

Why Don't People and Institutions Do What They Know They Should?

David M. Cutler*

I propose as a central question for the social and behavioral sciences the following topic: *why do people and institutions not do things that are so obviously in their self-interest, even when they want to do so?* We have numerous examples of this phenomenon, from individual behavior such as seatbelt use and medication adherence, to firm outcomes such as quality improvement or cost reduction. The ability to encourage what people know to be right is central in many policy debates, including the recent health reform discussion in the United States. I indicate three lines of inquiry as promising in understanding this question: characterizing the motivation of individuals; understanding group decision-making; and undertaking interventions.

This work is licensed under the Creative Commons Attribution-NoDerivs 3.0 Unported License. To view a copy of this license, visit <http://creativecommons.org/licenses/by-nd/3.0/> or send a letter to Creative Commons, 171 Second Street, Suite 300, San Francisco, California, 94105, USA.

* Department of Economics, Harvard University, 1875 Cambridge Street, Cambridge MA, 02138; dcutler@harvard.edu; and NBER

David M. Cutler

Doing the right thing

Allegheny General Hospital is a 728-bed academic health center located just outside of Pittsburgh and serving the surrounding five-state area. The hospital is big and complex. In 2003, the medical and cardiac intensive care units at Allegheny saw 1,753 patients and placed 1,110 central lines – tubes leading to a main artery to administer nutrition and monitor blood gases. That year, there were 49 Central Line Associated Bloodstream Infections (CLABs), resulting in 19 deaths. A CLAB rate of 4.4 percent is the norm for American hospitals and certainly good enough for a hospital with many other pressing issues. But it was not good enough for the chief of medicine at Allegheny General, Rick Shannon.

In the next few years, Shannon introduced several changes in its central line practice. The placement and duration of central lines was standardized, and everyone involved in patient care was authorized to stop the process if a step was not followed. Infections were monitored in real time and corrective action was taken when an infection was observed. The intervention worked. Within just three years, the rate of central line infections fell by 95 percent. Since the cost of a central line associated bloodstream infection is about \$50,000, the hospital saved nearly \$2 million.¹

So far, so good. The problem is what comes next. In economic theory, other hospitals observe what has happened at Allegheny General and imitate it, and health care as a whole gets cheaper and safer. But that has not happened. Despite widespread publication of the results at Allegheny General and a few like institutions, national rates of hospital-acquired infection are going up. This problem is not a minor one. Nationally, about one in twenty hospital patients are harmed because of the care provided in the hospital, and medical errors are among the leading

¹ Pittsburgh Regional Healthcare Initiative, *Executive Summary*, March/April 2007.

David M. Cutler

Doing the right thing

causes of death. Hospital-acquired infections cost the medical system about \$30 billion annually.

Hospital infection control officers – every hospital has one – are frustrated. They know that medical errors lead to death and higher cost, but they can't get their institutions to focus on the problem. Standards, monitoring, and the ubiquitous checklist exist in theory, but not yet in practice. Indeed, when asked how long it would take for checklists to diffuse throughout the medical system, the leading evangelist for them, Peter Pronovost at Johns Hopkins, replied “At the current rate, it will never happen.”

Throughout the medical system – indeed, in every facet of life – people and institutions do not do things that are valuable, inexpensive, and relatively straightforward. In addition to the central line example, consider a few others:

- o American automobile makers never found a way to match the quality record of Japanese firms, despite a willingness of Japanese firms to share best practices;
- o Only 69 percent of Americans always wear a seatbelt when they drive, even though 95 percent of Americans believe that a seat belt would help them in an accident;
- o Three-quarters of Americans prescribed a drug for a chronic condition have stopped taking the medication by one year later. Even when the drug is free, long-term adherence is low.

These examples share common features. In all cases, everyone agrees on the right thing to do. There is little serious debate about whether seat belts save lives and no debate that giving people infections is a bad idea. Further, the monetary costs of undertaking the actions are low.

David M. Cutler

Doing the right thing

The monetary cost of the infection reduction program at Allegheny General was trivial, and fastening a seat belt costs nothing. But yet, the actions are not taken. I propose as a central question for the social and behavioral sciences the understanding of such problems: *why do people and institutions not do things that are so obviously in their self-interest, even when they want to do so?*

The literature in the social sciences has addressed this question in various guises. Behavioral economists have examined individual propensities to engage in different actions. Why do people not save for retirement or continue to smoke? A major theme of that research is that people are prone to procrastination. People do not quit smoking because they believe they will do so tomorrow. This theory is relevant in some settings; there are demonstrated successes getting people to save more by reducing the ability to procrastinate. But the theory is not right in all settings. When queried, hospital managers rarely announce that they will start infection control operations next month. Rather, they assert that they are already doing the best they can – the Allegheny General experience notwithstanding.

In sociology, the peer effects literature confronts similar questions. People wear their seatbelt if others around them do as well. Again, this theory has strengths. Smoking is clearly a social action, and so too are obesity and sexual behavior. But the theory fails in other settings. Allegheny General Hospital did not get better because like-minded people came to the conclusion that it had to change, or because of favorable peer interactions. It improved because the Chief of Medicine imposed changes. Further, the changes had to be continually monitored and stressed, or gains made one month would be undone the next.

In organizational behavior, there is a large focus on principal-agent problems within the firm. The firm's manager wants to do something new, but does not want to create new problems

David M. Cutler

Doing the right thing

while addressing existing ones. There are a variety of strategies that firms might use to surmount this issue. Organizational behavior specialists study the combination of hiring, compensation, and promotion processes that lead to better and worse outcomes. The question then becomes why some firms successfully tackle the problem and others do not. Aside from a specific person, what is different about Allegheny General relative to the thousands of other US hospitals that still have high rates of hospital-acquired infections?

All of these disciplines are right in some circumstances, but they all have limits. What we need to make progress is a scientific study of doing the right thing – what makes the right outcome happen or not, and what are the barriers to repeating success? I do not know what the answer to this question will be. But I believe there are some ways to address it. Three features of inquiry strike me as particularly salient.

First, we need to better understand how people view their social environment. Some people are motivated by the desire to fit in with others – they ‘go with the flow’ as much as possible. Others have a strong moral compass to always do what they perceive as right. Still others are motivated to be at the top of the hierarchy, or to avoid being at the bottom. What are the characteristics of people in each of these groups? Do people of similar types cluster together, or do different types co-exist? To date, we are not good at this type of measurement. Analyzing individual personality is likely to involve standard survey methodology, but the type of questions asked will be different from what is usual.

Second, we need to understand the processes of group decision-making. When people in an organization disagree about the best strategy, how are decisions made? Initial decisions are often made in a top-down setting – witness Allegheny General – but they are sustained by a culture of individual belonging and empowerment. Even at Allegheny General, infection control

David M. Cutler

Doing the right thing

would not happen if every nurse and every doctor did not buy into it. When asked, employees describe it as part of the culture. How are organizational cultures born, and how do they spread? Cultural changes, like behavioral changes, are not easy. Many firms that have imitated Toyota's production methods, for example, but not all firms have been successful. For this type of analysis, we will almost surely need new measurement techniques. There is relatively little literature on how to characterize an organization, as opposed to a collection of individuals.

Third, we need to conduct experiments to understand different theories of behavior and test different interventions. The most influential studies in economics have come from interventions – changes in the information people possess, the incentives they face, or the environment they operate in. The use of experiments has revolutionized the study of economic development, labor economics, and health economics, to name just a few areas. Experiments are by nature costly and time-consuming. But the return more than justifies the cost.

To see this, return to the health care example. In the past 18 months, the United States engaged in a prolonged health care debate. One of the major points of contention was whether health care reform could 'bend the cost curve' – that is, limit the increase in medical spending over time. If we can bend the cost trajectory, health reform will be a huge success. If we cannot, reform will be a failure, and we may well repeal the recent reform legislation.

Bending the cost curve is ultimately in the hands of institutions like Allegheny General. If hospitals in general can do what Allegheny General has done, overall medical costs will fall more than enough to pay for the promises made. Thirty billion dollars of medical errors, after all, is a lot of money to save. In contrast, if Allegheny General remains an outlier a decade from now, the health reform effort will have failed. Differing views about the ability to spread best

David M. Cutler

Doing the right thing

practice explain a good share of the differing views between legislation proponents and detractors.

At present, we know that savings are *possible*. If the social and behavioral sciences can turn possible into *certain*, or even *probable*, we will have contributed more than our fair share to improving human welfare.