

**HEALTH DATA COLLECTION AND DISSEMINATION UNDER THE WHA:
HOW NEW GOVERNANCE COULD STRENGTHEN ITS UTILITY FOR
REGULATING HOSPITAL QUALITY AND ACCESS**

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INTRODUCTION

Wisconsin has long seen the collection and dissemination of hospital data to be central to attaining its goals of improving hospital access and quality.¹ Data collection and dissemination has a number of “regulatory” uses, including providing the data necessary to inform policymaking and to review regulatory compliance. In addition, the very process of collecting and disseminating data is also useful for informing the marketplace and the medical community, which can provide their own sanctions for inferior performance.² Given that hospital data clearly play such a pivotal role in regulating hospitals, the question of *how* the collection and dissemination of the data will be administered should not be taken lightly as it could have far-reaching and unforeseeable effects on our quality and access missions.³ Those with an interest in these missions, then, should be keenly interested in the how Wisconsin collects and disseminates data because the strength of the data collection and dissemination system could ultimately affect how well hospitals are regulated for access and quality.

¹ Wis. Stat. § 153.05 (1987). Interview with Barbara Rudolph. Although the original statute never exactly made the access mission clear, it can be pieced together through a reading of the statute and was always seen as a part of the statute by DHFS. *Id.*

² Interview with Barbara Rudolph, UW-Madison scientist and former director of the Wisconsin Bureau of Health Information, in Madison, Wis. (Oct. 27, 2005). The third “market” function is sometimes referred to as “regulation by information.” Interview with Louise G. Trubek, Professor, UW Law School, in Madison, Wis. (Nov. 23, 2005).

³ No matter which function the data serve, that function will be served better if the data collection and dissemination is functioning at its optimal level. Conversely, a failure to collect and disseminate data in the most effective and useful way could undermine the function, by thwarting the goal of an informed marketplace or by providing policymakers with incorrect, incomplete or untimely information with limited utility in informing and reviewing policymaking and compliance.

Until a recent move privatizing the data collection and dissemination function to the Wisconsin Hospital Association (WHA), Wisconsin had long employed a top-down approach to ensure the strength of its data collection and dissemination function for the various regulatory uses.⁴ In contrast, the new arrangement while maintaining many top-down mechanisms, relies largely on market incentives and contractual duties to ensure the data collection and dissemination function's strength.⁵ Given that the new collecting entity is the trade association for the regulated entity (hospitals), some have worried that the arrangement is not sufficient to ensure that the WHA will administer a data collection and dissemination system optimally suited for the regulatory uses, since regulation may be against members' interests.⁶ These worries have only been intensified by the rather "under the radar" nature of the arrangement's passage, which have left some questioning its legitimacy. Amongst skeptics of the arrangement are proponents of New Governance theory, a group that argues that such arrangements would benefit from inclusion of mechanisms to increase accountability, stakeholder participation and flexibility.⁷

Throughout this paper, it must be remembered that "regulation" is occurring on two distinct, but interdependent levels. First, there is regulation of the data collection and dissemination mechanisms themselves to ensure a high quality process. In the case of a privatized data collection and dissemination function, this means making sure the private entity is doing a "good job" of collecting and disseminating data. Second, there is regulation of hospitals for access and quality, *using* the data that has been collected and disseminated by the

⁴ See Wis. Stat. § 153.05 (2001).

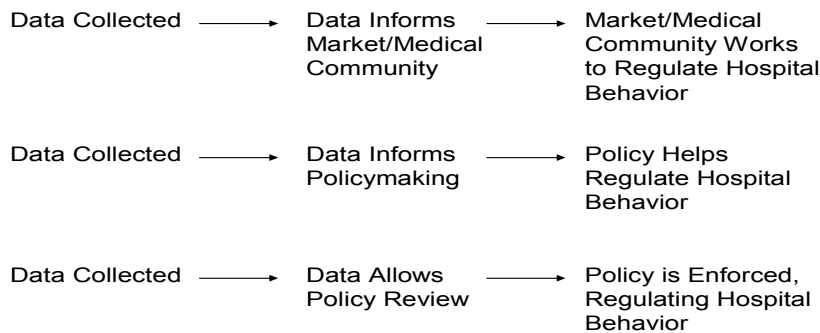
⁵ See Wis. Stat. § 153.05 (2005).

⁶ Some might even analogize this arrangement as "the fox guarding the hen house." See Interview with Eric Borgerding, WHA Senior Vice President for Governmental Affairs, in Madison, Wis. (Nov. 11, 2005).

⁷ Interview with Louise Trubek. See also, generally, Louise G. Trubek, New Governance and Soft Law in Health Care Reform 12 (July 2005) (unpublished manuscript on file with author).

collecting entity. As it is used in the second level to regulate the hospitals, we will often refer to the data collection and dissemination as a “regulatory tool.” The chart below shows how the data collection and dissemination function can be used as a regulatory tool to regulate hospital behavior.

The Logic of Data Collection: Improving Access and Quality



Central to our thesis is the idea that the collecting entity is doing a “good job” if the data collection and dissemination is performed in a way that makes it most useful for regulating the hospitals through these means. For example, if our goal were to regulate for quality using market forces, the collecting entity would be doing a “good job” if they are collecting and disseminating the data in such a way that the market was optimally informed and people were best able to choose one hospital over another, inducing quality-enhancing behavior. We have chosen in this paper not to address whether the regulatory uses at the second level are optimal to improving access and quality. Rather, we will focus on how the arrangement will likely

strengthen or weaken the regulatory tool for the various regulatory uses, such as informing the market, informing policymaking and reviewing compliance.

This paper has four main functions. First, the paper aims to provide a thorough introduction to the concepts of New Governance. In doing so, we also introduce the other regulatory models available to Wisconsin, including the market and top-down models and review the extent of their utility. Second, this paper aims to review the history of Wisconsin's efforts to regulate hospitals through the collection and dissemination of data, focusing on the mechanisms employed to ensure that the data collection and dissemination tool functions at its most effective. Third and most importantly, this paper aims to evaluate the current administration of the data collection and dissemination function. Foremost, this involves a discussion of how suitable the program is for strengthening the regulatory tool of data collection and dissemination. It also includes an analysis, from a New Governance perspective, of whether the program has included a suitable amount of accountability, stakeholder participation and flexibility. We ultimately conclude that although the WHA appears to be doing a fine job, New Governance mechanisms should be incorporated in order to address legitimacy concerns and to ensure that the data collection and dissemination tool is optimally strengthened for attaining access goals. Finally, looking forward, we suggest some opportunities to incorporate these mechanisms and to generally strengthen the utility of data collection as a regulatory tool.

I. NEW GOVERNANCE: PUSHING PAST THE LIMITATIONS OF THE TRADITIONAL MODELS WHILE MAINTAINING THEIR UTILITY

New Governance, a regulatory model associated with the pragmatic and soft law schools of regulatory scholarship, calls for an alternative to more familiar healthcare regulatory models.⁸

⁸ Trubek, *supra* note 7.

New Governance is generally spoken about in contrast to one or more of the traditional approaches such as self-regulation, top-down command and control and the market-based approach.⁹ Often, however, New Governance seeks to solve problems associated with these approaches by injecting mechanisms for accountability, transparency, flexibility, stakeholder participation and collaboration into systems centered on these more traditional approaches.¹⁰ This section will highlight some of the major limitations of the more traditional models in solving access and quality problems before going on to discuss how New Governance mechanisms can be used to push past these limitations. Each model will be discussed in turn.

A. SELF-REGULATION: THE FOX GUARDING THE HEN HOUSE

For a period from about 1880 until 1960, the self-regulation model dominated the regulation of hospitals for both access and quality. Self-regulation has been described as the government's "unparalleled faith in the ability of medical professionals to regulate themselves" and emphasized physician autonomy in patient care.¹¹ Generally, the only regulation that physicians faced was lax peer review and the reviewing of credentials by hospital administrators.¹² This emphasis on physician autonomy in regulation bled over onto the hospitals as well, as courts often found them not liable for accidents and injuries because "no hospital administrator could presume to control an eminent physician."¹³

⁹ Louise G. Trubek, Seminar, Special Topics in Administrative Law: Regulatory Reform, Fall 2005.

¹⁰ David M. Trubek & Louise G. Trubek, *The Coexistence of New Governance and Legal Regulation: Complementarity or Rivalry?*, Paper Presented at the Annual Meeting of the Research Committee on the Sociology of Law, Paris 5-6 (July, 2005).

¹¹ Rand E. Rosenblatt, *supra* note 8, at 165.

¹² *Id.*

¹³ *Id.* at 164-65, citing *Schloendorff v. Society of New York Hospital*, 105 N.E. 92 (1914).

This model proved largely insufficient to solve many of the problems facing healthcare. On the access end, minorities, the elderly, the poor, and those living in rural areas had almost no access to proper healthcare.¹⁴ Although physicians and hospitals were supposed to meet the need through Charity Care, the need often went unmet and care was often poor when received.¹⁵ Since physicians and hospitals were self-regulating, there was nothing in place to force the care to be provided and it wasn't.¹⁶ On the quality end, patients received harmful and injurious care from incompetent physicians and hospital staff with almost no recourse.¹⁷ Standards of care were often set so low that all but the most egregious negligence and incompetence would pass.¹⁸ Further, the only people charged with policing physician behavior were other physicians who often had fraternal or self-interested reasons for failing to report physician misconduct.¹⁹ Despite the inadequacies of the self-regulation model, some aspects of it are still utilized and considered successful today, although they are most often used in conjunction with top-down regulations.²⁰

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ It wasn't until World War II when a staggering number of Americans were found physically unfit for service that the problem of access was illuminated to policymakers. It had become clear that it was against state and national interests to have such limited access. It was equally clear that allowing physicians and hospitals to regulate themselves was insufficient. *Id.*

¹⁷ *Id.*

¹⁸ *Id.* After several physicians bungled unnecessary surgeries, the courts finally responded by rejecting the self-imposed standards and imposing a "socially defined standard of care." *Id.*

¹⁹ *Id.* For example, in many cases, physicians depended on each other for referrals; so "turning in" a physician for misconduct could work against a physician's self-interest. *Id.*

²⁰ Hospitals' medical leadership still "reviews the credentials of physician applicants, admits only those who are believed to meet high standards, and periodically reviews the care provided by individual doctors to determine whether or not to continue their staff privileges." They have also continued to "self-regulate" through accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), an organization dominated by physician and hospital representatives that is dedicated to promulgating accreditation standards. Although state and federal government are responsible for making hospital licensure decisions and Medicare participation decisions, the JCAHO standards have largely been adopted as authoritative by both state and federal governments. Michelle Mello, Carly N. Kelly and Troyen A. Brennan, *Fostering Rational Regulation of Patient Safety*, 30 *J. Health Pol. & Law* 375 (2005).

B. TOP-DOWN: OSSIFICATION, ADVERSARIALISM & THE LIMITS OF THE TORT SYSTEM

The top-down, command and control model of regulation began to compete for dominance with “self-regulation” in the 1930s.²¹ The top-down model rejected the self-regulation model as “dangerous and self-interested” and provided a much greater role for government in physician and hospital regulation.²² The model recognized a “context of inequality between patients and actors” (such as hospitals, physicians, insurance companies) and a need to override industry and professional customs to “define and enforce a social contract.”²³ The top-down approach effected three major changes. First, it enacted comprehensive statutory regulation including statutes regulating quality and complex entitlement programs to improve access for the poor, disabled and elderly.²⁴ Second, administrative agencies were set up to enforce statutory mandates and promulgate administrative rules to which hospitals and physicians would be subject.²⁵ Finally, the judiciary took a more active role in promoting access and quality goals by enforcing entitlements and imposing a more nationally determined standard of care.²⁶

Despite monumental increases in both healthcare access and quality, the top-down approach has been criticized as unable to go beyond what it has already done. Critics of the

²¹ Rosenblatt, *supra* note 8 at 170.

²² *Id.* at 166-167. This underlying theme explains why some authors refer to this era in health regulation as “the model of egalitarian social contract. *See Id.*

²³ *Id.* at 167.

²⁴ *Id.* See also Medicaid Act, 42 U.S.C. §1396; Medicare 42 U.S.C. §1395.

²⁵ *Id.*

²⁶ *Id.*

model suggest that the modern administrative state is “ossified.”²⁷ They suggest that the strict procedural and analytical requirements of rulemaking has lead to a situation where progress is stalled, agencies rarely revisited old rules and frustrated agencies seek regulatory alternatives to informal rulemaking, such as policy statements, in order to make regulations while covertly bypassing notice and comment requirements, thereby limiting public oversight.²⁸ As a result of this, as well as the budgetary process, agencies are unable to invest in and adapt to advances in technology that could improve processes and outcomes.²⁹ The adversarial nature of interest representation further contributes to this “rigid rule-making and implementation process that fails to encourage creativity, adaptation and cooperation in solving regulatory problems.”³⁰ The courts have been similarly unable to address access and quality problems, as the tort system is haphazard and inefficient.³¹

²⁷ Thomas O. McGarity, *Some Thoughts on “Deossifying” the Rulemaking Process*, 41 Duke L.J. 1385, 1387-88 (1992) (referring to the traditional rulemaking process as “ossified.”). See also Thomas O. McGarity, *The Courts and the Ossification of Rulemaking*, 75 Tex. L. Rev. 525, 528 (1997). Professor Jody Freeman has suggested that this phenomenon of ossification has worsened in recent years, as the analytic requirements imposed on agencies have increased and there has been a “reinvigoration of aggressive judicial review in recent appellate cases.” Jody Freeman, *Collaborative Governance in the Administrative State*, 45 UCLA L. Rev. 1, 10 (1997).

²⁸ *Id.* at 1392-93. See also Freeman, *supra* note 28, at 10 (Noting that agencies “increasingly rely upon regulatory instruments such as interpretive rules, policy statements, guidance documents, enforcement discretion, and even press releases” to avoid additional procedures.)

²⁹ McGarity, *supra* note 28 at 1392. “This inflexibility is especially unfortunate in the context of programs in which agencies must regulate on the “frontiers of scientific knowledge” with particularly treacherous “facts.” New scientific discoveries can erode the technical basis for a rule that was promulgated only a few years ago. New technologies can make available fresh alternatives that were not considered at the time the agency first examined the issues. However, the agencies are understandably reluctant to rock the boat when to do so requires an enormously expensive rulemaking in which a successful outcome is by no means assured.” *Id.*

³⁰ Freeman, *supra* note 28, at 18.

³¹ William Simon, *Solving Problems vs. Claiming Rights: The Pragmatist Challenge to Legal Liberalism*, 46 Wm and Mary L. Rev. 127, 193-94 (2004). Simon explains that only a minority of injured persons making claims and little correlation between the severity of injury and likelihood of suit

C. MARKET & PRIVATIZATION: NO MARKET FOR CHARITY CARE, LESS ACCOUNTABILITY

The “Market Incentives” model of regulation began to take a strong hold in the 1970s, corresponding with a broadly felt distrust of government to solve social problems.³² The market incentives model argued that market mechanisms would better solve our healthcare problems.³³ These programs generally involved either exposing the subject of regulation to market forces through informing the market—in what has been termed “regulation by information”—or privatization, whereby the management of a service or activity is transferred from the government to the private sector where it can be subject to the efficiency and cost requirements of the market. Market advocates criticized the dominant top-down system of being sluggish, expensive and incapable of solving complex problems.³⁴ They argued that agencies were subject to capture and that even if they avoided capture, “lacked the technical skills and political authority to influence the powerful forces of economic self-interest that operated in the healthcare industry as they did everywhere else.”³⁵

Much like the top-down and self-regulatory approaches, the market-based model has proven insufficient to solve many problems in healthcare, especially access problems. The poor cannot wield their purchasing power to induce changes in hospital behavior. For a market-centered model to work for access there would have to be some sort of top-down style regulation (providing subsidies for charity care, etc), and this is inconsistent with the laissez faire values

³² Rosenblatt, *supra* note 8 at 175-176.

³³ This model assumes that if consumers of healthcare were forced to purchase their healthcare on the open market, they would not waste resources. Similarly, if healthcare providers were forced to compete with each other, the forces of the market would induce their good performance.

³⁴ Rosenblatt, *supra* note 8 at 175-176.

³⁵*Id.* In capture, “powerful and well-organized interests” were able to manipulate the agencies in order to get what they want, often defeating the purpose of regulation.

and interests underlying the market approach.³⁶ As Rand Rosenblatt points out, the market-based model involves:

“a considerable shift of wealth and power from physicians and hospitals to employers, managed care entrepreneurs and others imposing cost containment, while denying hospitalization to some patients who need it, and denial of most or all coverage to some easily targeted high cost patients with serious illnesses, disabilities and chronic conditions.”³⁷

Even in the area of quality, there is some question as to whether the market can work. In contrast to many consumer purchases, the purchase of healthcare is not organically a rational calculation of value.³⁸ Other considerations such as proximity, personal history and convenience play a central role in determining which hospital or physician one chooses, while consumers lack the information necessary to make decisions based on hospital quality.³⁹ The market, then, fails to weed out low quality vendors, while rewarding and punishing based on spurious factors.

Further, especially in the context of privatization, there is a threat that the system loses democratic accountability. As the people making everyday decisions about administering the program are even more insulated from electoral accountability and the public eye than agencies, they can take advantage of that to fulfill their own self-interest.⁴⁰ The loss of accountability

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³⁶ *Id.* at 189.

³⁷ *Id.*

³⁸ Whereas persons in the market for tires might utilize a rough cost benefit analysis utilizing price and quality to determine value, people’s choices of healthcare are much more complicated and much less predictable and accurate. Most healthcare consumers consume their healthcare services without a whole lot of information about the services they are receiving. One might go to a particular hospital or doctor because the telephone number was handy in the phonebook, because a friend recommended it or because they just always have. The decision can often actually have very little to do with which choice represents the best value.

³⁹ See Richard Hillestad, *Healthcare IT Adoption Could Save \$162 Billion - New RAND Study Reveals Technology's Potential Impact on Consumers*, CERNER QUARTERLY, Q4, 2005, available at <http://www.cerner.com/public/CernerQuarterly.asp?id=24102> (“[C]onsumers generally lack the information they need about costs or quality to make informed decisions when seeking and selecting healthcare services.”).

⁴⁰ [Lawrence Church, Constitutional Law Lecture \(Fall 2005\)](#).

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becomes especially problematic in what we call “increased-risk situations,” in which it becomes easier for the private entity to get away with wrongdoing. Increased-risk situations include: (1) when market failure or abuse of power is most likely, (2) where the private entity holds a monopoly on provision of particular services, (3) where the services provided are complex, (4) where competitive market pressures are limited and (5) where the intended beneficiaries are relatively powerless.⁴¹ In these situations, it is not enough to rely on the market and some have suggested that additional governmental monitoring is warranted.⁴²

D. NEW GOVERNANCE: PUSHING PAST THE LIMITS OF THE TRADITIONAL MODELS

In response to the limitations mentioned above, the New Governance body of scholarship has suggested replacing or supplementing these programs with mechanisms to increase (1) Stakeholder Participation and Collaboration, (2) Flexibility and Reviseability, and (3) Transparency and Accountability.⁴³ Despite the somewhat “revolutionary” nature of New Governance, it should be noted that although some or all of these mechanisms may be included, the underlying structure of the regulation would often look like one of our traditional models (self-regulation, top-down or market).⁴⁴ Thus, where self-regulatory, top-down or market approaches have proven useful, the model can be retained while improving the regulation through the incorporation of these principles. Each of these principles will be discussed in turn.

⁴¹ Gillian E. Metzger, *Privatization as Delegation*, 103 *Colum. L. Rev.* 1367 (2003). See also Michael C. Dorf & Charles F. Sabel, 53 *Vand. L. Rev.* 831, 865-68 (2000); Michael J. Trebilcock & Edward M. Lacobucci, *Privatization and Accountability*, 116 *Harv. L. Rev.* 1422, 1435-1451 (2003).

⁴² DONALD F. KETTL, *SHARING POWER: PUBLIC GOVERNANCE AND PRIVATE MARKETS* 39-43 (1993).

⁴³ *Id.*

⁴⁴ See generally, David M. Trubek and Louise G. Trubek, *The Coexistence of New Governance and Legal Regulation: Complementarity or Rivalry?*, (July 2005) (on file with authors).

(1) Increased Stakeholder Participation and Collaboration

Largely in response to the aforementioned limitations of the market and top-down approaches, New Governance advocates call for an increase in stakeholder participation and collaboration in rulemaking.⁴⁵ Generally, there are two categories of stakeholders that New Governance is interested in including: (1) regulated entity stakeholders and (2) non-regulated stakeholders. The regulated entity participates by negotiating with the regulator to devise rules and benchmarks to which it will later be held.⁴⁶ Through continued contact, the agency becomes familiar with the entity's strengths and weaknesses, abilities and limitations. This leads to a less adversarial relationship between the regulated and the regulators and to a regulatory structure that is both realistic and goal attaining.⁴⁷ At the same time, other non-regulated stakeholders are invited to provide their insight.⁴⁸ Not only does the increased participation add to the "marketplace of ideas," leading to better outcomes, but it also provides the interested parties with a sense of civic empowerment that may reduce the adversarial nature of relationships and breed trust between the parties.⁴⁹ Critics point out that this collaboration is impossible because of the widely divergent interests of the parties, but New Governance proponents suggest that as situations and technology rapidly change, parties will become less sure of their own interests and will become more willing to collaborate for what appears to be the common good.⁵⁰

⁴⁵ *Id.* See also, Louise G. Trubek, *New Governance Practices in U.S. Health Care*, LAW AND NEW GOVERNANCE IN THE EUROPEAN UNION AND THE UNITED STATES 2 (Deburca and Scott eds., 2006); Freeman, *supra* note 28, at 1.

⁴⁶ Freeman, *supra* note 28, at 22.

⁴⁷ *Id.* at 22-23.

⁴⁸ In the context of healthcare, this would include consumer groups or patients' organizations with a stake in hospital access and quality.

⁴⁹ *Id.* at 24.

⁵⁰ Louise G. Trubek, Seminar: Special Topics in Administrative Law: Regulatory Reform, (Fall 2005).

(2) Flexibility and Reviseability

Under New Governance theory, “rules are viewed as temporary and subject to revision,” in direct contrast to the ossified black box rulemaking ascribed to the top-down approach.⁵¹ This “provisionalism” is critical because “a flexible, adaptive system capable of responding to advances in science, technology, knowledge and shifting human judgments will produce better rules that are more likely to produce legislative goals.”⁵² Rules are not static but rather “they are building blocks in a process, alternative hypotheses to be deployed and revised in light of experience.”⁵³ As such, this provisionalism requires that the parties create mechanisms both to evaluate how a particular plan is working and also to alter the system should learning lead to an understanding that the system is deficient.⁵⁴ As Jodi Freeman points out, provisionalism might require a greater willingness to:

“(1) engage in site-specific rulemaking to tailor rules to particular problems and contexts; (2) create mechanisms that, while potentially costly, facilitate revisiting or modifying rules; or (3) establish rules sufficiently general that their requirements can be met in any number of ways, allowing for flexible implementation through informal adjudication between the agency and relevant parties.”⁵⁵

Although critics suggest that this revisability may lead to instability, proponents of New Governance argue that the level of deliberation required will ensure that rules change slowly and only in response to clear evidence of need.⁵⁶

⁵¹ Freeman, *supra* note 28, at 22.

⁵² *Id.* at 28.

⁵³ *Id.* at 29.

⁵⁴ Often this will be through the collection and evaluation of data.

⁵⁵ *Id.*

⁵⁶ *Id.*

(3) Increased Transparency and Accountability

Increased transparency is both a result of and a requirement of the New Governance model.⁵⁷ In the context of a revisable system, transparency of the *regulated* entity is crucial because the system will only be revised if failures are visible upon evaluation.⁵⁸ This transparency requirement, New Governance proponents suggest, will be met because regulated entities will feel more comfortable handing over evidence of their failures since they no longer face the binding sanctions that had formerly promoted silence.

At the same time, transparency of the *regulating* entity is crucial to ensuring democratic accountability. As the regulating entity grows to include numerous non-appointed, non-elected stakeholders sharing the administrative function, critics of New Governance argue that the people will lose their ability to hold the process accountable as they could under the top-down approach. In response, New Governance proponents argue that accountability will actually increase because the process will be taken out of the “black box,” enabling numerous parties to view the process, thus increasing transparency and ensuring that indiscretions will be detected. As market-based privatization generally lacks mechanisms for ensuring democratic accountability, introduction of New Governance mechanisms should inevitably increase accountability.

⁵⁷ Trubek, *supra* note 7, at 48. See also Simon, *supra* note 32, at 192; Freeman, *supra* note 28, at 22.

⁵⁸ *Id.* For example, if an agency creates a revisable regulatory system with hospitals to increase safety, the parties will be unable to evaluate the system’s effectiveness unless the hospital is willing to turn over data on accidents and injuries

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II. ADMINISTERING THE DATA COLLECTION AND DISSEMINATION FUNCTION: FROM TOP-DOWN TO “PRIVATIZATION PLUS”

A. WISCONSIN’S FIRST ATTEMPT AT REGULATING THROUGH DATA: A TOP-DOWN APPROACH TO ENSURING THE UTILITY OF THE COLLECTION AND DISSEMINATION TOOL

Wisconsin’s first attempt to regulate hospitals using data collection happened in 1987 with the passage of Wis. Stat. 153.05 (1987). The passage of the legislation reflected the desires of three important stakeholders: the state, the Wisconsin Hospital Association (WHA) and the consumers.⁵⁹ From the standpoint of the state, the primary goal of the legislation had been to provide the market with the information necessary to work effectively to increase hospital quality.⁶⁰ To at least some extent, the state was responding to a nation-wide movement toward making information on healthcare available to consumers.⁶¹ In addition, there is some evidence to suggest that the state was also motivated by an interest in increasing access by making the access information available to the medical community for shaming purposes and to policymakers for policymaking and review.⁶²

From the standpoint of the consumers, generally well-organized business groups who purchase massive amounts of healthcare, the mandatory data collection and dissemination were regarded as a way to minimize costs associated with low quality healthcare and with accidents and injuries.⁶³ Recognizing the force of the national movement and hoping to avoid the

⁵⁹ Interview with Chris Queram, former Director of the Employer Healthcare Alliance and present CEO of the Wisconsin Collaborative for Healthcare Quality and Vice Chair of the Wisconsin Board on Health Care Information, in Madison, WI. (Oct. 2005).

⁶⁰ *Id.*; Interview with Barbara Rudolph; Interview with Louise Trubek. *See also* Wis. Stat. § 153.05. The collection of uncompensated care data and general hospital data are generally associated with access and quality goals, respectively. Matthew J. Landis, *Badgering Our Non-for-Profit Hospitals* (December 2004) (on file with authors).

⁶¹ Interview with Queram.

⁶² Interview with Barbara Rudolph; Interview with Louise Trubek.

⁶³ *Id.*

reestablishment of mandatory ratemaking, the hospitals, represented by the WHA signed on and support the legislation as well.⁶⁴

The legislation generally reflected a top-down command and control approach to strengthening the data collection and dissemination tool. The legislation mandated that certain types of data be collected, including general hospital data and data on uncompensated care, among others.⁶⁵ The legislation also established the Office of Health Care Information (OHCI) to be housed in what is now called the Department of Health and Family Services (DHFS).⁶⁶ The OHCI was given the responsibility to collect and disseminate the data according to rules promulgated under Chapter 153 by the DHFS.⁶⁷ It was the job of the DHFS to create a series of administrative rules and procedures for collection and dissemination that would ultimately lead to strengthening data collection and dissemination as a regulatory tool.⁶⁸ It would be the job of the OHCI to carry out these procedures and enforce these rules. OHCI would be funded through assessments levied on hospitals with freestanding ambulatory surgery centers and through selling regularly issued and custom-made reports.⁶⁹

⁶⁴ *Id.*

⁶⁵ Wis. Stat. § 153.05. General hospital data is generally utilized in increasing quality, while uncompensated care data is generally utilized to improve access. One of the most common usages for uncompensated care data is to review compliance with the tax code that provides favored tax status to “charitable hospitals.” Landis, *supra* note 61.

⁶⁶ *Id.*

⁶⁷ *Id.* See Ch. H.F.S. 120.

⁶⁸ *Id.*, Interview with Barbara Rudolph

⁶⁹ The WHA estimates that in BHI’s last year of collecting data, roughly 87 percent of its revenue came from the assessment, with data sales only accounting for the remaining 13 percent. Interview with Joe Kachelski, WHA Information Center Vice President (November 11, 2005).

Initially, OHCI had a rather small number of data sets to collect, including hospital discharges and ambulatory surgery.⁷⁰ By 2002, however, OHCI had taken on more data collection and began to collect data across 14 different categories of providers (e.g., physicians, dentists, optometrists, nurses) at the time of the provider's licensing and re-licensing and also began collecting data on Physician Office Visit Data (POVD) in order to improve access and quality in the context of physician office visits.⁷¹ In addition to increasing the data sets collected, the OHCI expanded its dissemination in 1997 when the legislature passed an act requiring the DHFS to assemble and publish a consumer guide designed to aid the public in selecting health care plans and/or providers.⁷² This act had reflected expanding consumer interest in quality, as opposed to just cost.

Problems in the administration of the data collection and dissemination function, especially in the area of POVD, left some, including Governor James Doyle, wondering whether or not to continue data collection and dissemination at all.⁷³ A major problem under the OHCI (by now the Bureau of Health Information (BHI)) administration of data collection and dissemination was that there was no serious review for errors in the data.⁷⁴ Although hospitals were required to turn in accurate data, the BHI system didn't have a mechanism for crosschecking that would make errors immediately visible and administrative practice did not

⁷⁰ LEGISLATIVE REFERENCE BUREAU, WISCONSIN BRIEFS 2-6 (August 2005).

⁷¹ *Id.*

⁷² Wis. Stat. § 153.05 (1998).

⁷³ Legislative Reference Bureau, *supra* note 71 at 2-6.

⁷⁴ *Id.*, Interview with Joe Kachelski.

require hospitals to fix errors in the data after they had been illuminated.⁷⁵ Much of this was probably due to the failure of the state to update computer systems.⁷⁶ A second problem was that it took over six years from the beginning of the POVD data collection process for DHFS to publish anything useful to consumers.⁷⁷ Further, at least in the case of POVD, the DHFS only managed to disseminate data for one year, 2003.⁷⁸

B. THE TRANSITION FROM BHI TO WHA ADMINISTRATION: SERENDIPITY IS THE WORD

Although much of the transition from the BHI-run system to the WHA-run system is shrouded in mystery and disagreement, it is clear that a bit of serendipity was involved.⁷⁹ During the 2003-2004 session of the Wisconsin Legislature, policy statements posted on the WHA website had been arguing that the data collection and dissemination function should be privatized to the WHA.⁸⁰ At the same time, frustration with the collection and dissemination of POVD, and data collection more generally, was reaching a boiling point and work began on a bill to get rid

⁷⁵LEGISLATIVE AUDIT BUREAU, LETTER REPORT PHYSICIAN OFFICE VISIT DATA PROGRAM (2005); Interview with Joe Kachelski. Some believed that the statutes that governed BHI and the data collection process failed to provide any incentive for the BHI to provide as high a quality data set as possible and didn't encourage the BHI to continuously revise and improve its processes or products.

⁷⁶ Interview with Joe Kachelski.

⁷⁷Legislative Audit Bureau, *supra* note 76.

⁷⁸ *Id.* at 11.

⁷⁹ Although in disagreement on some aspects of the facts and fundamentals of the transition story, both Chris Queram, and Joe Kachelski both described the transition as "serendipitous." Interviews with Queram and Kachelski.

⁸⁰ The WHA suggested that they could reduce the assessments on their member hospitals and pointed to the successes of hospital association-run programs in Iowa and elsewhere. Interview with Joe Kachelski. *See also* Patricia Simms, *Hospital Data Collection May Change- Joint Finance Panel Decides State Agency Isn't The Best For The Job*, Wisconsin State Journal, May 24, 2003, at B1 ("There's no question we can do a significantly better job at producing the data sets," said Steve Brenton, president of the Wisconsin Hospital Association. "We believe we can do it in a much more timely basis and can produce the claims information at least six months faster, using new technology and greater efficiencies." He said the association will also include more outpatient data.").

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of POVd collection altogether.⁸¹ In the final draft of the bill, the language used did not limit the cessation of collection to POVd and would have ended all data collection and dissemination mandated under Chapter 153.⁸² In an effort to keep data collection going, an amendment to the budget bill, calling for the privatization of the collection and dissemination function was offered and the Budget Bill passed as written.⁸³ Although the WHA was not specifically named in the budget bill, it turns out that they were the only entity capable of meeting the requirements.⁸⁴ Pursuant to the legislation, the state signed a contract with the WHA on October 31, 2003.⁸⁵

The process through which the change occurred—through the budget bill and without competitive bidding—led to many criticisms. Critics argued that a decision of this magnitude should not have been passed as part of the budget but required its own bill, with all of the attendant notice, legislative debate and public comment.⁸⁶ The DHFS and other stakeholders only became involved after the fact. Further, because of the way that the bill was written, there was no real chance for a competitive bidding process.⁸⁷ Although most of the criticism was about the manner of passage and not necessarily the privatization itself, some felt that the

⁸¹ There was also a general frustration with the size of government at play here. Simms, *supra* note 81 (Governor Doyle’s spokesman, Dan Lestikow, stated that the “goal is to get accurate, timely, good data. If there is a way to do that more efficiently through the hospital association, then that should be pursued. This is about reducing the size of government and making agencies work better.”).

⁸² Interview with Chris Queram.

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ Contract for Professional Services Between the State of Wisconsin Department of Administration and the Wisconsin Hospital Association, Inc. (hereinafter the Contract).

⁸⁶ Interview with Chris Queram. For example of such criticism, see former BHI employee John Chapin’s unpublished manuscript “Health Care Data in a Banana Republic,” (January 2005) ([on file with authors](#)). See also Simms, *supra* note 81 (“[Barbara] Rudolph said health-care data belongs in the public arena. ‘It affects all of us, and it seems to me it should be in the public domain.’”).

⁸⁷ Interview with Chris Queram.

privatization itself was inappropriate. Some suggested that even if the privatization was a good idea, the fact that it had been privatized to an organization representing the regulated entity, posed serious legitimacy problems and that the legislation itself failed to take proper precautions to ensure that the effectiveness of the data collection and dissemination tool would not be sacrificed to the interests of the hospitals.⁸⁸

C. WISCONSIN'S SECOND ATTEMPT AT REGULATING THROUGH DATA: A "PRIVATIZATION PLUS" APPROACH TO ENSURING THE UTILITY OF THE COLLECTION AND DISSEMINATION TOOL

Wisconsin's current system for ensuring the utility of the data collection and dissemination function—the Chapter 153 legislation and pursuant contract—can best be described as a “privatization plus,” as it includes elements of the market-based privatization approach as well as top-down and self-regulatory features. In most ways, the arrangement is a classic privatization. The state has contracted out its data collection and dissemination function to a private entity that it believes can do the job more efficiently and effectively.⁸⁹ The contract provides the WHA with wide discretion to determine the “means and manner” through which the data collection and dissemination is carried out and the contract can only be rescinded for failure to follow the statute or if a review board, the Board on Health Care Information (BHCI), determines that the WHA has failed with regard to the “timeliness, completeness, quality, and accuracy of the reports generated.”⁹⁰ With a few exceptions, the state cannot even use the data

⁸⁸ Interview with Barbara Rudolph.

⁸⁹ Wis. Stat. § 153.05(1)(b). The legislation requires the state to contract with a private entity to collect health data and disseminate it in “language that is understandable to lay persons.” *Id.* The legislation further required that the contract be signed within two months of the governor’s signing of the bill

⁹⁰ The Contract.

collected unless it does so pursuant a separate contract (data use agreement) completed between the state and the WHA.⁹¹

Although it is clearly some sort of privatization, the arrangement retains several key elements of self-regulatory and top-down approaches. The fact that the entity to which the duty was privatized is the Wisconsin Hospital Association smacks of self-regulation, even if that isn't an exactly accurate categorization.⁹² At the same time, the WHA must follow all of the legislative mandates under Chapter 153 and all of the administrative rules promulgated thereunder that had been followed by the BHI.⁹³ This ensures that the WHA will collect all of the data sets that the BHI had been collecting pursuant to the statute. Second, a review board, which advises the Secretary of DHFS, also allows the DHFS to maintain some control over the WHA.⁹⁴ If the Secretary of DHFS is dissatisfied with WHA's performance in one or more of these areas, the Secretary may recommend to DOA that it use a competitive request-for-proposal process to solicit offers from other organizations to perform the services required by Chapter 153 and the Contract. To effectuate such review, the WHA is required to keep DOA and the BHCI informed of its activities under Chapter 153 by reporting to the BHCI and DOA upon request."⁹⁵

In taking advantage of the "means and manner" discretion provided in the contract, the WHA has invested heavily in new technology and has created a cutting edge data collection and

⁹¹ Standard reports must be made available to the Governor, legislature and review board for no charge. The WHA may also sign such agreements with other data consumers.

⁹² We will argue that although it may technically employ a self-regulatory element in privatizing to the association representing the hospitals, there are significant safeguards from the market and top-down approaches to ensure that this self-regulation is not as weak as the self-regulation prominent from the 1880s-1960s. Whether there safeguards are enough is another story to be discussed below.

⁹³ The Contract.

⁹⁴ *Id.* See also Wis. Stat. § 153.67.

⁹⁵ *Id.*

dissemination system that is allowing it to do more than the BHI ever could.⁹⁶ The WHA estimates that it processes 1.9 million records a quarter, as opposed to the 770,000 that was produced under BHI.⁹⁷ In addition to the reports provided by BHI and required under the contract, the WHA also disseminates data on two user-friendly websites, called CheckPoint and PricePoint which provide consumers with the opportunity to compare hospital services by price, as well as a number of other indicators.⁹⁸ The WHA's system is also much more technically sophisticated in that errors are detected more quickly and can be corrected more efficiently.⁹⁹ As submitters fill out submission forms on the computer, the system will not allow a transaction to be processed if it detects an error.¹⁰⁰

To date, the WHA has finalized over fifty Data Use Agreements (DUA) with clients across the country.¹⁰¹ Unlike the flat rate system in place under the BHI, the WHA employs a three-tier fee system to charge customers, and these fee levels are subject to approval by

⁹⁶ Interview with Joe Kachelski

⁹⁷ *Id.*

⁹⁸ *Id.* See also PricePoint system at www.wipricepoint.org. The PricePoint system allows users to choose either a basic or comprehensive query. If a basic query is done, users can check charges and utilization information for about 64 types of hospitalizations, representing about half of all hospital stays in Wisconsin. The benefit to a basic query is that it is written in more user-friendly terms. If the user wants information on ALL hospital stays in Wisconsin, they can do a comprehensive query but this requires some familiarity with hospital codes. The WHA plans to make information on ALL hospitals available through a basic query in the near future. *Id.* See also CheckPoint website at <http://www.wicheckpoint.org/>. "Wisconsin hospitals are committed to sharing information about the quality and safety of the health care services that they deliver in their communities. CheckPoint provides reliable data on 14 interventions that medical experts agree should be taken to treat heart attacks, heart failure and pneumonia, and five error prevention goals. These measures represent the beginning of more measures that will be added to this site in the future. The 126 hospitals reporting to CheckPoint provide care to nearly 99 percent of the state's patient population." *Id.*

⁹⁹ Interview with Joe Kachelski

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

DHFS.¹⁰² Members of the public pay the least, while businesses that plan to resell the data pay the most.¹⁰³ So far, satisfaction appears to be high amongst hospital submitters and data customers alike.¹⁰⁴ Recent satisfaction surveys show that submitters find the WHA system easier to use, while customers feel they are getting a better product, quicker than they had from the BHI when it administered the system.¹⁰⁵ Unfortunately, to this date, the WHA has not yet managed to provide the data to the State of Wisconsin, which is entitled to it free of charge. Despite months of negotiations, the two parties have yet to conclude a DUA.¹⁰⁶

III. EVALUATING PRIVATIZATION PLUS: THE ABILITIES AND LIMITS OF “PRIVATIZATION PLUS” TO ENSURE THE STRENGTH OF THE DATA COLLECTION AND DISSEMINATION TOOL AND THEIR IMPACT ON THE SUCCESS OF OUR QUALITY AND ACCESS MISSIONS.

As we have mentioned above, the “privatization plus” model, although centered on a market-based privatization, includes significant elements of the top-down approach and (at least the appearance of) the self-regulatory model. In this section, we look at the strengths and weaknesses of these models and determine what this means for the utility of the data collection and dissemination tool under this arrangement. Coming from a New Governance perspective that values stakeholder participation and collaboration, flexibility, and accountability, we review the interrelationship of the models present in “privatization plus.” Specifically, we will show how the various models work together to ensure the strength of data collection and dissemination as a regulatory tool. We then show how the privatization plus model is limited in its capability

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Id.*, Customer Satisfaction Surveys.

¹⁰⁵ *Id.*

¹⁰⁶ Interview with Joe Kachelski, Interview with Chris Queram, Interview with Barbara Rudolph, Interview with Jim Johnston.

to ensure the strength of the collection and dissemination tool. Finally, we will go on to speculate as to how the overall ability to ensure the strength of the regulatory tool will impact our two missions: increased quality and increased access.

A. “PRIVATIZATION PLUS”: HOW THE REGULATORY MIX WORKS TOGETHER TO STRENGTHEN THE DATA COLLECTION AND DISSEMINATION TOOL

It is our contention that the “privatization plus” model shows a fair amount of promise as a means of ensuring the regulatory strength of the data collection and dissemination tool, especially for its function of informing the marketplace. Although history has proven the self-regulatory, top-down and market approaches imperfect, we believe that the regulatory mixture employed here minimizes many of the problems associated with the individual approaches. Below, we attempt to show the role each approach plays in the overall scheme and how the models work together to create a system better than the sum of its parts.

(1) The Arrangement’s Use of the Self-Regulatory Model: Appearance and Reality

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As we have mentioned above, the current WHA administration of the data collection and dissemination function certainly has elements of the self-regulatory model. The regulated entity is Wisconsin’s hospitals, and yet the entity in charge of ensuring the success of the central regulatory tool is an organization representing the interests of those very hospitals. As we have seen, there were serious problems with relying on a self-regulatory approach, namely that individuals and entities are self-interested and will not actually self-regulate when it is against their own interests.¹⁰⁷ In this particular context, looking back at history, one might worry that the WHA might not perform the functions necessary to strengthen the regulatory tool because the

¹⁰⁷ See generally Rosenblatt, *supra* note 8. See also Chapin, *supra* note 86.

member hospitals do not in fact want to be regulated.¹⁰⁸ Even if this were not the actual case and the WHA was motivated solely by a genuine interest in regulating quality, there would always be an appearance of illegitimacy and a worry that the WHA could forsake our quality and access missions at any moment to suit the hospitals' interests with little accountability to the public.

(2) The Arrangement's Use of Top-Down Features: Minimum Standards and Legitimacy

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Certainly some of this fear associated with self-regulation should be allayed by the retention of the top-down mechanisms employed during the BHI administration. As has been discussed above, the arrangement requires that the WHA follow all requirements under the prior Chapter 153 that had been followed by BHI, including the administrative rules promulgated thereunder.¹⁰⁹ If the WHA fails to do so, it could lose its contract for a material breach.¹¹⁰ Further, if the Secretary of DHFS determines that based on the BHCI biennial review the WHA is not satisfactorily abiding by these rules, the contract may be rescinded.¹¹¹ This ensures, at the very least, that the data sets, which have been determined to be most helpful in informing the public, will be collected and disseminated in certain ways. Thus, the "disaster scenario" in which the WHA would stop collecting and disseminating certain data sets altogether, in order to avoid placing market and community pressures on member hospitals, is all but impossible. The fact that the WHA must follow the administrative rules promulgated under the statute further ensures that the WHA cannot merely "hide" the data through poor collection and dissemination practices, without violating both the statute and the contract.

¹⁰⁸ This, in fact, has been raised as a concern by Barbara Rudolph. Interview with Barbara Rudolph.

¹⁰⁹ The Contract.

¹¹⁰ *Id.* If there is such a "material breach" the WHA has 90 days to cure. [*Id.*](#)

¹¹¹ *Id.*

Of course, as we have shown, history counsels that the top-down approach is itself limited in its capabilities. In this context, critics might worry that the WHA administration of the data collection and dissemination function will just produce more of the same lackluster results that had been achieved under the BHI administration. After all, the WHA is subject to the same statutory mandate and administrative rules to which BHI was subject. In theory, the WHA would face the same inability to respond to changes in technology and situation, the same ossification of rulemaking, black box rulemaking, failure to include relevant stakeholders, and lack of incentive to improve data quality that the BHI had operated under.

(3) The Arrangement’s Use of the Market-Based Model: Bringing New Technology, Market Accountability and Consumer Voices to the Original Model

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We believe the market-based elements of the current administration answer many of the critiques of the top-down approach and should go a long way to ensuring a high quality tool. The WHA is more likely to create a high quality product because it has a market incentive to do so. “The WHA is a business,” at least with regards to data collection and dissemination.¹¹² As such, its success is subject to the forces of the market. If the WHA does not create a high quality product, it will lose revenue and be forced out of business. The WHA currently has a number of data-purchasing clients and they could potentially lose this business and face contract liability if they do not provide the most complete and accurate data.¹¹³ The WHA is constantly aware of the fact that if they don’t produce the best product, their clients will stop purchasing it.¹¹⁴ Although it is true that the WHA has a “monopoly” on Wisconsin data, all that this means is that potential

¹¹² Interview with Joe Kachelski

¹¹³ *Id.*

¹¹⁴ *Id.* In contrast with the state-run system, which operated by means of a guaranteed source of revenue-hospital assessments, the WHA does not have a guaranteed revenue source. There is thus an incentive to have quality data so that it does not lose significant business and be forced out of existence.

clients cannot go somewhere else for it. It does not mean that clients will not stop purchasing it; they will, since it is better to have *no* data than inaccurate, untimely or otherwise imperfect data.¹¹⁵ This provides “market accountability,” distancing the arrangement from self-regulation.

Further, even if it suited the WHA and its member hospitals to weaken the data collection tool, the WHA would be remiss to do so because it has invested significant amounts of its own money into developing the best possible system.¹¹⁶ The WHA has only received an initial \$725,000 from the state and it has spent significantly more than that on developing a cutting-edge collection and dissemination system.¹¹⁷ The only way to make any return on that investment is to actually produce the best possible data sets and make the best possible data compilations.¹¹⁸ The BHI, of course, never had similar market incentives to increase the quality of the data collection and dissemination tool, as the program was run on the assessments levied from hospitals and not utilizing limited BHI funds.¹¹⁹ This provides additional assurance that the WHA will administer the data collection and dissemination to its highest possible standards.

The fact that the WHA is a business allows these standards to be quite high because the WHA can respond to advances in technology. The arrangement capitalizes on the fact that the WHA is a business (as opposed to the government) and can, therefore, make the kinds of long-term investments in technology, that are essential to strengthening the data collection and dissemination tool. As we have mentioned above, one of the major critiques of the top-down system is its failure to capitalize on new technology and information. The contrast between the

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ *Id.*

technology and capability of the BHI and that of the WHA is startling. The WHA employs a computer system capable of turning out more data, more efficiently than BHI had.¹²⁰ Its technologically advanced crosschecking system ensures efficient error detection and correction not possible under the BHI system.¹²¹ As we have mentioned earlier, the WHA has also invested in the technology and time to create the CheckPoint and PricePoint systems which are capable of bringing data to thousands more individual consumers than the original system could.¹²² The CheckPoint and PricePoint systems also make the data much more easily accessible and useable.¹²³

The market aspects of the “privatization plus” model also allow for increased stakeholder participation because the WHA will inevitably adjust the “means and manner” of the data collection and administration in response to customer desire so that it will attract more business. The WHA’s customers are a diverse group including, among others, business groups and data resellers.¹²⁴ Each of these customers has different interests and represents different goals associated with the data collection and dissemination. As the WHA takes these people and entities on as clients, their desires in terms of how data, although not necessarily which data, is collected and disseminated will be incorporated into the WHA’s plan, insofar as it is consistent with the WHA’s contract and Chapter 153. The WHA is also likely to be interested in what other data users have to say about bettering the system, especially if they utilize data in ways

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.*

¹²³ *Id.* The CheckPoint and PricePoint systems have queries for both knowledgeable users and those unfamiliar with hospital codes. *Id.*

¹²⁴ *Id.*

similar to the WHA’s potential clients.¹²⁵ This may create an opportunity for groups interested in our healthcare missions to get their opinions heard by an entity with some control over the process.¹²⁶

B. THE LIMITATIONS OF PRIVATIZATION PLUS: A LACK OF FLEXIBILITY, DEMOCRATIC ACCOUNTABILITY, STAKEHOLDER PARTICIPATION AND COLLABORATION.

Despite viewing the “privatization plus” regulatory mixture as a rather solid arrangement to ensure the strength of data collection and dissemination as a regulatory tool, we think that the arrangement lacks the flexibility, transparency and stakeholder participation that could make it an ideal program. Specifically, we think that given the “self-regulatory” appearance of the program and the fear of impropriety, the inclusion of these mechanisms would go a long way toward lending some legitimacy to the program as well as providing safeguards to make the program more solid and acceptable to its opponents. In an effort to lay the groundwork for our ultimate conclusions and for our recommendations on strengthening the system through the use of New Governance, we address each of these limitations in turn.

(1) Not Enough Stakeholder Participation and Collaboration

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Although the arrangement has utilized some stakeholder participation, the arrangement has failed to include an optimal number of stakeholders in creating or administering the data collection and dissemination function. It should be noted that the arrangement utilizes more

¹²⁵ Although the arrangement does not specifically provide for increased participation by those we have termed “otherwise interested parties,” there is some suggestion that this may be an unintended result. At least one otherwise interested party, the Wisconsin Collaborative for Healthcare Quality (Collaborative), has seen the move as a “window of opportunity” to create better relationships with providers and purchasers in order to promote quality goals. This sentiment has been echoed by the WHA, which has asserted that the move has allowed for improved participation and collaboration with the Collaborative, as well as with the Employer Healthcare Alliance Cooperative (Alliance), a purchaser representative group formerly outspoken against the WHA arrangement. In fact, long-time protestor of WHA-control, the Alliance’s Chris Queram, has recently moved over to the Collaborative and to a more collaborative role with the WHA. Although there are murky and conflicting explanations as to why the WHA arrangement may have had such a consequences for interested party participation, we suggest that the WHA recognizes that it is in their business interest to listen to these groups, who are data consumers.

¹²⁶ Interview with Chris Queram, Interview with Kachelski.

regulated stakeholder participation than the BHI-run system, in that it allows the regulated stakeholders (the hospitals through the WHA) to have control over the “means and manner” of the collection and dissemination and allowed them minimal participation in deciding on a few additional data sets to collect.¹²⁷ Further, as we have seen, the WHA has begun a cooperative relationship with some *non-regulated* stakeholders, including the Wisconsin Collaborative for Healthcare Quality, with which it has entered into a working partnership.¹²⁸

However, the arrangement has failed to utilize stakeholder participation to an ideal level. From its inception, the arrangement failed to solicit public input and it was passed without the kind of debate normally attendant to a change of this magnitude.¹²⁹ Thus, there was little opportunity for stakeholders such as purchasers, physicians, consumers and the public, as well as those interested in access and quality, to chime in on how to best structure the program.¹³⁰ Although the review board (BHCI) could theoretically be a place for stakeholders to get involved, there is no requirement that the Board have certain key stakeholders, and today, it lacks consumer and access-minded representatives.¹³¹ Further, even though the WHA is currently involved in a collaborative relationship with stakeholders like the Wisconsin Collaborative, there is nothing in the arrangement that requires the WHA to utilize the input of such stakeholders before making decisions pursuant to its discretion under the “means and manner” clause. There

¹²⁷ The Contract.

¹²⁸ Interview with Joe Kachelski, “Working Together to Improve Quality, The Wisconsin Hospital Association and the Wisconsin Collaborative for Healthcare Quality,” available at <http://www.wicheckpoint.org/reports/collaborative.pdf>.

¹²⁹ Interview with Chris Queram.

¹³⁰ *Id.*

¹³¹ A non-hospital representative of note on the Board is Chris Queram, former Director of the Alliance and present CEO of the Collaborative.

is also no indication that the WHA has similar relationships with other non-regulated stakeholders.

Further, the WHA and the State, or at least the DHFS, have had serious problems collaborating with each other. Despite the fact that the two parties have been in negotiations over a DUA for almost eighteen months now, no contract has been signed. The negotiations have been contentious, involving squabbling over small details and efforts to renegotiate on already settled terms.¹³² In an interview with Joe Kachelski of the WHA, he noted that there were times when the WHA and the state didn't speak for weeks at a time.¹³³ This is clearly not the "collaborative" relationship envisioned by New Governance proponents.

(2) Lacks Flexibility and Reviseability (Provisional Solutions)

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Despite some flexibility in implementation housed in the "means and manner" clause of the contract, the arrangement provides for surprisingly little flexibility in changing the "rules."¹³⁴ As has been discussed above, the arrangement definitely provides for some additional flexibility in implementation. As the WHA is a private entity willing to invest in technology, they can respond to advances in technology that will allow for an increasingly better product. When it comes to actually altering the "rules" in response to experiential learning, however, the arrangement falls short of the flexibility goals of New Governance. The WHA must collect and disseminate the specific data sets mandated by the statute and a few extra ones provided for in the legislation.¹³⁵ If, for example, the WHA determined through its experience and

¹³² Interview with Kachelski.

¹³³ This reflects a common criticism of New Governance that the parties on opposite sides of the regulation will not be willing to work in a cooperative manner with one another, thereby complicating the success of such regulatory innovations.

¹³⁴ The Contract.

¹³⁵ The Contract, Interview with Barbara Rudolph, Interview with Chris Queram.

communication with data users that a particular item was not useful, the WHA would have no authority to cease collecting and disseminating that data set in favor of a more useful, non-mandated one that consumers could use to make wiser healthcare choices. At the same time, the state has given itself a limited amount of flexibility to limit practices that it deems imprudent or otherwise offensive at a future date if it wasn't laid out in the contract.¹³⁶

(3) Needs More Non-Market Accountability

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Despite all of the *market* accountability and *contract* accountability described above, “privatization plus” fails to provide much *democratic* accountability. What if the market doesn’t hold the WHA accountable? What if the WHA doesn’t mind a reduction in market share? What redress does the public have? Under our top-down system, there was at least an appointment relationship between the DHFS/ BHI and an elected official. Here, the voters have almost no recourse should they find the work that the WHA does to be sub-par or objectionable. Of course, if the WHA is in “material breach” or if the review board (BHCI) determines that it has failed its duties under the statute to provide data in a timely, accurate, complete and high quality manner, the Secretary of DHFS may request that the contract be rescinded. As we mentioned above, however, the Board’s composition in terms of stakeholder inclusion is not ideal. Although the BHCI is more than likely unbiased and fair, it is of little comfort to know that a board lacking proportional consumer and access-minded representatives will review the WHA. Further, it is not clear that the BHCI is actively monitoring the work of the WHA, having been described as “moribund” by at least one commentator.¹³⁷

¹³⁶ There are few options other than scrapping the contract and that can only be done in a limited number of situations.

¹³⁷ Interview with Louise G. Trubek (November 20, 2005). For instance, the Board has no ability to intervene with regards to the failure to approve the DUA.

Of further concern is the fact that almost all of the “increased-risk situations” that we described in our section critiquing markets are present here, making a strong mechanism for accountability especially important. First, the WHA holds a monopoly over the services that it provides by virtue of the fact that the state has agreed to allow the WHA sole control over data collection. This is problematic because the state (or others) has no ability to compare the data being collected by the WHA to the data of others in order to tell whether it is of the highest possible quality. Second, the services being provided are complex. The technology and processes of data collection are extraordinarily complicated and the WHA could easily do less than optimal work without detection simply because those in the government may not necessarily understand what is involved in the high tech collection. Further complicating the matter is the fact that in many privatization scenarios, the government would retain some ability to monitor the private entity’s work by using data. Here, however, any data that the state could potentially use to monitor the WHA’s performance is the data controlled entirely by the WHA.¹³⁸

Two of the other increased-risk situations are most relevant in the context of refining the data collection and dissemination tool for use in access improvement. As we will explore more fully in our analysis of the impact on access, there are not particularly effective market pressures when it comes to improving the data collection and dissemination tool for use in solving access problems. Although in the case of quality many of the WHA’s customers may be businesses or trade organizations utilizing the data for quality purposes—and therefore the WHA would have incentive to improve the tool for those purposes—far fewer of the WHA’s clients will utilize the

¹³⁸ Louise G. Trubek, Seminar, Special Topics in Administrative Law: Regulatory Reform, Fall 2005. Professor Trubek says that data is crucial to monitoring both the success of and compliance to various regulatory schemes.

data for access problems.¹³⁹ This will leave the WHA with less of an incentive to improve the tool for access purposes. Finally, as we have mentioned above, we should be especially concerned about privatization when the intended beneficiaries are relatively powerless. Certainly, in the context of access, our intended beneficiaries are often groups representing the poor, a group that generally can claim far less technological sophistication and resources than, say a business group interested in quality.¹⁴⁰

C. SPECULATION ON THE WHA ADMINISTRATION'S IMPACT ON ACCESS AND QUALITY IMPROVEMENT IN WISCONSIN: STEPPING BACK TO SEE THE BIG PICTURES

(1) A WHA Administered Data Collection and Dissemination Tool, A Net Gain for Quality

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We are confident that the WHA-administered system will prove a net gain to Wisconsin's quality mission. As we have explained throughout this discussion, hospital quality should increase, as the regulatory tool of data collection and dissemination is itself strengthened. This is because the market can only induce quality if consumers make choices based on the actual level of hospital quality and not on spurious factors, which they tend to do if they don't have the information. The WHA system is going a long way to ensure that consumers in the market are well informed about the healthcare choices that they are making. The WHA is providing more accurate, timely and complete data in a more user-friendly form than the BHI ever did, as well as providing more data sets.¹⁴¹ Tools such as CheckPoint and PricePoint will help to ensure that consumers have meaningful access to the data and tools like the crosschecking system will

¹³⁹ This will be fleshed out more thoroughly below. Interview with Louise Trubek. Professor Trubek says that groups interested in access have generally not utilized the opportunity to use data to further their missions. *Id.*

¹⁴⁰ *Id.*

¹⁴¹ See Contract, CheckPoint, PricePoint, Interview with Joe Kachelski

ensure that the data is an accurate reflection of actual quality.¹⁴² Although we concede that not all consumers will utilize the websites, and therefore this arrangement cannot create a completely informed market, large scale consumers will utilize the improved system and this alone should induce changes in the behavior of low-quality hospitals.¹⁴³

We are further confident that the WHA will allow the system to become an even stronger tool to induce quality over time. Even though the WHA is not required to establish relationships with other stakeholders like the Collaborative and the Alliance, we believe that such relationships will persist because it is in the WHA's business interest to perfect its data collection and dissemination system in ways that potential clients would want. As a client, the Alliance can provide the WHA with valuable input on how the data collection and dissemination would be the most useful to its business members. The WHA has much to gain by bringing in more business purchaser clients and is likely to take heed of such input. Through the inclusion of these stakeholders, we believe that the system will have the opportunity to continually grow within the bounds of the "means and manner" clause of the contract to make the most useful data collection and dissemination tool and, hence the strongest one to regulate quality.

And what impact will the failure to sign a DUA have on quality? Although it is clearly in everyone's best interest for the state and the WHA to sign a data use agreement, the current failure to do so will likely have little impact on Wisconsin's quality mission. Wisconsin's quality regulation rests largely on the rules and standards created and enforced by the informed market. Even without a DUA signed, this market continues to regulate the hospitals, even while

¹⁴² *Id.*

¹⁴³ Interview with Chris Queram. Queram says that its not the individual consumers, but the business purchasers that have the ability to impact hospital behavior. This sentiment is echoed by Barbara Rudolph. Interview with Barbara Rudolph.

the state remains limited in its power to use the WHA-collected data. The WHA has collected all of the data that it is required to collect from the regulated hospitals.¹⁴⁴ The WHA is still releasing this data for use to a number of clients and it is also posting the data on its PricePoint and CheckPoint sites. The hospitals are still subject to market pressure and to peer review because the data is still available to the medical community and to consumers. A DUA, of course, should be signed so that the state can use the data for its additional regulatory and non-regulatory initiatives, top-down or otherwise.

(2) WHA Administered Data Collection and Dissemination Tool, Close Net Loss for Access

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Despite our rather optimistic view of the potential for quality improvement, we are somewhat pessimistic about the arrangement's ability to advance the access mission. Of course, as we have discussed in great length, the WHA administration has great potential for informing the market. But in the case of access, there isn't really a working market. People utilizing charity care cannot "wield their purchasing power" by withholding in order to induce hospitals to increase access. So what can the WHA-administered data collection and dissemination tool do for access? No doubt, the medical community could use the more accurate, timely and complete data to shame those hospitals that fail to comply with community-set access standards. The problem is that in order to make the data collection and dissemination most useful for this purpose, we would want the WHA to establish relationships with those interested in hospital access in order to allow them to influence the WHA to adapt the "means and manner" of collection and dissemination to make it most useful for this purpose. Not only do we have no report that the WHA has established such relationships, but groups interested in access are also

¹⁴⁴ Interview with Joe Kachelski.

much more likely than quality-minded groups to be unable to create a client-based relationship with the WHA due to the barriers of cost of data.¹⁴⁵

Further, this community-shaming device is not the only or even the primary use for the data. Access data, most likely uncompensated care data, is also used for a host of other purposes (including informing policymaking and policy review) and there is no mechanism to ensure that the WHA system strengthens the use of data collection and dissemination for these other purposes. Unlike the case with perfecting the system for informing the market, there is nothing in place to induce the WHA to ensure the strength of the data collection and dissemination tool for use in policymaking and review. The state, unlike WHA's other data purchasers, does not have the option to "wield its purchasing power" and move on to another data collector if the WHA's data collection and dissemination is not best suited to informing or reviewing policy. The state must use the WHA because the primary data they are interested in using is that on Wisconsin hospitals, and the WHA is the sole collector. Unless the failure reaches the level where the contract could be rescinded, the state has little ability to require the WHA to increase the utility of the tool for its purposes.

There is also reason to believe that the current system will increase barriers to data for those researching access. First, the cost of the data has increased, since the WHA is not paying for the administration using assessments. This will be felt deeply by many researchers that are interested in access issues working off of limited grant money or researchers associated with non-profit access organizations. There is also a group of researchers, namely state-supported researchers that are not contracted with the state, which will now have to pay for data that they

¹⁴⁵ Whereas, a business groups such as the Alliance or Leap Frog are data-savvy and affluent enough to create a client-WHA influential relationship, most access groups lack the knowledge and the money to do so.

used to get for free from the DHFS.¹⁴⁶ This includes researchers doing state supported work on epidemiology and minority access to healthcare.¹⁴⁷ Further, because of the WHA's greater exposure to liability as a private entity, without the protection of administrative privilege and immunity, the WHA will be unable to release certain types of data.¹⁴⁸ For example, a researcher will be unable to get from the WHA access to certain data, such as vital records, health survey, program data (such as WIC) because they have personal identifiers in them and the WHA may be liable under patient privacy laws.¹⁴⁹

We find this failure to ensure the utility of the data collection and dissemination tool for access problems to be completely predictable. In many ways, going back to the original data collection mandate, access has always been an afterthought. The forces pushing for the original collection mandate were all quality-centered and the finished product reflects this. Although the statute calls for collection of uncompensated care data and the DHFS apparently saw it as part of the mission of data collection, there was never very much built into the actual system to ensure the data collection tool's utility for this purpose.¹⁵⁰ This latest move, regrettably, is quite consistent with the energy and attention that Wisconsin has historically given to using data collection and dissemination as a tool to regulate access.

¹⁴⁶ Email from Ron Cisler, Director, Center for Urban Population Health, to Louise Trubek, Professor UW Law School (August 12, 2005)(On file with author).

¹⁴⁷ *Id.*

¹⁴⁸ Interview with Joe Kachelski

¹⁴⁹ [Cisler, supra note 145](#).

¹⁵⁰ See generally, Wis. Stat. 153.05 and Ch. H.F.S. 120.

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IV. USING THE POVD OPPORTUNITY TO PUSH PAST THE LIMITS OF PRIVATIZATION PLUS: HOW THE ARRANGEMENT COULD BE IMPROVED BY INCORPORATING NEW GOVERNANCE MECHANISMS

As we have discussed above, the current WHA administration of the data collection and dissemination function lacks the flexibility, accountability and stakeholder participation that is recommended under by the New Governance literature discussed. At the same time, however, the WHA is clearly doing a far better job at getting out accurate, complete, timely data to a larger audience than the BHI ever had. We believe that the answer to many of the New Governance theorist's concerns lays in the review board (BHCI), which we believe could be transformed into a means of incorporating stakeholders, increasing flexibility and ensuring accountability. Current discussion about what to do with the POVD collection and dissemination function may provide the perfect opportunity to expand the WHA duties to include the POVD, while using the opportunity to renegotiate some aspects of the current system to incorporate New Governance.

A. WHY WE SHOULD HAVE THE WHA TAKE ON THE POVD PROBLEM:

The current DHFS-run collection of POVD has been harshly criticized. In an April 2005 Letter Report completed by the Legislative Audit Bureau, the Bureau reviewed the current POVD collection and concluded that the program was seriously lacking.¹⁵¹ In a letter to the Co-Chairs of the Joint Legislative Audit Committee, the auditor wrote:

We found numerous problems with the program, including serious concerns with the quality, comparability, and comprehensiveness of the data. For example, there are inconsistencies in reported charges, service delivery locations, and types of services being provided. Further DHFS is collecting information from 13 medical practice groups, representing only 30.9 percent of Wisconsin physicians, and has released data only for 2003...DHFS has yet to produce information that is useable by the general public.¹⁵²

¹⁵¹ See generally, Legislative Audit Bureau, *supra* note 76.

¹⁵² *Id.*

In other parts of the report, the auditor found that the DHFS did not make efforts to obtain updated information against which to check submitted data and that “DHFS does not require physicians to correct errors that are identified after data are submitted.”¹⁵³ As a result of these inefficiencies, some have proposed that Wisconsin stop collecting and disseminating POVD altogether.¹⁵⁴

We prefer the idea of transferring the responsibility for collecting and disseminating POVD to the WHA. First, under the WHA system, reporting inconsistencies and errors could be corrected more efficiently. As mentioned above, the WHA’s input system automatically catches errors and will not let a physician or hospital administrator complete the input transaction if an error or inconsistency exists. The DHFS program could not catch errors so quickly because there was no computerized nexus crosschecking the lists, but rather a human being. Second, the problem of the failure to actually get POVD out would not occur under the WHA because they would be motivated by both potential loss of contract and potential loss of business. Finally, incorporating the POVD into the CheckPoint and PricePoint programs would ensure that the data would be available to the public in a user-friendly form. Although the DHFS could theoretically make the investments necessary to develop a system similar to the WHA, it would be hard to justify considering that it has already outsourced all of the other data collection to the WHA. Even with the investments, however, they would never have the contract and market motivations or the singular focus that would ensure that the function always took a top priority.

¹⁵³ *Id.*

¹⁵⁴ *Id.*

B. USING THE CARROT OF THE POVD CONTRACT TO NEGOTIATE “NEW GOVERNANCE” CHANGES IN THE STRUCTURE OF THE CURRENT ADMINISTRATION¹⁵⁵

The WHA appears to be interested in taking over the POVD function and the “carrot” of a potentially lucrative POVD contract could potentially be used to get the WHA back to the table to negotiate some New Governance mechanisms into the current system.¹⁵⁶ Despite assurances from WHA leadership that the WHA is “not interested” in taking on the function, we are confident that they would want the POVD contract, given the chance.¹⁵⁷ It should be remembered that before taking on the hospital data function, the WHA’s official stance was that they were similarly “not interested” in the job.¹⁵⁸ With this “carrot,” we propose that the state leverage some changes in the current arrangement to make it more flexible, accountable and stakeholder dependent. We see making alterations to the review board (BHCI) as the best way to meet these goals.

As the centerpiece of the changes, the BHCI should be reconfigured to require increased stakeholder participation on the Board. For example, the contract could be amended to require that representatives from all of the following groups constitute the Board: (1) Business (large-scale) consumers; (2) Individual consumers; (3) Physicians; (4) the State; (5) Researchers; and

¹⁵⁵ According to the Alliance, it and a number of other entities are working to solve the POVD problem by collaborating to create an independent longitudinal database that would serve the functions that are going underserved by the current POVD administration. See Interview with Mark Xistris. We are not confident that this arrangement will not prove an effective solution. The system would lack the state influence necessary to make sure that its interests in the data are being served.

¹⁵⁶ Stephen Brenton, *President’s Column*, July 7, 2005, http://www.wha.org/pubarchive/friday_packet/vv7-8-05.htm. Stephen Brenton says “the WHA looks forward to working with your administration on a new program to replace POVD. In the meantime, there should be direction provided to the existing program, as per the LAB report, to demonstrate some level of credibility and responsiveness, particularly if the state might retain some limited role in future physician data collection efforts. Our experience with the privatization of hospital data collection has been nothing short of spectacular – an excellent example of how privatization can work. I appreciate the confidence you and your administration have shown in the hospital data program and the excellent working relationship we have established, particularly with the Department of Administration, under your leadership.” *Id.*

¹⁵⁷ Email from Joe Kachelski, WHA Information Center Vice President, to Rebecca Estelle (Dec. 4, 2005).

¹⁵⁸ Interview with Kachelski.

(6) Charitable Care consumers, as represented by a non-profit or other access minded group. This would go a long way in ensuring that the unique needs of those using the data for access rather than quality purposes were not just ignored. Not only would this “board configuration” requirement ensure that a number of different groups can have a chance at influencing the WHA’s administration of the function, but it also adds significant accountability, as the board would not just be representing hospital interests but other interests that may conflict with the WHA. Therefore, if the WHA failed to perform in any way, we would be more likely to see board action. This would increase not only accountability, but it would also make the WHA arrangement appear more legitimate and less self-regulatory to the public and other stakeholders.

We would also recommend that the review board’s function be increased to include some additional ability to affect the “means and manner” of WHA’s administration of the data collection and dissemination function. In keeping with New Governance, we do not suggest giving the Board rulemaking power. Rather, we suggest giving the board the ability to suggest revisions to the WHA’s plan. Although these “suggestions” would not be binding, the Board would be able to consider the WHA’s failure to take them into consideration at the biennial review and the WHA will be given the opportunity to explain why it has decided not to utilize the suggestions. Suggestions that prove successful can be negotiated into the contract at a later date. We think that this will allow the stakeholders some input and allow all parties involved, especially the WHA, to prove that they are team players. The working relationship between the WHA and the stakeholders should also allow the parties to increase the level of *trust*, an important function given the contentious mythology surrounding the arrangement’s beginnings.

Similarly, there could be a mechanism for the WHA to get approval from the BHCI in the event that it wants to experiment with new technology or procedure it, in its expertise, sees as

beneficial. The WHA could get a “waiver” of specific requirements of the contract in order to temporarily implement an “experimental” procedure. For example, the Board could waive the requirement that the WHA collect one of the “extra” negotiated data sets if the WHA offered an alternative plan that would be more useable and useful to consumers of data. The stakeholders represented on the board could ensure that the interests of the various groups they represent were not jeopardized by the experiment. It would allow the WHA to utilize experiential learning, advances in technology and in human understanding, while the board retained the right to renege the waiver if it proved ineffective to promote the states’ goals.

V. IN CONCLUSION

We are satisfied that, in many ways, the data collection and dissemination tool will be strengthened by the move to WHA administration. Given the BHI’s limitations and the WHA’s motivations and capabilities, it’s hard to see how the move couldn’t at least prove a net gain in the quality area. On the access end, of course, the story is different. Although it is quite likely that the WHA-administered system could prove a net gain for access, there aren’t enough safeguards in place to ensure that the tool is optimally strengthened for uses relevant to the access mission. We see the POVVD discussion as the perfect way to bring the WHA’s obvious capability to a troubled area of data collection, while allowing us to revisit the current data collection arrangement and add safeguards to ensure that the data collection and dissemination tool is optimally strengthened to promote access goals. Although we have placed most of our hopes in the idea of a strengthened review board, we are sure that many other innovative and useful solutions to the problems posed could be worked out once we get the parties back to the table, this time with a few added voices.