'Best Doctor' Lists Are Fraught With Difficulty

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WASHINGTON — The lists of "best doctors" published in magazines may not be all they're cracked up to be, several speakers said at a health care competition conference sponsored by Health Affairs journal and the Center for Studying Health System Change.

"Outcomes are much more difficult to measure in health care" than in other industries like auto repair or roofing, said Robert Krughoff, president and founder of the Center for the Study of Services, which publishes the service-rating magazine "Consumers' Checkbook" in several cities nationwide. "Consumers know right away if [the plumber is good]. With a health care provider, they may not know until 5 or 10 years out."

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Further, an outcome cannot always be attributed to the intervention of the health care provider, he said. And because of health insurance, consumers often are insulated from the true costs of care, so it's hard to talk about who provides the best value for the money.

Taking a regional approach to physician rating could have value, Mr. Krughoff suggested. "Patients would report their experience with physicians—they would tell how well the physician listens, how well he or she coordinates care, and whether they are good at working with patients to devise acceptable prevention behaviors," he said.

The cost of doing such a survey would be a concern, but Mr. Krughoff said he thought it could be done for less than $200 per physician and it wouldn't have to be done annually, although a physician should be able to pay for a re-survey if he or she made improvements to the practice.

Tom Scully, former administrator of the Centers for Medicare and Medicaid Services, agreed that information is key to getting patients involved as consumers.

"The health care system is pitiful when it comes to public information," said Mr. Scully, now senior counsel at Alston & Bird LLP, a Washington law firm. "As much as people avoid it and fight it, it works to change behavior. I've never run across any instance where providers, as much as they didn't like it when they were forced to share information, didn't come back a year or two later and say, 'You know what? It's worked out pretty well, it's changed my behavior, and it wasn't that difficult after all.' "

Although health care in this country will never be a pure market economy, "in some sense supply and demand will help, and there is no way to have supply and demand if you don't send consumers information and give them some understanding of what they're buying and what the relative price and quality is," Mr. Scully said. The problem is getting providers to provide the information, and the best way to do that is with monetary incentives.

For example, when CMS wanted hospitals to voluntarily report on 10 quality measures, "we put through a little teeny thing [into the Medicare budget legislation] that said, 'It's totally voluntary—you don't have to give us the 10 measures, but if you don't, we'll volunteer to pay four-tenths of a percent less of the market-basket rate" for hospital costs, he said. "We went from zero compliance to 99% compliance in a year. I personally believe as a Republican that you shouldn't mandate anything—just voluntarily pay people less if they don't behave right."

That may work for health care providers, but the health care industry alone can't make patients better consumers, said Bernard Tyson, senior vice president for brand strategy and management for Kaiser Foundation Health Plan. "There isn't a health care system in place today that can support that kind of consumer interaction and behavior," he said. "It will take forces outside the industry itself to enforce that change. Two outside forces that can really help move this are government and employers."

One vital need is to "demystify" the health care industry, Mr. Tyson said. "The average consumer does not know how to measure [health care] and really doesn't know how to define [its] value." ■