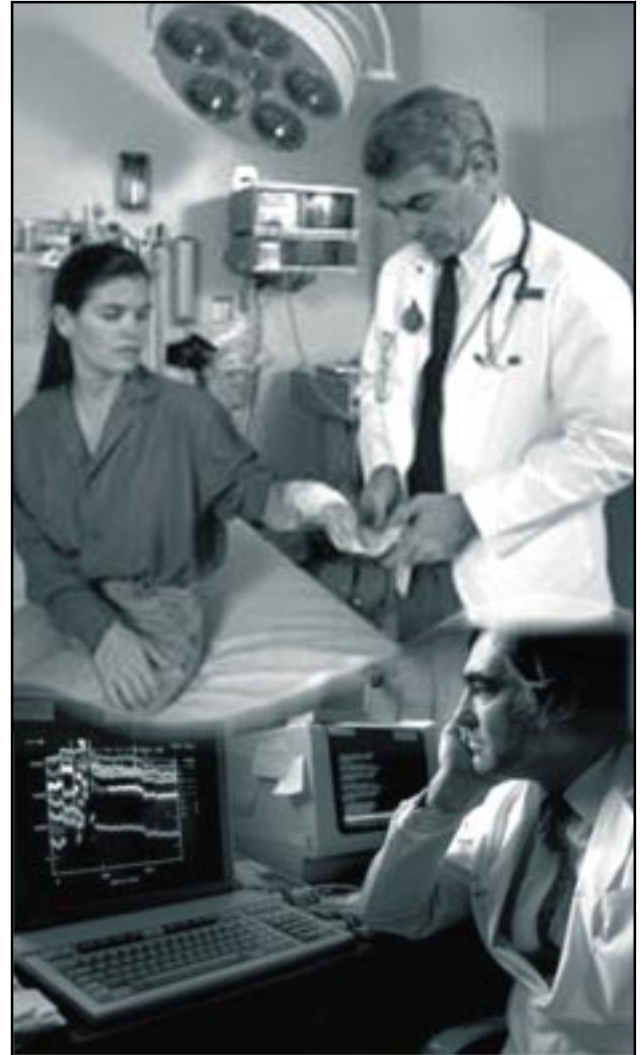


Beyond the
Managed Care
Backlash
Medicine in the
Information Age



Health Priorities Project
Policy Report No.1

Michael L. Millenson

July 1997

Progressive Policy Institute's Health Priorities Project

The Health Priorities Project's purpose is to promote the creation of an Information Age health care system that joins individual choice and responsibility with universal access to the information and resources that people need to improve their health. It recognizes the complex interactions between science, politics, and the marketplace and seeks to develop a coherent, dynamic, and integrated health policy that can achieve the following goals:

- 1) Enhance accountability for health by enabling and encouraging health professionals to improve their performance and individuals to take better care of themselves.
- 2) Modernize Medicare and Medicaid not only to preserve them for future generations, but also to create a universal system of affordable, private health insurance.
- 3) Organize the information that people need to make good health decisions and to reduce the over-consumption of health services, and invest more in health research and prevention.

Overall, the project envisions a shift from a "top-down," illness-oriented system to a "bottom-up" system that promotes health and well-being.

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1. Introduction

“We can no longer afford to provide health care without knowing more about its successes and failures. The Era of Assessment and Accountability is dawning at last.”

—Arnold S. Relman, editor-in-chief,
New England Journal of Medicine, November 3, 1988

The decades-long national argument about “socialized medicine” has been repackaged with a new villain: the “greedy capitalists” of managed care. Like some sort of refurbished Cold War spy movie, the characters have been reshuffled while the basic plot remains the same. The public is warned it faces a choice between the decisions made by “good” doctors or by “bad” bureaucrats—albeit corporate rather than government ones. We are tirelessly told that preserving total physician freedom is the way to “preserve” high-quality medical treatment, and we are constantly cautioned that any other path leads inexorably to ruin.

This story line, while appealing, is a gross oversimplification. There’s no question that an unchecked business ethic can dangerously distort medical decision making. The dangers have been vividly illustrated in recent months in news accounts and in testimony before Congress. Nonetheless, the greatest achievements and worst failures of American medicine have little to do with the strengths and weaknesses of insurance companies. Instead, they emerge directly from decisions by health professionals.

Policymakers can help ensure that our health care system delivers measurably consistent treat-

ment of the highest quality. To do so, however, their actions should be based on four key principles that take into account both the much-acclaimed strengths and the often-hidden weaknesses of American medicine.

1. The myth of a lost “Golden Age” of medicine before the advent of managed care should be rejected. Marcus Welby isn’t just dead; he never lived in the first place. False nostalgia notwithstanding, the old guild structure of professional self-policing demonstrably failed to protect patients from ineffective, inappropriate, and even dangerous care. Policymakers should not let the yearning for a mythical past obscure the need for a professional accountability that goes hand in hand with professional autonomy.
2. Everyday medical practice should be anchored to the greatest extent possible in science. While public attention focuses on access to care, few realize that more than half of all medical treatment—and perhaps as much as 85 percent—has never been validated by a clinical trial. Even more worrisome, study after study documents that important therapeutic advances that have been shown to be effective often take years to

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work their way into everyday care. This grim failure costs tens of thousands of lives unnecessarily every year. Policymakers must enable professionals to take effective corrective action.

3. The tools and methods of the Information Age can and should be implemented in medical practice more widely and effectively. The health care field lags badly in its use of digitized information for clinical purposes. For example, easy-to-use software can provide doctors with treatment protocols based on the latest science or a database of drug interactions designed to protect patients against possibly deadly adverse reactions. Similarly, consumers, employers, and others can be given reliable information about the likely outcome of choosing one treatment over another, or one hospital or doctor over another. Policymakers must speed this revolution by strengthening the financial and regulatory incentives favoring an information-based health care system.

4. The policy debate should explicitly acknowledge that spending our limited resources only on care that is appropriate and effective is more than an economic necessity: It is also an ethical obligation. Medicare and Medicaid expenditures are hemmed in by drum-tight federal and state budgets. Private companies face intense competitive pressure to control their health benefits costs. Although constraints are inevitable under these circumstances, explicit “rationing” of worthwhile care is not. Cardinal Joseph Bernardin, the late archbishop of Chicago, spoke eloquently before his death from cancer in late 1996 of decisions based on the principle of “stewardship.” The key question, asserted Bernardin, is “how do we best protect human

life and enhance human dignity in a situation of limited health resources?”¹

This paper argues that appropriate professional autonomy and accountability, evidence-based medical practice, implementation of computer technology, and stewardship must all rest on a foundation of widely distributed, reliable information about the processes and outcomes of care. “We now have sophisticated and efficient methods of measuring quality that can help clinicians and institutions improve the quality of the medical care they provide,” wrote RAND Corp.’s Robert Brook

and colleagues. “Our goal should be to ensure that all patients receive care considered to be high in quality on the basis of scientific data and expert judgment.”² The research-and-applications work necessary

If we would only remove the blinders of our present policy debate, we would see a gathering revolution that is poised to transform the everyday practice of medicine.

to improve the quality of medical care is not an alternative to the work of discovery performed by biomedical researchers. Rather, it is a fulfillment of the promise of that biomedical revolution.

If we would only remove the blinders of our present policy debate, we would see a gathering revolution that is poised to transform the everyday practice of medicine. Owing more to laptops than lab coats, it is an information revolution, driven by the goal of finding the most appropriate and effective therapy for each individual patient. It seeks to solve a critical problem: How can doctors and hospitals consistently provide the best possible care?

In search of the answer, researchers are working to turn everyday treatment into a kind of ongoing experiment, one that Yale epidemiologist Alvan Feinstein has called the “observation of clinical events under natural conditions.” Much of the information that results will allow health professionals to improve their traditional work as clinicians and enable patients to become true partners

in their care. Other information will provide unprecedented data for “report cards.”

Which health plan consistently detects and treats breast cancer at its earliest stages? What are the chances of surviving open-heart surgery at the local hospital? Does the choice of surgeon make any difference? Which group of doctors does the best job of preventing acute attacks of asthma or the serious complications of diabetes? Information available to consumers should include not only traditional clinical indicators—say, that a certain drug is effective in shrinking cancer tumors—but also patient-centered measures, such as how quickly a treatment allows an individual to return to work or the routines of family life. Timothy Quill and Howard Brody, physicians and ethicists, write of the advent of an “enhanced autonomy” model of medicine, one in which patients and doctors share information and decision-making responsibility.³

Stewardship demands that our health care system move beyond simply reacting to illness and disease. Although managed care plans cannot, of course, be held accountable for all the factors that influence a person’s overall health, they must begin to reach out to help their members maximize

health and prevent illness—and be judged, at least in part, on how well they fulfill that role. Unless health plans take on the responsibility, managed care will deserve its label as nothing more than the rationing agent of managed cost.

The government, too, has an important role in enabling individuals and health professionals to judge health plans’ quality of care. Congress can move the nation toward the most effective health care system by avoiding ineffective regulations; enabling, encouraging, and disseminating information; and investing in research to advance the measurement of quality of care.

There is little doubt that policymakers will continue to debate the best way to hold down the cost of medical care while ensuring fair access for every American. But the time has come for equal attention to what happens once that access is attained. Trust and pride in the medical community, while deserved, is not and should not be a substitute for accountability. Donald Berwick, a Harvard-trained pediatrician who is one of the nation’s most respected authorities on quality of care measurement and management, frames the challenge facing American medicine this way: “How good you are,” asserts Berwick, “doesn’t say how good you could be.”⁴

2. Marcus Welby Doesn't Live Here Anymore

“The great enemy of the truth is very often not the lie—deliberate, contrived and dishonest—but the myth—persistent, persuasive and unrealistic.”

—President John F. Kennedy (1962)

As our health care system undergoes rapid and often unsettling change, critics have become fond of unfavorably comparing it to the “Marcus Welby-style medicine” that is supposedly being replaced. As spin-control sound bites go, this is a clever one. *Marcus Welby, M.D.* was one of the most popular television shows ever. The genial family physician of the show’s title, portrayed by *Father Knows Best* star Robert Young, was both caring and competent. He never worried about an insurer approving his referrals to a specialist, and no reviewer ever second-guessed his clinical judgment. As University of Pennsylvania communications professor Joseph Turow noted, Welby always “made sure that his patients received cutting-edge care in the shortest possible time.”⁵

Unfortunately, neither Marcus Welby nor the Golden Age of medical practice evoked by his name ever existed. Indeed, far from being representative of the medical care of his time, the fictional Welby made his debut on television precisely when physician autonomy as a guarantor of good care was being discredited in real life. The public and policymakers fully understood the difference between entertainment and reality. So should we.

Consider: When *Marcus Welby, M.D.* premiered on television in 1969, 90 percent of Americans were

covered by some form of public or private health insurance. (Today the figure is about 82 percent.) Virtually all of that insurance used fee-for-service reimbursement, and the much-criticized “utilization management”—the review of the treating doctor’s decisions—was nonexistent.⁶ Yet this system did not produce widespread contentment and good health; instead, public dissatisfaction was pervasive. In 1967, Surgeon General William Stewart openly called U.S. medical care “often of low quality, fragmented and impersonal,” while the House of Delegates of the American Medical Association (AMA) urged doctors to show more restraint in how much they charged.⁷ By 1969, politicians of both political parties were deeply concerned about both cost and quality issues. At a White House press conference, President Richard Nixon spoke of a “massive crisis” in American medicine and called for “revolutionary change.”

The depth of the public unhappiness with medicine in the 1970s is all the more striking because it was such an enormous change from the public attitude toward medicine just 20 years before. The achievements of biomedical research in the years following World War II seemed nothing short of miraculous. There were antibiotics to cure infections, vaccines to prevent infectious disease, and

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new operations for age-old ills. The existence of greedy doctors, poorly run hospitals, and professional cover-ups was no secret, but gratitude muted the griping. “The physician, after all, is organized into a guild whose rules require mutual back scratching and forbid face clawing,” a 1954 article in *Fortune* clucked in an indulgent tone typical of that era. “The physician cannot say aloud that a hospital has weak departments or that a medical school has inadequate equipment.”⁸

But as the years passed, this tolerance wore thin. The bemusement of *Fortune* circa 1954 was conspicuously absent from an editorial in *Fortune* in 1970. “Much of U.S. medical care, particularly the everyday business of preventing and treating routine illnesses...[is] inferior in quality, wastefully dispensed and inequitably financed,” the editorial declared. “[M]ost Americans are badly served by the obsolete, over-strained medical system that has grown up about them helter-skelter.” Like Nixon, a Republican president, the conservative *Fortune* believed the time had come for “radical change.”⁹

Liberals believed that this “radical change” should take the form of a government-financed health insurance system guaranteeing care to all. Conservatives and moderates feared socialized medicine and pushed for a private-sector alternative. The liberals lost, and the result was passage of the Health Maintenance Organization Act of 1973, which gave government support to the establishment of HMOs. The HMO Act was originated by the Nixon Administration and supported by the AMA. This decision to reform health care through marketplace competition, of course, led directly to the present system.

Liberals and conservatives of that time did agree on one point: Accountability in medicine required government intervention. Professional self-control was tried, and it failed. To give just one example, the original 1965 Medicare legislation prohibited

direct government oversight of care. Instead, hospital medical staffs were told to set up their own review committees to make sure that the elderly received appropriate treatment. Yet half of all hospitals never bothered to comply with even this gentle mandate. Congress eventually responded in the 1970s with more comprehensive federal oversight, first by means of Professional Standards Review Organizations (PSROs) and then with Peer Review Organizations (PROs) some years later.

In 1974, with *Marcus Welby, M.D.* still popular, the AMA gave actors Robert Young and James Brolin, who played Welby’s young partner, an award for helping build a positive image of doctors. Meanwhile, in real life, a House subcommittee held the first public hearings on inappropriate care. The public learned about the

Policymakers would do well to remember, even if the nostalgia-mongers do not, that the managed care backlash was preceded by a plain old doctor-and-hospital backlash.

children who were dying because of complications suffered during unnecessary tonsillectomies. (One researcher had found that only 2 percent of tonsillectomies at a group of community hospitals were justified.) Unneeded hysterectomies were also exacting a terrible toll, with young women in their 20s and 30s having their uteruses removed with virtually no clinical justification.

In 1976, *Welby’s* last season on the prime-time airwaves, the *New York Times* ran a series of front-page articles about the dangerous failings of real-life American doctors and hospitals. It is a series that some in the news media might do well to re-read today. At the time, less than 10 percent of the population belonged to HMOs.

Sometime during the Reagan Administration, HMOs and HMO-like health plans became known collectively as “managed care.” Given the experience with *unmanaged* care, managed care seemed an attractive alternative. In 1982, for example, the President’s Commission for the Study of Ethical Problems in Medical and Biological and Behavioral Research concluded that as much as 35 percent of some high-tech hospital care was unnecessary.

(That same year, Congress voted to allow Medicare to try out HMOs on a pilot basis.) By 1993, as national health reform took center stage, a poll commissioned by the AMA found that 70 percent of the population was beginning to lose faith in its doctors. Sixty-nine percent of respondents thought doctors were too interested in making money, up from 60 percent in 1982.

Policymakers would do well to remember, even if the nostalgia-mongers do not, that the managed care backlash was preceded by a plain old doctor-and-hospital backlash. While rapid change always brings with it the temptation to

look backward through rose-colored lenses, the hard truth remains that deep public dissatisfaction with unfettered doctor and hospital autonomy was what led to the explosive growth in managed care in the first place.

We will not succeed in fixing the real problems of managed care that confront us today if we base those efforts on returning to a mythological “good old days” that never were. Instead, we must go forward with a revolution that recognizes both the failings and the triumphs of American medicine.

3. The Science of Caring

“If the study of the history of medicine teaches us anything, it is that clinical judgment without the check of scientific controls is a highly fallible compass.”

—Arthur Shafer, M.D. (1982)

More than half of all medical treatments, and perhaps as many as 85 percent, have never been validated by clinical trials.¹⁰ Even so, the sheer number of articles printed in the scientific literature remains daunting; two out of three physicians claim the volume is unmanageable. In one unnerving illustration of the problem, one-fifth to one-half of the physicians polled in a random survey failed to make use of clinical advances in treating diabetes, asthma, congestive heart failure, and three other common conditions. The doctors either did not know about the newer treatments or had not put them to use.¹¹

The most formidable barrier to consistent excellence in American medicine is neither doctors whose skills are poor nor skilled doctors whose decisions are corrupted by insidious financial incentives. Rather, it is the failure by well-intentioned and competent physicians to carefully examine what works best and then integrate those findings—from the research literature and from systematic evaluation of everyday care—into routine use.

“The perception we all want to have is that medicine is firmly based on reality, [that] our research enterprise systematically identifies important problems, and...information is transmitted

speedily to [doctors], who apply it unerringly,” writes David Eddy, a physician and mathematician who has spent some two decades examining the scientific basis of physician decisions. “Unfortunately, the truth is that the practice of medicine is not based firmly on reality,...the transmission of research information into practice is precarious and the results are used selectively by practitioners.”¹²

The impact of this problem is enormous, but the attention it has received from policymakers and the public is minuscule. By even the most conservative reading of the scientific literature, turning “community care” into “best care” would save tens of thousands of lives each year. It would also fulfill Cardinal Bernardin’s definition of “stewardship”: protecting life and enhancing dignity in a situation of limited health resources. One of the most compelling examples of what is at stake involves heart disease.

Heart disease is deadly and common (the number one cause of death among both men and women in the United States), and it is expensive (total health care costs for cardiovascular disease is more than \$150 billion annually¹³). Yet despite clinical advances that have significantly reduced death and disability from this disease, “how good

we are” is nowhere close to “how good we could be.” For example:

- Inappropriate invasive procedures are distressingly prevalent. Harvard University researchers found that one-quarter of the heart bypasses, angioplasties, and catheterizations (measuring blood flow and blood pressure in the heart) performed on elderly heart attack victims have no effect on patient survival. In other words, thousands of these expensive treatments—which pose a significant risk of complications or death—could be eliminated without any effect on the most critical outcome: life or death.¹⁴ Indeed, a separate study that appeared in May of this year supported the Harvard work, concluding that the strikingly higher frequency of cardiac procedures in the United States versus Canada had no apparent effect on the long-term survival rates of elderly U.S. heart attack victims.¹⁵

- Proven drug therapies, meanwhile, go unused, leading to thousands of unnecessary deaths. For example, one study that carefully examined Medicare records in New Jersey found that just one-fifth of eligible heart attack victims received beta blocker therapy that could have increased their chances of survival by 20 percent to 40 percent.¹⁶ Separately, the Medicare program looked at the treatment of heart attack victims in four states. One-fifth of the victims never received indicated thrombolytic (“clot buster”) therapy that can be critical to survival. In addition, over one-third of the patients who should have been instructed to take one aspirin daily to prevent further blood clots left the hospital without being given that advice.¹⁷

Every 20 seconds, someone in this country suf-

fers a heart attack. As the president of the American Heart Association put it, “All our hard-won knowledge, all the tools we have developed have little value” unless that knowledge is used.¹⁸

- Professional standards governing “best care” are ignored, and the profession does nothing to enforce them. There is a long and well-documented connection between a hospital’s performing a high volume of bypass surgeries and increased patient survival. Yet nearly *one-third* of the 1,023 U.S. hospitals performing open-heart surgery in 1994-95 performed fewer than

the 200 cases per year that professional societies recommend as a minimum.¹⁹

If a television exposé showed that the heart disease patients being cared for by a for-profit hospital corporation, a health maintenance

organization, or a government health facility received the kind of deficient therapy outlined above, there would be an enormous public outcry and demands for change. Yet, because the studies that document these avoidable deaths are academic ones, without pre-identified victims or villains for the nightly news, there is no policy debate at all. Unfortunately, the reality is that the same problems that hurt the quality of heart disease care crop up again and again in the treatment of many other diseases and conditions.

“If we asked the question of whether physicians have based their practice on scientific principles,” says Kenneth I. Shine, president of the Institute of Medicine, “it is clear that the profession has been sorely lacking.”²⁰

Absent the discipline of evidence-based practice and systematic measurement of results, subjectivity reigns. In 1984, the Senate Finance Committee held groundbreaking hearings on the topic of medical practice variation. Since then, little progress has been made. Variation characterizes treatment for

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even the most common of complaints. For instance, when family practitioners in the state of Washington were queried about treating a simple urinary tract infection in women, 82 physicians responded with 137 different strategies!²¹ Too often, however, that variation remains invisible to policymakers and the public.

In late 1996, the revelation that some health plans were denying an overnight hospital stay for women with mastectomies quickly blossomed into a national scandal. Outpatient mastectomies fit easily into the “bureaucrats versus doctors” story line mentioned at the beginning of this paper. (And never mind that later data showed outpatient mastectomies to be more prevalent among fee-for-service providers than among HMOs.) Yet equally worrisome information about variation in breast cancer treatment attracted much more limited attention.

A report from the Dartmouth Center for the Evaluative Clinical Sciences released early in 1996 showed a nearly 35-fold variation in the rate of mastectomies versus breast-conserving surgery given Medicare beneficiaries across the country. Where somebody lived turned out to be an important predictor of treatment for breast cancer, back pain, prostate disease, and other conditions. The Dartmouth researchers concluded that as far as health care is concerned, “geography is destiny.”

Which is more disturbing, a woman’s being given only a 24-hour hospital stay after a mastectomy, or her unnecessarily losing that breast to surgery in the first place based on where she lives? To even pose that question illuminates the importance of viewing quality of care as something synonymous with physician practice, not just physician autonomy.

There is perhaps no better example of the pressing need for autonomy to be balanced with accountability than the care of pregnant women. After all, the poster child of the managed care backlash was the united effort against “drive-by deliveries.” State legislatures, Congress, and the President all responded to the alarm sounded by the American College of Obstetricians and Gynecologists (ACOG) about potentially dangerous in-

adequate postpartum stays for mother and baby. ACOG members felt that their ability to be advocates for their patients was compromised by health plans interested only in reducing the hospital expenses of their members.

But consider, for a moment, the pitfalls of unchecked autonomy, as seen by the profession’s reaction to a book called *Effective Care in Pregnancy and Childbirth (ECPC)*. *ECPC*, while generally unknown to the public, is a groundbreaking work. It contains the most comprehensive review anywhere of all clinical trials in the world related to childbirth. Disturbingly, it concluded that one in five clinical interventions actually did more harm than good, while many others were unproven.

I asked an official of ACOG why *ECPC*—and its successor, a database of clinical trials on childbirth—had been virtually ignored by American obstetricians. She cited its cost for a hospital—\$500 to \$600—and the fact that it was not published in the United States and contained many clinical trials from other nations. In fact, *ECPC* was published in England (although it is available here) by the Cochrane Collaboration, whose long-time head is affiliated with Oxford University. “I don’t say [*ECPC*] is not valuable,” the ACOG official told me, “It’s just basically not made from things in this country.”²²

Perhaps. But the *American Journal of Obstetrics and Gynecology* recently confirmed in its pages that routine episiotomies—one of the procedures singled out by *ECPC* as doing more harm than good—are often unjustified. The common surgical procedure was “introduced in clinical practice in the eighteenth century without having strong scientific evidence of its benefits,” said the journal article. However, based on the evidence of five randomized controlled trials, “there is no reliable evidence that routine use of episiotomy has any beneficial effect; on the contrary, there is clear evidence that it may cause harm”—including “a poorer future sexual capability.”²³

Is a treatment that helps or harms a mother and baby in Manchester, England, really of no interest to a mother and baby in Manchester, Connecticut? And should the United States, a nation whose

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population is scattered over the width of a continent and in islands located on two oceans, really accept that “geography is destiny” when it comes to the best medical treatment?

To be sure, patients also bear some blame for the lack of science-based medical practice. One moment, we are acceding to the doctor’s judgment about therapy without asking a single question about treatment alternatives or expected outcomes. The next moment we are brushing aside the doctor’s judgment and demanding treatments that are unproven or of dubious value. The same public that fervently believes that “medical costs are unreasonable”²⁴ also thinks that “health insurance should pay for any treatment that will save lives, regardless of the cost to save one life.”²⁵ If patients

are to hold health professionals accountable, then we must also hold ourselves accountable for responsible behavior. That, too, is part of stewardship.

The task of making sure that everyday medical practice conforms to the best available scientific evidence is one that goes beyond the American medical community and confronts health professionals worldwide. In 1994, the *British Medical Journal* called on doctors “to promote the uptake of innovations that have been shown to be effective, to delay the spread of those that have not yet been shown to be effective and to prevent the uptake of ineffective innovations.”²⁶ It is past time for the public and policymakers to help health professionals take up that challenge.

4. Accountability in the Information Age

“What has not emerged from the oft-times emotional discussions [of managed care] is a cogent examination of the impact of the transformation of medical practice from a cottage industry to a corporate enterprise.”

—Carolyn Clancy and Howard Brody,
Journal of the American Medical Association, January 25, 1995

“Managed care means managed information.”

—*Modern Healthcare*, February 13, 1995

As this paper has shown, the need to examine our care more closely has no intrinsic connection to a particular health insurance mechanism. Just as the medical profession has been unable to adequately police itself, so, too, have managed care plans failed to patrol their own ranks despite obvious signs of trouble. For example, HMO “horror stories” centering on denied access to needed care appeared in the news media in Chicago, Houston, Miami, and Minneapolis-St. Paul during the mid-1980s. During this same period, the first lawsuits were filed accusing HMOs of improper “gatekeeper” incentives.

Yet in the absence of the pressure generated by national media coverage or threatened government regulation, the HMO industry did nothing. The American Association of Health Plans’ “Patients First” initiative contains a number of praiseworthy proposals, but the effort is primarily a reaction to the scores of anti-managed-care bills in state legislatures and Congress. The group’s actions call to mind the writer Samuel Johnson’s acerbic observation that “when a man knows he is to be hanged in a fortnight, it concentrates his mind wonderfully.”

Still, the potential for a well-organized health

plan to provide truly effective care management remains a powerful argument in the industry’s favor. As far back as 1952, the President’s Commission on the Health Needs of the Nation, chaired by the eminent surgeon Paul B. Magnuson, suggested that physicians working in group practices could provide higher quality care at relatively lower cost by pooling scientific knowledge and sharing overhead. Today, some health plans and integrated delivery systems are finally accepting the challenge to efficiently organize the actual practice of medicine. In doing so, they provide an example of actions policymakers should encourage. For instance:

- In Boston, Harvard Pilgrim Health Care has pioneered a “disease management” approach toward children with asthma. Data on drug prescriptions, hospital admissions, and emergency room visits were used to identify those at risk. An outreach program—teaching children and their parents how to use peak-flow meters and inhalers—cut inpatient admissions by 86 percent and emergency room visits by 79 percent in the initial pilot phase and has continued to be successful as more children are included. Moreover, asthmatic children reported

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a significant increase in their ability to function at school or home, as measured by a standardized, patient-oriented, health status questionnaire.

Chronic conditions such as asthma affect an estimated 100 million Americans. The “disease management” approach for asthma treatment was endorsed earlier this year by a consensus panel of the National Institutes of Health (NIH).

- Kaiser Permanente’s Southern California region is a leader in managing preventive care to maximize the health of its entire member population. Kaiser physicians historically used the Pap smear screening test for cervical cancer the same way as their fee-for-service counterparts. Women who visited their doctor got an annual screening and were given an appointment for a new screening the next year. But an analysis of the plan’s membership rolls showed that only six out of 10 women eligible for the Pap test were receiving it. Kaiser’s response was to stretch out the testing of women who were not at risk for contracting this slow-growing cancer to every two to three years—a change consistent with the scientific literature. Next, the plan launched an outreach program aimed at filling the appointment slots that then became available with those women who were not typically tested.

Kaiser ended up administering one-third *fewer* tests for each thousand women members, yet the number of cervical cancer detected at an invasive stage did not increase. To the contrary: the new policy *doubled* the number of women who were found with precancerous cells. Treatment at that stage, of course, is far more effective and less expensive—not to mention less worrisome for the patient. Last year, an NIH consensus panel concluded that nearly all the 5,000 deaths attributed to cervical cancer each year in the United States could be eliminated if screening were extended to the women who are now overlooked.

- In Twin Falls, Idaho, the Magic Valley Health Network, an organization owned by physicians, is undertaking population-based outcomes studies to determine the effectiveness of the care its members provide and then improve it. As part of its contract with the local medical center, the doctors’ organization has agreed to build a clinical database allowing its members to monitor what happens to patients not just in the hospital but in doctors’ offices and in the broader community. One of the group’s first projects is improving the outcomes of heart attack patients.

There are many, many similar examples of health plans and integrated delivery systems across the country. For instance, Albuquerque’s Lovelace Clinic Foundation is using patient surveys, medical records data, charts, administrative data, and other sources to track patient outcomes. Patients visiting different clinic sites for treatment of back pain now get more consistent and better therapy throughout each episode, the foundation says. At the same time, many Lovelace physicians welcome the support and guidance they are getting toward giving “best care.”²⁷

All projects, however, share one common thread. It is not technology or the size of a metropolitan area that is the most important ingredient for success. Instead, proper financial incentives and management willpower are the keys to moving toward a health care system that uses the tools of the clinical evaluative sciences to attain measurable medical excellence. Financially, none of these projects would ever have been undertaken—or ever was undertaken—in the bygone Golden Age world of “the more you do, the more you get paid” medicine.

Regina Herzlinger, a professor at Harvard Business School, says accountability in the marketplace depends on what she calls DADS: disclosure, analysis, and dissemination of performance information.²⁸ Until very recently, there has been little reason for those in medicine to commit the time

and money necessary to make DADS work. When doctors and hospitals controlled the market, a high price was simply labeled a proxy for high quality. In the absence of information about outcomes, patients accepted “trying hard,” “doing everything,” or “caring.” That era, however, is nearing an end.

For example, 13 of the largest and most prestigious U.S. cancer treatment centers last year formed a National Comprehensive Cancer Network. By doing so, they all committed themselves to using practice guidelines “to diminish variations that negatively impact quality of care and health care costs,” as Rodger Winn, a medical oncologist at Houston’s M.D. Anderson Cancer Center, told the Reuters news agency. Winn, the chairman of the group’s guidelines steering committee, acknowledged that economic competition provided the impetus for this unique pact to measure, manage, and improve cancer treatment.

In fact, a number of organizations, both for-profit and not-for-profit, are following a similar strategy of collecting information on quality of care for competitive advantage. Oxford Health Plans, based in Norwalk, Connecticut, is moving rapidly to assemble performance data on groups of health professionals who provide treatment for precisely the kind of specific clinical conditions that interest patients; for example, cataract removal and bypass surgery. Consumers should welcome this trend: If there is ever a 35-fold variation in the rate of mastectomy versus breast-conserving surgery at two competing cancer care networks, one can be sure that the difference will receive a great deal of attention.

As the above examples make clear, the actions of health plans, hospitals, and health professionals are a direct response to the pressure of the marketplace—to capitalism, if you will. “You can’t manage what you can’t measure” has become a rallying cry of a growing number of large corpora-

tions. Almost two years ago, in a September 1995 report, the U.S. General Accounting Office concluded: “Employers and individual consumers we interviewed wanted performance reporting efforts to continue. In fact, they are requesting more data than are publicly available.”

In the private sector, leaders in “value purchasing” on the basis of quality as well as cost include such well-known names as GTE; Hershey Foods; PepsiCo; and Xerox. Employers have also banded together in coalitions, with the more prominent exponents of value purchasing including the New York-based National HMO Purchasing Coalition;

Cleveland Health Quality Choice; the Twin Cities’ Buyers Health Care Action Group; and the San Francisco-based Pacific Business Group on

Health. In addition, employers have joined with consumer groups and government agencies to form the Foundation for Accountability, Inc. (FAACT), which pushes for the use of standardized performance measures.

Marketplace pressures have also motivated virtually every professional and trade group in health care to push for better measures of its members’ performance. More than a decade ago, George Lundberg, editor of the *Journal of the American Medical Association (JAMA)* urged: “The single most important thing that American medicine...should do is define quality indicators and follow them.”²⁹ Finally, the medical community is starting to follow that advice.

Still, although the infrastructure of an Information Age medicine is under construction, it remains to be seen how fast it will be built, whether health professionals and others will use it, and whether the information that private organizations make public will be that which is needed the most. It is in assuring the availability, standardization, comprehensiveness, and fairness of information that the role of the government becomes crucial.

“You can’t manage what
you can’t measure”

5. The Role of Government

“The provision of medical care has become one of the largest industries of the country. Within the lives of many now living, revolutionary changes in science have transformed medicine from a comparatively simple field into a complex domain....Until recently, people...rested content because medicine is in good hands. But the unprecedented growth of medicine, the enormous expansion of personnel and facilities, the investment of billions of dollars have created issues from which society cannot escape merely through its own optimism or through confidence in the high character of medical practitioners.”

—Former AMA president Ray Lyman Wilbur, M.D.,
Chairman of the Committee on the
Costs of Medical Care, in a 1933
committee report

The introduction of marketplace discipline into economically protected industries is not a pretty sight. Managed care horror stories are not much different in kind from the tales of paid-by-the-mile truckers falling asleep at the wheel or of discount airlines cutting corners on maintenance. Congress, however, has been able to differentiate between the need for tough oversight of the Federal Aviation Administration and the need for a federal law mandating a certain number of rest hours for pilots. Legislators should exercise the same wisdom in health care. “Legislating by body part” may propitiate the gods of public opinion polls and send a satisfying message to managed care miscreants. But unfortunately, politicians at both the state and federal level are far too ready to rush in where even knowledgeable physicians fear to tread.

What should be the proper role of government in moving the nation toward a health care system of consistent and measurable excellence? The test of any legislative proposal must be its ability to follow the four principles enunciated in the beginning of this paper:

1. Avoid false nostalgia by encouraging appropriate physician autonomy and accountability;
2. Move toward evidence-based medical practice;
3. Speed the implementation of Information Age medicine; and
4. Build a system that balances the needs of economics with the ethics of stewardship.

Below are some steps Congress should take along this path.

Avoid Ineffective Regulations

When government attacks nuanced medical controversies with the blunt stick of legislation, there is a large potential for mistakes. The law of unintended consequences may turn out to be just as important as the original legislative purpose.

For instance, while it may seem self-evident that

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a physician's judgment about the best course of patient care should never be muzzled in the name of profit maximization, consider this twist on "gag rules." As we have seen, individual physicians can hold strong opinions that simply are not supported by the scientific evidence. If, for example, an obstetrician insists that each pregnant patient receive three ultrasound scans, and the evidence supports only one, should the doctor be permitted to tell her patients and/or the local media that the plan is "rationing" care? Similarly, "any willing provider" laws undermine the ability of a health plan to choose doctors and hospitals willing to standardize their practices to meet the quality goals of a particular "brand name" network.

Policymakers intent on protecting appropriate professional autonomy should not be deceived by the Golden Age of Medicine spin-meisters and inadvertently shield doctors from needed accountability.

"Legislating by body part" also places lawmakers in the absurd position of trying to determine the proper way to practice medicine—and then freezing that practice into law even as science and technology continue to advance. Letting Congress and state legislators write detailed patient treatment plans is like commissioning the Defense Department to write specifications for hammers and toilet seats.

"Congress should stay out of this process," argued Harvard Medical School's Suzanne Fletcher in a recent *New England Journal of Medicine* commentary reviewing the controversy over the proper interval for screening mammograms for women in their 40s. "In the long run, the health of Americans will not benefit if this technical task moves from the scientific community to the Congress....Where scientific disagreement is strong, policymakers should take note and move cautiously, if at all...."³⁰

Enable, Encourage, and Disseminate Information on Care

Early in the first Reagan Administration, the Federal Trade Commission (FTC) explored what role was best played by government and by the private

sector in making markets work efficiently. In a July 1981 report entitled *Comparative Performance Information*, the FTC staff concluded that some vital actions related to information were not likely to be taken by the private sector because the benefits tend to accrue to the public at large. These included:

- The development of a standard system of measurement, a standard test, or even a standard use of language;
- The education of consumers concerning such standards; and
- The production and collation of general information or of information applicable to all brands of a given product.

Today, consumers and purchasers have ready access to information about the cost of care. Quality is a different story. Even consumers savvy enough to ask the right questions are far from assured that they will get substantive answers. Indeed, the Iowa Supreme Court recently rejected the request of an Iowa woman who sought to find out the nosocomial (hospitalization-caused) infection rate at the University of Iowa Hospitals & Clinics prior to undergoing surgery there. The 52-year-old woman unsuccessfully argued that the state-funded institution was subject to freedom of information laws. However, the hospital, with the support of the state hospital association, persuaded the court that releasing the data would cause doctors to stop reporting infections, thereby running counter to the public interest. (On the other hand, the Iowa Medical Society said it plans to produce reports on patient clinical outcomes that society members can use in marketing—a somewhat different definition of public interest.)

Clearly, government intervention is needed in the following ways to promote the public's interests:

Developing standards that enable the production of information. The information gap on health professional performance must be filled with reliable data on everything from health plans' rules and

procedures, to outcomes information about specific hospitals and, eventually, physicians. The free flow of reliable information about the quality of care is necessary to encourage and support the development of best practices for medical care. The government's primary role, however, should be to ensure the provision of information that enables individuals and health professionals to judge the quality of care, not to do the judging itself. Just as the government ensures that financial investors have access to comprehensive and standardized information on publicly held companies, it must make certain that consumers have comparable access to information on the quality of health care. For example, one little-known Florida hospital truthfully advertised itself as having a lower rate of bypass surgery deaths than the Mayo Clinic, the Cleveland Clinic, or the Texas Heart Institute. However, the mortality rate, drawn from government figures, was not risk-adjusted to account for how sick the patients were before treatment. If properly scored, the Florida hospital would very likely not rate as high.

Several bills before the 105th Congress address this issue of reliable information. Senate and House of Representatives versions of the Balanced Budget Act of 1997, which would enact the budget agreement between President Clinton and congressional leaders, would require managed care plans to provide data on the outcomes of the health care they provide. Senator Joseph Lieberman (D-CT), along with a bipartisan group of senators, recently introduced legislation to establish a public/private partnership to set requirements for health care plans contracting with the government to release information on their quality of care. Separately, Senator Ron Wyden (D-OR) has sponsored legislation to set quality indicators for managed care plans and public reports that would give Medicare ben-

eficiaries clear comparisons with which to make choices about a plan.

Regardless of the information strategy that is finally adopted, the government will certainly retain its regulatory role, making sure that health plans and health professionals meet certain standards. Although licensure and inspections have been the traditional tools used, a more innovative approach would be to "deem" private sector accreditation organizations with the power to achieve ambitious publicly set goals. That technique both

pulls in more resources to quality improvement from outside the parched federal budget and allows for more flexible management. One example is a California law, effective July 1, 1998, that gives terminally ill patients the right to an external, independent appeal of a health plan's

decision to deny coverage for an experimental or investigational treatment. That appeal is heard by a private, science-based organization, not by a government agency.

Promoting the use of information. Government can support public awareness and education programs, the way that it has done on environmental issues or on nutrition. Moreover, federal agencies such as the Department of Veterans Affairs (VA) or the Health Care Financing Administration (HCFA) can throw their weight into local educational efforts. The federal government can also require dissemination of accurate information about the quality of care by any hospital or health plan serving Medicare patients—a step with the potential to transform the information marketplace virtually overnight.

Additionally, policymakers should consider giving health professionals new legal protection from the possible repercussions of quality "report cards" that will inevitably show differences in performance. Two Brooklyn Law School professors have noted that

The government's primary role should be to enable individuals and health professionals to judge the quality of care, not to do the judging itself.

a patient might be able to successfully sue for damages if his hospital's mortality rates for a procedure were relatively high, "even in the absence of proof that the procedure itself was poorly performed [on the patient]." ³¹ In a society where criminals successfully sue the police for shooting them, opportunistic malpractice suits could quickly turn the Information Age into the Deposition Depression.

Invest in Research to Advance Quality Measurement

Whatever other actions are ultimately decided upon, the need for more research to boost evidence-based practice is clear.

In 1989, Congress responded to a burst of concern about variation in medical practice by establishing the Agency for Health Care Policy and Research (AHCPR). However, the little-known agency was almost killed in 1995, in part because a group of spine surgeons greatly disliked an evidence-based guideline that downplayed the need for back surgery. The agency was reprieved at the last minute, but continues to labor under a limited budget that can produce shocking gaps between research the public desperately needs and the resources available to fund it.

For example, at a time when the public and policymakers have urgent questions about quality of care, AHCPR recently announced that it has all of \$2 million to fund projects that will provide "the essential science base" for tools "to measure the effect of rapid changes in the delivery of health

service." Moreover, that \$2 million for "essential science" research in medical quality measurement and improvement isn't available until 1998, and it must be stretched to cover projects of up to five years in length.

To put that funding into further context, \$2 million is one-hundredth of the amount the government plans to spend to subsidize the production and marketing of sheep and goat products. ³²

Congress should provide a fresh infusion of research funding that reflects this area's growing importance. At the same time, Congress should also insist on coordination of the current research in this area sponsored by AHCPR, the VA, the National Institutes of Health, the Centers for Disease Control and Prevention, and others. Congress should also support HCFA's innovative efforts to bring understandable information about the quality of care to Medicare beneficiaries in a variety of formats, including on-line through the Internet. Accountability and responsibility will always be two sides of the same coin, and consumers should be encouraged to take responsibility for their own health.

Promoting the use of performance information in medicine is truly a bipartisan issue. It was recommended by the National Information Infrastructure Task Force of Vice President Al Gore. And as House Speaker Newt Gingrich told the American Hospital Association in a January 30, 1995, speech: "You've got to have marketplace information available so people can call and say, 'What do you do? How much do you charge? And what is your outcome like?' And they need to be able to do it before, not after [receiving care]."

6. The Common Goal

“[T]he natural interests of the practicing physician are identical with the natural interest of the consuming public. The enemy, after all, is neither patient nor doctor. The enemy is disease.”

—Richard Carter, *The Doctor Business* (1958)

“He who saves one life...is as if he saved the entire world.”

—The Talmud, *Sanhedrin* 37:A

Regardless of a country’s system for financing medical treatment, there will always be an urgent need to measure, manage, and improve the quality of care. Indeed, the same forces that have brought the movement to improve quality to prominence in this country are international in scope. Britain’s National Health Service is a leader in evidence-based medicine. Government ministries in Australia and Austria are trying to reduce medical errors. The French are backing development of a medical information infrastructure, and Norway’s general practitioners are exploring the use of quality indicators and standards and the development of medical records software. Even Chinese leader Jiang Zemin exhorted physicians at a conference last year

to “work hard to improve their quality” in the face of economic pressures to control costs.³³

The revolution that is now transforming medicine does not mean that physicians will have to practice according to the dictates of some rule book. Nor will it force individuals who are sick into becoming medical comparison shoppers at the time of their greatest vulnerability. To the contrary: the information revolution in medicine brings with it a precious opportunity to greatly enhance both curing and caring. The goal is a patient-physician partnership that consistently uses the best of medical knowledge to help every person who needs care. The pursuit of genuine stewardship of our health care resources demands that we settle for nothing less.

Notes

- ¹ Cardinal Joseph Bernardin, "Managing Managed Care" (address to the International Association of Catholic Medical Schools, Loyola University, Chicago, IL, May 13, 1996). Official text from the Archdiocese of Chicago.
- ² Robert Brook, Elizabeth McGlynn, and Paul Cleary, "Part 2: Measuring Quality of Care," *New England Journal of Medicine* 335, no. 13 (September 26, 1996): 966, 969.
- ³ Timothy E. Quill and Howard Brody, "Physician Recommendations and Patient Autonomy: Finding a Balance between Physician Power and Patient Choice," *Annals of Internal Medicine* 125, no. 9 (November 1, 1996): 763-69.
- ⁴ Donald Berwick, M.D., interview by author, March 1, 1995.
- ⁵ Joseph Turow, *Playing Doctor: Television, Storytelling, and Medical Power* (New York: Oxford University Press, 1989), 133.
- ⁶ In 1970, there were just three million people, out of a total U.S. population of 203 million, enrolled in 33 HMOs nationwide. There were no Medicare or Medicaid HMOs, and even among the privately insured, HMOs covered less than 2 percent of the population.
- ⁷ "The privilege of a physician to charge usual and customary fees will continue to require prudence," the American Medical Association House of Delegates advised in a 1967 resolution.
- ⁸ Henry Maurer, "The M.D.'s Are Off Their Pedestal," *Fortune* (February 1954): 139-186.
- ⁹ "It's Time to Operate," *Fortune* (January 1970): 79.
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- ¹² David M. Eddy, "Medicine, Money and Mathematics," *American College of Surgeons Bulletin* 77, no. 6 (June 1992): 36-49.
- ¹³ American Heart Association, *1997 Heart and Stroke Statistical Update* (1997), 28.
- ¹⁴ Mark McClellan, Barbara J. McNeil, and Joseph P. Newhouse, "Does More Intensive Treatment of Acute Myocardial Infarction in the Elderly Reduce Mortality?" *JAMA* 272, no. 11 (September 21, 1994): 859-66.
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- ¹⁶ Stephen B. Soumerai et al., "Adverse Outcomes of Underuse of beta-Blockers in Elderly Survivors of Acute Myocardial Infarction," *JAMA* 277, no. 2 (January 8, 1997): 115-21.
- ¹⁷ Similarly, a study by Yale University's Harlan M. Krumholz and colleagues in the June 4, 1997, issue of *JAMA* concluded that "many eligible and ideal [elderly] patients for thrombolytic therapy are not treated."
- ¹⁸ Statement of Sydney Smith Jr., president of the American Heart Association, to the opening session of the group's 1995 annual meeting. See Associated Press, "Study: Many Miss Heart Care" (November 14, 1995), transmitted via ClariNet Corp.

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- ¹⁹ Data from SMG Marketing Co., Chicago, for 1994-95, based on government statistics. Personal communication by author with John Henderson, president of SMG, on June 13, 1996.
- ²⁰ Remarks of Kenneth I. Shine, M.D., contained in a press release of the New York Academy of Sciences for its conference, "Beyond the Crisis: Preserving the Capacity for Excellence in Health Care and Medical Science," February 14-15, 1994.
- ²¹ A.O. Berg, "Variations Among Family Physicians' Management Strategies for Lower Urinary Tract Infection in Women: A Report from the Washington Physicians Collaborative Research Network," *Journal of the American Board of Family Practice* (September/October 1991): 327-30.
- ²² Luella Klein, M.D., interview by author, October 3, 1995. Klein, professor of gynecology and obstetrics at Emory University and the director of women's health issues for the American College of Obstetrics and Gynecology, noted that the two-volume *Effective Care in Pregnancy and Childbirth* cost \$500 to \$600. Klein said that she personally was a fan of the Cochrane Collaboration's director, Iain Chalmers, but "it's a very expensive book, it's not an American textbook, and it's not a book that's well-known in this country....It may be very provincial to say that, but we don't very much read English, European, or other textbooks....I don't say it's not valuable, [but] it's just basically not made from things in this country."
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- ³¹ Aaron D. Twerski and Neil B. Cohen, "Comparing Medical Providers: A First Look at the New Era of Medical Statistics," *Brooklyn Law Review* 58, no. 1 (Spring 1992): 5-34.
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