

JAMA Forum: The Battle for Control of Medical Care

BY [DAVID CUTLER, PHD](#) on [JULY 25, 2012](#)

Findings from a study reported just last week have major implications for the future of medical care. The study evaluated a new payment model called the Alternative Quality Contract (AQC), devised by Blue Cross Blue Shield of Massachusetts. Unlike payment arrangements that involve reimbursing physicians for each test and procedure performed and disputes over those rates, the AQC gives groups of physicians a cost target for their patients as a whole. If medical costs come in below the target and quality of care is high, physicians earn a bonus. If costs exceed the target, physicians suffer financially. Because Blue Cross Blue Shield of Massachusetts is so large, the AQC is a big part of the medical system in Massachusetts.



David Cutler, PhD

The study,* led by Zirui Song and Michael Chernew, PhD, of Harvard Medical School in Boston, showed that the AQC lowered medical spending by 2% in the first year and even more in the second year. And even as costs fell, quality increased. It was a win for providers, a win for the insurer, and a win for patients.

Why is this so important? There is wide agreement among health care analysts of all stripes that health care is too expensive and quality is haphazard. Consider a thought experiment. Suppose you could change the entire spectrum of care for the patients in your practice so that it matches what you believe to be best: people get the care they need when they need it,

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and care that is wasteful or duplicative is eliminated. As a result of this, people would receive higher-quality medicine. Would medical spending rise or fall?

I have asked this question to a large number of physicians, in groups large and small. The sample is an informal one, to be sure, but the conclusions are common: the typical doctor guesses that medical spending would fall by 25% to 40% if the medical system worked better. Empirical research backs this up. [About one-third of medical care is estimated to be excessive](#), primarily because medical care is organized into silos, and too many people fall through the cracks between the silos. What kind of rational system makes it hard for primary care physicians and specialists to coordinate care or makes many preventive services money losers?

Ways of Increasing Value

On these points, there is near-universal agreement. But how does one fix this situation? Here is where opinions start to diverge.

One approach to make the system work, favored by many conservatives, is to rely on less-well-insured patients, those who have high-deductible insurance plans. Because such individuals have financial “skin in the game,” they will look out for the most cost-effective care and drive efficiency. Mitt Romney [shares this view](#): “I want to get health care to act more like a consumer market, meaning like the things we deal with every day in our lives: the purchases of tires, of automobiles, of air filters, of all sorts of products.”

To be sure, doctors want patients more involved in their care, understanding what is going on and taking responsibility for the things they can control. But most people agree that managing complex clinical decision making is not something patients do well.

A second view is that the system will get better when insurers are more in charge of the care people receive. The proposal is called premium support. The idea is that insurers will limit acute care services as necessary and promote preventive care.

I like private insurance more than most progressives; insurers have done good things, as with the AQC. But it doesn't seem advisable to push this too far. Many of the premium support proposals sound like managed care all over again. Which insurers these days focus on limiting costly acute care and reaching out to patients? Listening to premium support fans, I wonder if we have forgotten the lessons of the 1990s.

Among liberals, the most popular idea is single-payer health care. Whatever merits or demerits single-payer medical care has, it is sufficient here to say that single payer will not be taking over most of the country. Maybe if single-payer efforts are successful in [Vermont](#) or elsewhere, more people will pay attention.

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Physician Control

That leaves a fourth proposal, and it is the one that appeals most to physicians: give physicians the resources and the ability to do what is right, and let them make the system work. This approach, which is often called the accountable care organization (ACO) model, involves pooling medical dollars into a basket and letting those who treat patients divvy it up, using services as they deem appropriate. If costs are low and quality is high, they will make money. They lose, however, if they go over the target or can't increase quality.

The AQC was one of the first iterations of an ACO. Medicare began an ACO program this year, and many private insurers are following along. To listen to conservatives, the ACO proposal is already a failure. They say, "[none of it is working](#)"; it is a "[fatal conceit](#)" that is "[sinking like a stone](#)"; it is "[bound to fail](#)."

This is where the study findings on the AQC results are important, showing that this type of program does work. Combined with evidence that [bundled episode payments save money for cardiac and orthopedic patients](#), the data are increasingly clear that physician management is a good way to simultaneously reduce spending and increase quality.

The AQC model is fundamentally different from the premium support and high cost-sharing models. And this is where the battle lines are drawn. Will physicians be in charge of medical care? Or will it be insurers or less-well-insured patients?

This is a challenge for society, but more than that, it is a challenge for physicians. If physicians want the job of stewarding medical care, they need to step forward and say so—and demand the money and autonomy to organize care the way it should be done, increase quality, and reduce spending. Now is the time for physicians to prove they can manage the system, or the opportunity may slip away for good.

*The author notes that his spouse is one of the coauthors of the study mentioned here.

About the author: David M. Cutler, PhD, is the Otto Eckstein Professor of Applied Economics in the Department of Economics and Kennedy School of Government at Harvard University and a member of the Institute of Medicine. He served on the Council of Economic Advisers and the National Economic Council during the Clinton Administration and was senior health care advisor to Barack Obama's presidential campaign.

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