run, but in the long run they succumb to the fate of all government price-control schemes. Providers collectively fight with government over prices. The provider union sits down at the bargaining table with the purchaser union. This collective war is the weakness of all such countervailing power theories. Individual merit is not rewarded in such collective deals; political skill and gaming the system are rewarded. Providers win by overproducing services when the government guesses too high a price, and by underproducing services when government guesses too low. The conscientious provider trying to produce better health for less cost loses. Since there is no science to knowing the right prices or to keeping them up to date, we will fall into the European swamp of a health care system distorted by artificial prices rather than one driven by quality and efficiency. Compare this with a sound market in which providers vie with each other (not purchasers) on rigorously assessed quality and efficiency, and merit is rewarded with patients.

Systems Reform: The Role Of Foundations

Q: Your organization is basically created and set up to reform the health care system. How are you able to finance an operation like that? You are dependent on private foundation grants, among other sources, I suppose, but how does an organization like yours manage in that world?

A: Poorly.

Q: And why is that? Are the foundations not interested?

A: There are several reasons. First, we are new, and while I think our track record is outstanding, particularly for so small a group, it is not known with confidence by most foundations. Second, we do not fit any of the usual categories most foundations are familiar with. We are not an academic research institute, a provider, a purchaser, or any other recognized party, nor do we have any particular political cast. But third, and most peculiar, our products and methods are simply unfamiliar to most foundations.

Our product is strategy and action to reform large societal systems. We specialize in health care, but there is no reason our methods could not be applied to other problem systems such as education, child development, criminal justice, and the private commercial sector. And if it wouldn't compromise our health system work, I would like to take on another system. You might call us large-system architects.

Large systems are complicated, expert systems. We don't design airplanes in the Congress of the United States; we put them out for bids to expert planemakers. We do design health care systems in Congress, and for some reason we expect them to work. When airplane designs come in, we don't compromise by taking the wings from one, the tail from another, and the body from a third, and expect the plane to fly. But we routinely do that to health care system designs and other large systems. Then we wonder why they are so ineffective and inefficient.

With the worker/dependent ratio falling from 3:1 to 2:1 in the next couple of decades, I don't believe the U.S. can afford the sloppy, ineffective, inefficient large systems it now tolerates without serious loss to our standard of living. We will have to make them humanely but ferociously efficient and effective at their goals. And we won't be able to do that by tinkering with what we have. We will have to design them from scratch, and then restructure them into the new design. We will need to put them out for bids to expert large-system architects, who will design not only the new system but the restructuring strategy. Then Congress or society can choose from among the rival expert designs, collaborating with the architects (as the defense department does with planemakers) for various desired modifications.

This large-system architecture is what the center does for the health care system, using a formal analytic approach we call structure and incentive analysis. We know that large systems perform as they are structured and rewarded to perform. So we carefully analyze the current system for the faulty structure and incentives that cause its malperformance, and we craft new designs for a new improved health care system with carefully wrought structure and incentives that reward it to pursue its goals and punish it when it strays from them. Then we craft restructuring strategies based on who has incentives to move toward the new system (these strategies must be constantly updated as each party's move

affects the incentives of the others). Finally, we field test and disseminate them.

Note how much careful design work and time is needed to craft these strategies before we ever get them to the field for testing. This is what is so hard to fund. It is not research, although we use research like crazy. So the research-oriented foundations aren't disposed to it. The action-oriented foundations like the fieldwork, but the design work isn't action, so they aren't captivated by it. Strategy design—large-system architecture—seems to fall through the cracks in the foundation world. Foundations need to recognize these bridges between research and action if we are to restructure our vital large systems comprehensively and thoughtfully.

Another reason for difficulty in attracting foundation support is that restructuring a large system inevitably changes the power, income, status, and habits of powerful interest groups, and some of their most successful members are often trustees of foundations. We have to look for foundations whose trustees will rise above special interest for the good of society.

Finally, large system restructuring takes a long time. This is the twenty-first anniversary of Kerr White's *New England Journal of Medicine* article first describing the competition model. I have been at it personally for eighteen years. The March of Dimes Foundation took on polio and stayed the course. But not many foundations will do that. Too many foundations seem oriented to the quick payoff. We need foundations that will take on restructuring of a large system and see it through. Who else can do it? Governments turn over every four to eight years. Interest groups have special interests by definition.

The most precious money in this country is in voluntary foundations. They have the time and few encumbrances. A foundation could support several rival design teams and present their rival restructuring strategies to government and other forums for their choice. How else will we get the wholesale large system reform we will need in the next few decades?