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# LETTERS

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## Health Care And Consumers: Some Amplification

To the Editor:

If war is too important to be left to the generals, health care is too important to be put in the hands of policy analysts such as James Robinson, whose review of my best-selling, award-winning book, *Market-Driven Health Care*, reveals a complete lack of understanding of health care management (“Apotheosis of the Health Care Consumer,” *Health Affairs*, November/December 1997).

As my book describes, the market forces that revolutionized the once-bloated U.S. economy are now reshaping health care. Activist consumers’ demands for accountability, convenience, and control are making the system more informative and accessible. The focused-factory concepts that revived the nation’s manufacturing sector and fashioned its world-class service sector are now shaping high-quality, cost-controlled health care delivery systems. And the sort of technological innovations that have increased productivity since the Industrial Revolution are improving the quality of health care while controlling costs. Brilliant entrepreneurs are using the managerial lessons learned from successes such as Sam Walton to create a better, cheaper, more accessible health care system.

Although full-page reviews of my book in journals as diverse as the *Journal of the American Medical Association* and the *Economist* lauded its focus on management issues, in Robinson’s view the forces that shape our free-market economy cannot do the same in health care.<sup>1</sup> For one, consumers are too stupid, he feels, to function effectively in the health care market.

True, not everyone in the market is brilliant, but markets could never function if they required genius IQs of all their participants. As I discuss in the book, good markets require that approximately 16–20 percent of consumers be knowledgeable. These thought leaders are used as sources of information by others.<sup>2</sup> Abundant, reliable, published information is another characteristic of effective markets. The computer market is a perfect illustration of this dynamic. Reliable evaluations and thought leaders have caused computers to become better and cheaper, although most of the buyers are not highly knowledgeable about the technology.<sup>3</sup> The health care market certainly has enough activist consumers; all it needs now is information.<sup>4</sup>

As for lessons to be learned from suppliers, businesspeople such as Walton—don’t make Robinson laugh. To his way of thinking, that creator of stores that provide a wide variety of merchandise at low prices in underserved rural areas, and of wondrous worker teams, supplier relationships, and information systems, has nothing to teach him about health care.<sup>5</sup> Robinson also dismisses the lessons for health care from the focused factories that revived our manufacturing sector and the focused service organizations, such as Federal Express, that shaped our service sector.<sup>6</sup> These firms lower costs and improve quality, whether they are steel mini-mills; retailers, such as Wal-Mart; or health care providers, such as the open-heart facility led by the world-famous surgeon Denton Cooley, whose high-quality procedures came at a price 33 percent lower than that charged by unfocused, everything-for-everybody providers.<sup>7</sup>

Robinson’s lack of interest in management is evident in his review. Although he calls Johnson & Johnson (J&J) a conglomerate, most others know the difference between a multidivisional health care product company such as J&J and the virtually abandoned conglomerate form, once manifested in ITT.<sup>8</sup> And I hope that not too many travel agents have

exploited Robinson's inability to distinguish diagnosis-related groups (DRGs) from a price for total disease care to sell him a plane ticket as the equivalent of an all-expense-paid vacation. This review does not even demonstrate the prowess in "orthodox economics" that Robinson claims can overcome the stupidity he sees all around him. For example, what theory supports his apparent belief that market-driven health care inevitably creates oligopolistic provider networks for managed care?

That having been said, is health care policy totally irrelevant to the transformation taking place in this country? Not at all. As I describe in my book, activist government is essential to generating accurate information, via a model akin to the Securities and Exchange Commission (SEC) and the Financial Accounting Standards Board (FASB); to

protecting against supplier and consumer fraud; and to providing a safety net for the poor. Yet here, too, Robinson misstates my views. His statements that I propose to "get rid of health insurance" and oppose insurance for "preventive and primary care" are preposterous. In fact, I advocate the opposite: I would require consumers to purchase health insurance that provides them with the ability to obtain all of the health care they need, and the focused-factory model I laud motivates providers to emphasize preventive care.

Not surprisingly, Robinson's review cannot accurately predict readers' response to my book. Despite his advice to physicians to "stay away," *Market-Driven Health Care* has been reprinted eight times and won the Book of the Year Award from the American College of Healthcare Executives in 1998. I have been invited to speak to tens of thousands of doctors and other providers in scores of meetings. The great majority of these persons understand that the lessons I draw from the experience of other industries can help them to do a better job of improving the quality and efficiency of

their responses to consumers' needs. They are empowered, not intimidated, by the lessons in my book.

An important test for any work affecting the public is to think about reactions to it on the pages of major newspapers such as the *New York Times*. The test challenges someone who may be mired in an insular intellectual framework to consider the impact of his or her views on a wider, more diverse audience. It will be interesting to see the results when this

test is applied to Robinson's denigration of the astuteness of the American consumer, altruism of the American public, competence of health care providers, and ability of businesspeople to provide high-quality, efficient goods and services. In this venue Robinson will likely find that these people hardly substantiate his portrayal of them as inferior beings who need health econo-

*"I would require consumers to purchase insurance that provides them with the ability to obtain all the health care they need."*

mists to guide them onto the right path.

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#### NOTES

1. "Books, Journals, New Media-Health Systems: Market-Driven Health Care," *Journal of the American Medical Association* (27 August 1997): 686; and "Hamburgers and Hernias," *Economist*, 9 August 1997, 55.
2. P.W. Turnbull and A. Meenaghan, "Diffusion of Innovation and Opinion Leadership," *European Journal of Marketing* 14, no. 1 (1980): 3-33.
3. See, for example, R. Langlois, "External Economies and Economic Progress: The Case of the Microcomputer Industry," *Business History Review* (Spring 1992): 1-50; and N. Templin, "Megabyte Markdown," *Wall Street Journal*, 6 May 1996, B1.
4. See, for example, R.E. Patterson, "Health Lifestyle Patterns of U.S. Adults," *Medical Benefits*, 15 October 1994, 11; and American Board of Family Practice, *Rights and Responsibilities Part 2* (Lexington, Ky.: American Board of Family Practice, May 1987), 38.
5. "The Evolution of Wal-Mart," *Harvard Business Review*, May-June 1993, 82; A. Beam, "Meltdown Main Street," *Boston Globe*, 27 October 1993, 11; and H. Rudnisky, "How Sam Walton Does It,"

*Forbes*, 16 August 1982, 42.

6. J.L. Haskett, W.E. Sasser, and C.W.L. Hart, *Service Breakthroughs* (New York: Free Press, 1990), 16.
7. S. Greenhouse, "Mini-Mills: Steel's Bright Star," *New York Times*, 24 February 1984, D1; Denton Cooley, personal communication, 31 July 1996; and A.R. Myerson, "It's a Business. No, It's a Religion," *New York Times*, 13 February 1994, D1, D6.
8. For example, in the obituary, "Harold Geneen" (*Economist*, 5 December 1997, 99), the writer clearly distinguishes between the conglomerate that Geneen created in ITT, which once owned hotels and telephone systems, and a multidivisional firm, such as General Motors and Johnson & Johnson.

## Health Care And Consumers: The Author Responds

To the Editor:

If you liked Regina Herzlinger's letter, you will love her book. In the larger work you will find the same measured tone, the same intellectual profundity, and the same judicious use of analogy and statistics. *Caveat emptor*.

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## Can Physicians Manage Physicians?

To the Editor:

I enjoyed Victor Fuchs's intelligent and perceptive comments ("Physicians as Agents of Social Control," *Health Affairs*, January/February 1998). Of particular interest are his views on the erosion of medical professionalism and the increasing "corporatization" of health care. Although I share his concerns, I hope that it is possible to build an organization of physicians and other health care professionals that, as a unit, believes that it has a fiduciary relationship with the population it serves.

Concerning the corporatization of medicine, we must not forget that both publicly traded and not-for-profit companies are capable of doing a poor job of health care delivery. On the brighter side, however, if the playing field is leveled to prevent risk-shifting and cherry-picking (inherent evils whenever the insurance function plays a major role), I do not see why for-profit entities must necessar-

ily shy away from doing the "right thing." There is still significant waste and inefficiency in the system, and, theoretically at least, profit-driven companies should have an incentive to invest in patient retention and disease prevention and to provide appropriate care. Moreover, for-profit entities should be interested in decreasing unnecessary practice variation, engaging in aggressive ambulatory care management, and understanding pharmacoeconomics. To do this successfully, however, requires active physician leadership and management. Doctors are more likely to be able to successfully manage physicians than any other managers are.

Fuchs's points are particularly relevant when viewed from my rapidly changing corner of the world in which provider groups and health maintenance organizations (HMOs) are large, and mergers and acquisitions run rampant. The health care scene has changed so much over the past decade that an organization such as ours can no longer survive. After a successful ten-year "run," the Medical Quality Commission (TMQC) ceased operations 31 March 1998.<sup>1</sup>

TMQC was formed based on a few founding principles. First and foremost, we understood that many industry problems could best be addressed by an organization governed and financed by multiple health care segments, including but not limited to health plans. Our industry and profession have always been plagued by thorny issues that adversely affect quality, patient satisfaction, and health care costs and that persist amid the competitive and adversarial milieu of stakeholders who hold the keys to solutions. Our belief in collaboration held that both the government and stakeholder institutions were at times incapable of effectively identifying and addressing such problems.

Through its brief ten-year history, TMQC engaged in a multitude of collaborative problem-solving ventures. Our role was to identify the problems and the stakeholders required for their solution. We then "bought the coffee and doughnuts," convened the group, locked the doors, and hunkered down until resolu-

tion was in sight. Our job was straightforward. Each participant agreed that (1) a problem existed that decreased quality and/or increased costs; (2) the necessary parties were at the table; (3) the problem had not been successfully addressed in the past and, but for this venture, would not be solved in the foreseeable future; (4) TMQC was a neutral convener; and (5) no one was going home until the problem was solved.

A second core TMQC belief was that provider organizations (medical groups, independent practice associations [IPAs,] and other weird arrangements, a.k.a. OWAs) should be scrutinized. Our primary product was, of course, medical group (and later, IPA) accreditation, an idea whose time, it seems, has not yet come. TMQC had its loyal core of western medical groups, almost all of which were Unified Medical Group Association (UMGA) members. But the marketplace never rewarded those early adopters who sought accreditation. Performance measures have recently been applied to medical groups and IPAs in the form of the Physician Value Check Survey, a joint project conducted with the Pacific Business Group on Health, but it is difficult to survive on research grants supporting performance measurement. In the end, an accreditation organization can not sustain itself on just a few accreditations per year. The National Committee for Quality Assurance (NCQA), through its Provider Organization Certification program, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), through its Network Accreditation product, both seek to enter the medical group accreditation market, but the jury is still out as to whether the market will provide sufficient volume for such endeavors to be financially stable. I think that we have got a ways to go before there is widespread demand for provider organization accreditation. I hope that I'm wrong.

*"It will be a long time before we can quickly, cheaply, and accurately measure the output of (and accredit) each and every physician."*

A third core TMQC belief came from its parent organization, the UMGA. We believed that one could "create the magic" by combining financial and clinical accountability in one delivery system managed by a partnership of physicians and business executives. Thus, we focused our accreditation and other activities on prepaid (capitated) medical groups, and we scrutinized those functions that were unique and important in those organizations. In addition to accreditation, we provided a rich spectrum of clinical and management education programs geared at ambulatory, population-based managed care from the provider group perspective. Our following was faithful but too small to carry the day.

The successful coalition of supporters who sustained us for ten years slowly dissolved as each segment became financially stressed and preoccupied with growing problems. The marketplace never encouraged medical group/IPA accreditation. We were, alas, thirteen to fifteen years ahead of our time in the late 1980s. Now, I fear, we are three to five years ahead of our time. Trying to survive ahead of the marketplace is a lonely place to be. You can not get upset at the market any more than you can get angry at the weather.

I continue to believe that we must direct our attention to accreditation and measuring performance at the provider organization level. That is where most care takes place. That is where the cost of health care is, for the most part, determined. And that is a practical and worthwhile unit of measurement for purchasers, consumers, and health plans alike. It will be a long time before we can quickly, cheaply, and accurately measure the output of (and accredit) each and every physician in America. Until then we should go beyond the acute care facilities and the health plans (which often share overlapping provider networks) and scrutinize all provider organizations. I hope that time is near, even though

TMQC won't be there when we reach the Promised Land.

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#### NOTE

1. TMQC was a public-benefit, not-for-profit 501(c)(4) corporation based in Seal Beach, California. It began as a function of the Unified Medical Group Association (UMGA) in 1987. In late 1990 TMQC incorporated and created its own board of directors consisting of representatives from health plans, medical groups/independent practice associations (IPAs), health care purchasers, and persons interested in pre-paid managed care. The author was TMQC's president and chief executive officer.

### Medicare Reform

To the Editor:

Henry Aaron and Robert Reischauer's reply to Theodore Marmor and Jonathan Oberlander ("Rethinking Medicare Reform' Needs Rethinking," *Health Affairs*, January/February 1998) makes a series of puzzling analyses.

Begin with their defense of vouchers. Aaron and Reischauer say that some voucher plans could be dangerous. Yet their own "more sophisticated" version would offer better benefits than current Medicare and save substantial amounts of money. They do recognize problems. But do they have credible solutions?

Consider how the vouchers would be priced. They assert that the average voucher could be set at "the median bid submitted in each market area." Yet there are all sorts of nasty technical difficulties in designing a competitive bidding system, as even its advocates admit.<sup>1</sup> Moreover, voucher advocates who claim savings from competitive bidding, instead of from central bargaining about premiums as occurs for the California Public Employees Retirement System (CalPERS) and the Federal Employees Health Benefits Program (FEHBP), normally have sought a defined contribution toward the low end of the bid spectrum, for a benefit package no better than the one they are replacing. The Congressional Budget Office under Reischauer's direc-

torship was skeptical of claimed savings from even such bidding systems when it evaluated the health care reform plans put forth by Rep. Jim Cooper (D-TN) and Sen. John H. Chafee (R-RI). If Aaron and Reischauer believe that new data show that savings could pay for extra benefits even at the median bid, they should say how and why.

They seem to propose a different solution in another passage. Explaining why their vouchers could avoid the pitfalls that Marmor and Oberlander fear, they write: "If risk adjustment is adequate, if all plans are required to offer as one option a standard comprehensive benefits package without supplements, if limits are placed on the maximum premium that can be charged for these basic policies" (emphasis added), and if people who cannot afford that premium are subsidized in ways similar to the current qualified Medicare beneficiary (QMB) and specified low-income Medicare beneficiary (SLIMB) programs, "universalism is preserved." Here, regulation is needed to keep premiums low enough.

That passage also includes some big ifs. We are a long way from implementing adequate risk adjustment. Given those programs' failings, can we be sure that a "functional equivalent" of QMB and SLIMB would protect people who could be at risk for far more than the value of the current Part B premium?

Turning to their critique of the alternative, Aaron and Reischauer accuse Marmor and Oberlander of proposing something "almost identical" to the Republican Medicare plan of 1995. This ignores the two main grounds for objection in 1995. One is whether any given global budget is realistically tight or not. It would be at best unfair to assume Marmor and Oberlander wish to apply global budgeting arbitrarily and too tightly. Even more important, the 1995 plan placed all the risk on the fee-for-service world. Any failures to control costs with the vouchers were to be paid for by automatic cuts to the remaining fee-for-service transactions. In the context of a discussion of vouchers, ignoring that aspect of the 1995 proposal is difficult to understand.

Then Aaron and Reischauer criticize non-

voucher approaches for doing “little to change Medicare’s incentives in ways that could promote efficiency.” Did the prospective payment system (PPS) provide no incentives for hospitals to be more efficient? If a system like Medicare’s volume performance standards (VPS) leads to lower prices per service and lower costs in total (as it does), that in most contexts (for example, if the purchasing were by a health maintenance organization [HMO]) would be called greater efficiency. How do Aaron and Reischauer define *efficiency*?

They argue correctly that the conditions for “global budgets” in other countries are more favorable than for Medicare, because Medicare is a smaller part of the market. But the real issue is whether, pushed by global targets, Medicare could apply stronger versions of the concrete sectoral controls used in other countries. That does not require that a single payer pay for everything—a situation that exists nowhere. Medicare clearly is big enough to apply methods such as a volume-adjusted fee schedule, because it does. Budgeting hospital costs would be harder. Yet foreign public and sickness fund payers have done that without being the sole source of hospital incomes. It is at least possible that Medicare has the market power to impose lump contracts on hospitals if the political will existed.

And if the question is political, we at least might remember that all cost control to date has been closer to Marmor and Oberlander’s model. Evidence of political support for the kinds of market controls that Aaron and Reischauer have in mind has been sorely lacking. The political difficulties of implementing even an experiment in competitive bidding have yet to be overcome. So why is it political realism to assume that a voucher system would work and in essence declare that we must end Medicare as we know it?

Maybe a better system could be built on Aaron and Reischauer’s principles. But the effort put into defining vouchers as the sole alternative would be better devoted to fighting for the experiments needed to test approaches to risk adjustment, pricing, and other matters, while simultaneously seeking to improve the

traditional system. Then the country could choose based on evidence, not hope.

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#### NOTE

1. See R. Feldman and B. Dowd, “Structuring Choice under Medicare,” in *Medicare: Preparing for the Challenges of the 21st Century*, ed. R. Reischauer, S. Butler, and J.R. Lave (Washington: National Academy of Social Insurance, 1997).

### Health Insurance For Low-Income Adults: The Issue Of Hispanics

To the Editor:

In their DataWatch, “Insurance Matters for Low-Income Adults: Results from a Five-State Survey” (*Health Affairs*, September/October 1997), Cathy Schoen and colleagues noted that low-income adults in five states have a greater chance of being uninsured, which affects access to and quality of health care. Two of these states (Florida and Texas) have large populations of Hispanics. Hispanics, one of the fastest-growing U.S. minorities, are especially vulnerable to being uninsured.<sup>1</sup> The annual average rate of growth (1977–1992) of uninsured persons was 9.7 percent for all U.S. Hispanics, compared with 2.3 percent for non-Hispanics, with highest growth rates for Mexican (10.7 percent) and “other” (mainly Central and South American origin) Hispanics (10.4 percent); Hispanics made up 20 percent of the uninsured population in 1992.<sup>2</sup>

The Bureau of the Census’s Current Population Survey provides data for Hispanics in each state, but sample sizes of Hispanics for many states are small.<sup>3</sup> Random digit-dialing surveys of Hispanics may be prohibitively expensive. A less expensive technique was used in 1992 in two areas in the Northeast with growing populations of Hispanics: Long Island (Nassau and Suffolk Counties, New York) and Connecticut.<sup>4</sup> The survey sampled telephone numbers of persons listed in directories whose surnames appeared on the list of Spanish surnames developed by the Census Bureau in 1980. After an adjustment for households not screened for eligibility (that is, with a His-

panic person ages twenty to seventy-four), the estimated response rate (665 respondents) was 73.7 percent, as detailed elsewhere.<sup>5</sup> Unpublished data from standardized Spanish and English versions of the survey show that the prevalence of uninsured persons among respondents ages twenty to sixty-four was associated with family income before taxes (total samples are in parentheses):

Family income	Uninsured (%)
\$20,000 or less	53.4% (148)
\$20,001-40,000	24.4% (217)
\$40,001+	9.7% (195)

A higher prevalence of uninsured persons, even within income level, was found among Central and South Americans than among other Hispanics, probably because of their lack of employer-based coverage and factors related to immigration status.<sup>6</sup>

The same sampling method has shown a high rate (34 percent) of uninsured persons in a random sample of 501 Mexican Americans ages eighteen to sixty-four in San Antonio, Texas, in 1992.<sup>7</sup> Although the use of telephone surveys and listed numbers may underestimate uninsurance rates, time trends should be valid (especially when stratified by income).<sup>8</sup>

In conclusion, it will be important to monitor, at the state level, uninsurance rates not only for all low-income adults (as noted by Schoen and colleagues) but also for Hispanic adults by income level and Hispanic subgroup. To monitor insurance trends and access to care among Hispanics within a state (for example, in inner-city areas), the survey method may be modified by preselecting telephone exchange numbers, or ZIP code of residence may be asked in the survey.

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## NOTES

1. R.B. Valdez et al., "Insuring Latinos against the Costs of Illness," *Journal of the American Medical Association* (17 February 1993): 889-894.
2. M.L. Berk, L.A. Albers, and C.L. Schur, "The Growth in the U.S. Uninsured Population: Trends in Hispanic Subgroups," *American Journal of Public Health* (April 1996): 572-576.
3. Valdez et al., "Insuring Latinos."
4. Survey supported by Grant no. P05-CA42101 from the National Cancer Institute to the Yale School of Medicine.
5. A.P. Polednak, "Estimating Smoking Prevalence in Hispanic Adults," *Health Values* (November/December 1994): 31-39.
6. Valdez et al., "Insuring Latinos," and Berk et al., "The Growth in the U.S. Uninsured Population."
7. R.F. Trevino et al., "Health Care Access among Mexican Americans with Different Health Insurance Coverage," *Journal of Health Care for the Poor and Underserved* (May 1996): 112-121.
8. S.R. Orden et al., "Random Digit Dialing in Chicago CARDIA: Comparison of Individuals with Listed and Unlisted Telephone Numbers," *American Journal of Epidemiology* (15 March 1992): 697-709.

## Emergency Departments Are Not The Problem

To the Editor:

In his discussion of the American Association of Health Plans' "Putting Patients First" initiative, David Jones, Humana's chairman and chief executive officer, commented on the difficulty that health maintenance organizations (HMOs) have in holding down the cost of emergency department visits ("Putting Patients First": A Philosophy in Practice," *Health Affairs*, November/December 1997). I searched in vain for a rebuttal by those commenting on his paper and in the letters section of the most recent issue. Alas, the task falls to me.

Patrick Tyrance and colleagues show convincingly that there is not a problem.<sup>1</sup> They present evidence that the cost of emergency medicine is less than 2 percent of total health care costs. Health Care Financing Administration (HCFA) data show that more Medicare funds are spent on interpreting electrocardiograms than on providing emergency care to our senior citizens.

Yes, you could save money by sending patients to clinics, but first you would have to build and staff the clinics. Community emergency departments are establishments with high fixed costs. The only way to save money in these departments is to close them—but who would provide the cardiac, trauma, and critical care that our communities need? Who

would provide the societal safety net? Canadians use emergency departments nearly twice as often as Americans do. Why? Because the fixed costs are already paid.

Jones has it wrong. Full-service emergency departments staffed by experienced nurses and physicians are an HMO's best friend. By working closely with the primary physician and using the diagnostic capabilities found only in a full-service hospital emergency department, the emergency physician can make sure that only those patients requiring (the really expensive) inpatient care are admitted.

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#### NOTE

1. P.H. Tyrance, D.U. Himmelstein, and S. Woolhandler, "U.S. Emergency Department Costs: No Emergency," *American Journal of Public Health* (November 1996): 1527-1531.

### The 'Shoe-Box Effect'

To the Editor:

Over the years there has been considerable discussion of the "shoe-box effect." When patients are required to submit paid receipts to receive reimbursement for prescription medications, these receipts frequently end up in a shoe box and are never actually submitted to the insurance company. Thus, the insurance company does not incur the expense of the unsubmitted prescription claims—the "shoe-box effect." Correspondingly, for those systems in which claims are submitted to the insurer by the pharmacy (usually online at the time of sale), insurance companies pay for claims that they would never have received under the former system. The question of interest is, How big is the shoe-box effect? Estimates range anywhere from 1 to 25 percent, but there is little empirical evidence to support any particular number.<sup>1</sup>

Express Scripts, Inc. (ESI), a national pharmacy benefit manager, examined this issue with a particular client group by requiring two drug claims before the prescription claim would be paid. When the prescription was filled, the member paid 100 percent of the cost, but the pharmacy had to submit an elec-

tronic claim to ESI. The member was required to submit a prescription receipt that had to match the electronic claim to receive reimbursement. Over a period of one year ESI received 32,294 electronic prescription claims from pharmacies. Of this total, 25,285 were paid, 4,272 were unpaid because the patient had not yet reached his or her deductible, and 2,737 were unpaid because the member never submitted the claim to ESI. Accordingly, the shoe-box effect was estimated to be 9.8 percent. Members' failure to submit claims reduced the plan's expenditures by an estimated 8.9 percent.

Although these findings suggest that the shoe-box effect is substantial in terms of dollars, it is unknown whether the effect within a particular group is relatively constant over time. It is reasonable to expect that patients would be more likely to submit their receipts over time, as they become accustomed to the process. We hope your readers find these results as interesting and important as we do.

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#### NOTE

1. J. Mandelker, "Get the Most out of Your PBM," *Business and Health* (November 1994): 37-42.

### Doctors As Decisionmakers

To the Editor:

The numerous papers in *Health Affairs* struggling to deal with the impact of managed care have missed (or avoided?) the real solution. While the term *managed care* covers a variety of processes with a bewildering assortment of acronyms, all of these processes have in common a system of review that is intended to certify that a requested medical service is appropriate. *Appropriate*, in this context, includes cost as well as medical suitability; therein lies the rub. The unstated, or at least understated, objective of managed care is to strike the best balance between cost and quality—not to ensure provision of the "best" health care or simply to contain health care costs, but to actu-

ally make economic and medical decisions at the same time.

The American cultural notion that all medical measures should be available to all regardless of cost causes great antipathy toward the idea of balance. Health care providers and patients alike are strongly resistant to cost considerations when it comes to medical decisions. But, as it has become increasingly obvious that American society cannot or will not supply the resources to provide the best available care to all, the question of how to obtain the best balance has become the crucial issue for managed care.

The managed care review and approval process assumes that a panel of experts examining medical care requests prospectively or medical decisions retrospectively can effectively achieve the right cost/quality balance. However, this process has given rise to widespread claims that high-quality care is being sacrificed at the altar of corporate profit.

The way out of this quandary is to make each health care provider an economic, as well as a medical, decisionmaker. Rather than having an impersonal panel of reviewers (government, corporate, or insurance company bureaucrats) impose unfeeling decisions regarding patient care, let's let the doctor decide, but let's give the doctor the tools to make good decisions.

What are these tools? Credible statistical data. Providers already respond to data from clinical trials of procedures, diagnostic tests, and pharmaceuticals. What has been missing from the practice of medicine is information that tells providers whether their medical decisions are within normal cost parameters, compared with those of their colleagues.

Cost is directly translatable to use of resources. If providers know how their utilization patterns relate to those of their peers, they can make informed judgments regarding frequency of use of specialty referrals, diagnostic tests, surgical procedures, hospital admissions and lengths-of-stay, and even the frequency and duration of patient visits.

For example, if a family practitioner refers every tenth patient to a dermatologist, when the norm for family practice is every twentieth

patient, or if an obstetrician-gynecologist has a cesarean section rate five times higher (or lower) than the norm, an examination of practice style is in order. (Underuse of services is as much a matter for investigation as overuse is because it can indicate a quality-of-care problem that also upsets the cost/quality balance.) But without credible utilization data at the individual provider level, significant practice variation is difficult to discern, and the provider cannot make informed, reliable decisions.

A puzzling aspect to this lack of information is that the requisite data exist. The information is recorded on the patient charts and standard forms that every health care office completes as a matter of course. It also is clear that valid statistical techniques exist that can confidently identify utilization "outliers."

Why, then, aren't these techniques used? The primary reason is that the individual provider is not recognized as the best source for decisions about cost/quality balance and is not considered responsible for economic as well as medical decisions.

A second reason is that providers resist making economic decisions because they view this as an additional burden outside the realm of the already demanding practice of medicine. Although this argument has intuitive appeal, the alternative of dueling with the growing power of the managed care reviewers seems much less appealing. If providers want to get the reviewers off their backs, they must take responsibility for the balance decisions.

The third reason weighing against the implementation of these techniques is the cost of data collection and reporting. But if the expert panel/review paradigm is to be shifted to each provider as the responsible decisionmaker, credible statistical data must be produced to enable providers to make good decisions and to enable health care managers to mentor providers in the process. The demand by employers, government agencies, and consumers for data of this type will grow. In the end, health care cannot be truly managed without it.

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