Pilot Programs: A Waste of Money

By John C. Goodman **March 11, 2011**

President Obama has repeatedly given us his vision of how to lower the cost of health care and raise its quality: Find out what works; then get everyone else to copy it. Toward that end, the administration is making millions of dollars available for pilot programs and demonstration projects. Will any of this work?

Ask yourself this question: Can you think of any other industry where low-cost, high-quality production has been achieved by the government running pilot programs? No? Well, if that approach doesn't work anywhere else, why would you expect health care to be different?

As I have previously noted, President Obama's approach to health care is exactly the same as his approach to education. The only difference is that in education we have been trying to find out what works and then copy it with no success for decades.

Here's the problem. Both in health care and in education we have lots of examples of low-cost, high quality service. As in other bureaucratic systems around the world, excellence exists, and it's often known about, acknowledged and even studied. It also tends to have three characteristics: (1) islands of excellence spring up in a sea of mediocrity and they tend to be distributed randomly—they're not correlated with anything; (2) they almost always exist because of the effort, ingenuity, enthusiasm, energy, and vision of a few people involved in actual production, and almost never are the result of anything that's happening on the demand side of the market; and (3) (most importantly) *they tend not to have any objective characteristics that anyone else can copy*.

A study of high-performing hospital regions (by researchers connected to the Brookings Institution) was unable to find any characteristics that could be replicated in a straightforward manner. Some had doctors on staff and paid them a salary. Some paid fee-for-service. Some had electronic medical records. Some did not. (See previous posts here, here, here.)

Another study, reported at the *Health Affairs Blog*, looked at 12 multispecialty group practices including such high-performing practices as the Cleveland Clinic, the Geisinger Clinic, the Intermountain Medical Group, the Mayo Clinic and the Virginia Mason Clinic. Of those

practices, only two employed physicians directly and the other ten paid fee-for-service. Conclusion: There is no relationship between high-quality, low-cost care and the way physicians are paid.

A third study by the Commonwealth Fund examined five high-performing health plans. The only commonalities researchers could find were subjective and qualitative (e.g., "forging and maintaining a strong relationship with physicians," plus that same idea expressed three or four different ways). Not the sort of things you can put in an operations manual and refer to as "marching orders."

Instead of a pilot-program approach, my colleagues and I at the National Center for Policy Analysis have consistently argued for an economic approach. Start paying more to the islands of excellence that are higher performers. Start paying less to the low performers. Eventually, stop dealing with the low performers altogether. Encourage every doctor, every hospital administrator and every other provider to come forward and propose different ways of being paid. As long as quality doesn't suffer, be prepared to pay 50 cents for every dollar the provider saves Medicare.

Finally, search for ways to empower patients — giving them control over their own health care dollars and give providers the freedom to repackage and reprice their services in patient-pleasing ways in order to compete for patients and their dollars.

Although I have called this approach the "economic approach," it is actually little more than common sense.