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## **Session 18SM**

### **Health Section Luncheon: “From Marcus Welby to Managed Care”**

Track: Health

Chairperson: DANIEL L. WOLAK  
Panelist: DAVID DRANOVE†

*Summary: David Dranove, the Walter Mc Nerney Distinguished Professor of Health Industry Management at Northwestern University, Kellogg’s Graduate School of Management speaks on the topic, “From Marcus Welby to Managed Care.”*

MR. DANIEL L. WOLAK: Our speaker is David Dranove who is the Walter Mc Nerney Distinguished Professor of Health Industry Management at Northwestern University, Kellogg’s Graduate School of Management. He primarily characterizes himself as a health care economist and also a business strategist. He has a Ph.D. from Stanford University and focuses on research, teaching, problems in industry, organizations, and business strategy, with an emphasis on the health care industry. He has published over 80 papers, monographs, and book chapters, and is a co-author of a popular textbook, *The Economics of Strategy*. His most recent book is *The Economic Evolution of American Healthcare*.

MR. DAVID DRANOVE The title of my talk is, “From Marcus Welby to Managed Care.” I’d like to actually go back in time before looking into the future. I do ascribe to the famous and well-known expression: Those who do not remember the past are condemned to repeat it.

I do think it is valuable to have a little history lesson. As I go through the history of the evolution of the American health care economy, I want to convince you that the one thread that has been constant throughout the evolution of that economy is what I call the shopping problem. The fundamental problem of the health economy, not just in the United States, but throughout the world, is that it is difficult for any

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person or any organization (whether it is a patient, a physician, a managed care organization, or the government) to be an efficient and effective purchaser of health care goods and services.

There are two elements to the shopping problem. The first is determining what health care services to buy. The second is to determine who to buy them from. Let's talk about determining what to buy. Based on your own experiences of buying goods and services, where does quality matter a lot? Say you're buying an automobile, or thinking of hiring an attorney, or choosing a business school to go to get your executive master's degree, or any such good or service. What are the ways that you go about trying to figure out what it is you want to buy, such as a car? You often rely on your own personal experiences. Have you driven a Buick in the past? Was it a good car? If so, then maybe you'll buy one another time around. In health care, by and large, and very thankfully, consumers lack a great deal of personal experience with the major purchases they're going to make. When my mom broke her hip and fell down, she had to make a decision as to whether to have a total hip replacement or just to have a screw put in her hip, because ultimately that was her call. Her physician, of course, advised her at great length because it was not as if she had a whole lot of other incidences where she'd broken lots of other hips. Nor could she rely on others the way we might ask a friend whether he likes his Chevy before deciding whether we might buy a Chevy. My mom knows very few people who have had hip replacement surgery, none of whom live within 50 miles of where she lives. Even if someone could tell her what to buy, she wouldn't necessarily be able to follow through on the advice because she lives in another area.

When push comes to shove, and we want to decide on what kind of car to buy, we can always look in *Consumer Reports* or use one of many resources, such as *Automobile* magazine or edmonds.com. Shopping guides are wonderful when it comes to buying a car, but a simple shopping guide is unlikely to help us decide whether we want that pin or whether we need a new hip. There's so much information that has to be conveyed to help us make that decision, that it seems unlikely that we can do that on our own.

I would argue that determining what to buy is clearly a very difficult problem. Determining who to buy from is another difficult problem. You might decide that you really do need a new hip, but how do you decide where to get it? Comparative information about provider quality is woefully lacking. I'll have more to say about that a little later on. Even in the case of, say, buying a new high-definition television, in which case we don't have information about the products that are on the market, we could always rely on brand names. We'll go out and buy a Sony. I don't know how many of you, if given a choice between a Sony and a Schmony, would choose the Schmony simply because it was cheaper. We don't do that. We would rely on a brand name.

Branding hasn't seemed to work very well in health care, and just to convince you of that, here's a little thought experiment. Hopefully you won't lose sleep over this. Think of all the brand names that have goodwill value in health care. By goodwill value I mean people would actually pay more to buy from that company as opposed to another. Columbia HCA has a well-known brand name, but it doesn't necessarily have positive goodwill value. You can think of the organizations that do have positive goodwill value, such as Johns Hopkins or the Mayo Clinic. Amongst health insurers, perhaps Blue Cross has goodwill value, and maybe with the HMO market, Kaiser has a good reputation. Here's what you'll find they all have in common: They're all as old as the hills. It's really hard to find a new brand name in health care (and by *new* I mean less than 50 years old), that has goodwill value. As for shopping for products and services where quality matters, we use personal experience, asking other folks about their experiences, reading about the product in a magazine, or relying on brand names. None of those solutions work when it comes to health care.

How have we solved this problem? Traditionally we solved it by asking somebody else to make the decisions for us, and that's what I call Marcus Welby medicine. Marcus Welby was this kindly television M.D. who did make house calls. He was played by Robert Young, who was also the father in *Father Knows Best*. He really was the kindly father figure, and he acted as an agent on behalf of his patients. He was responsible for delivering their primary care and for making referrals, and throughout the acute care episode, the hospital stay if necessary, he remained a staunch advocate for his patients.

Another major aspect of Marcus Welby medicine was that Dr. Welby and the specialist in his network were autonomous. They were independent contractors. They didn't work for anybody. The hospital administrator was really just a caretaker who made sure that there were enough bedpans so that the hospital didn't become a dirty place in which medicine was practiced. The insurance companies butted out. The doctor was the captain of the ship.

This is a very natural way of solving the shopping problem. Patients relied on somebody who knew a lot more about medicine than they did. This solution was built on a foundation of trust. Patients trusted that Dr. Welby was going to get the job done. There are several dimensions of trust that patients believed in. First was trusting compassion. Patients believed that Dr. Welby really was on their side. They assumed that their primary care physician was unselfish, placing his or her interests above their own. Certainly the Hippocratic Oath would be one of the fundamental elements in the foundation of trust. At the same time, patients had trust and control. Not only did they believe that Dr. Welby would take their side, they believed that no matter what was necessary to be done for them, Dr. Welby could harness those resources. Dr. Welby could order whatever tests were necessary. Dr. Welby could bring nurses to the surgical team. Whatever was needed, Dr. Welby could get it done. Moreover, they certainly believed that economics would never trump

patient care, and that Dr. Welby, acting purely on the basis of what was medically necessary in his judgment, would always have the final call.

Last, and certainly not least, patients trusted in Dr. Welby's competence. They believed that Dr. Welby was making the most appropriate referrals. They also believed that the referral network, or the specialists, were making the right decisions about things like whether or not the patient should be hospitalized, whether or not he or she should receive surgery, how long he or she should stay in the hospital, and so forth. They believed in compassion, control, and competence, and if you believed in all three of those things at present, what a wonderful health care system from the point of view of quality of care. This person is taking your side. They know what to do, and they get it right every time.

That begs the question of whether the trust was well founded. Was Marcus Welby medicine all it was cut out to be? Think about trust and compassion. The hidden assumption here is that physicians are somehow less selfish and more altruistic than the rest of us. We have all heard the expression that medicine is a calling, and it's really hard to know where one should stand on this. I give this type of lecture to my Kellogg students. In every class I have a few physicians and my Kellogg MBA students. Maybe the MBA students are afraid to step on the toes of the physicians or maybe they just don't want to disagree with their professor, but they claim to agree that medicine is a calling. Maybe deep down they're saying this because investment banking sure isn't a calling. But who should raise their hands in the class to object? It's the physicians. The physicians will say they are in it for the money. It's a great living, and it is a challenging occupation as well. These students say they are human like everybody else and succumb to incentives. It's ridiculous to place them on some kind of pedestal that you wouldn't place the investment bankers of the world upon.

Are physicians immune from human nature? I've even had the physicians in my class tell me that compassion is a great strategic marketing position. They've said that if you want to position yourself as a success in the health care market, you should be compassionate. They're not inherently compassionate. They do it because that's what the market demands. Do they have control? The autonomous physicians certainly have control. By the way, I really do believe that physicians, more than most other occupations, have chosen that profession because of a calling. Let's not forget if you're smart enough, get good enough grades, and are driven enough to go through medical school and residency training before you finally step into that uncertain world of setting up your own practice, you're also probably smart enough to go another route. You could work for two years on Wall Street and come back to Kellogg to receive an MBA, and then get a job in investment banking. If you do the dollar-to-dollar comparison and the proper discounting, it is actually more profitable to take the business track than it is to go on the medical track. There has to be something drawing these people to the profession besides the money.

I certainly believe that physicians under Marcus Welby medicine had control as well, but that leaves one big question mark—were we correct in placing trust in physician competence? Yes. They go through medical school, get degrees, and get licenses. We hope this sets a floor on competence, but does it do more than that? Does it guarantee that we will have the appropriate diagnoses, the appropriate treatment recommendations, and the appropriate implementation of those recommendations? Nowadays, when patients think of quality they generally think of having to choose their provider so they receive good quality. They equate free choice of provider with autonomy. My provider was able to do what he or she wanted to with quality. Quality involves much more than that. We know from a lot of research, for example, that when Dr. Welby, or the real world equivalent to Dr. Welby, put together a referral network, decisions were not necessarily based on who had the most training and experience to handle a particular illness but, in fact, on who was in the doctor's social network.

Think about the show *Marcus Welby, M.D.* The patient was doing great by the end of every episode. What we don't know is what happens half an hour later. For all we know the patient could have died. What happens after the show? Marcus Welby is now Robert Young, the actor, walking with the other actors. One of these actor's family members might have passed away. Robert Young goes to the funeral, consoles the next of kin, and they think he's a wonderful physician. He's so compassionate.

How many of you have a primary care physician who's of below-average quality? You have a sense that there are distributions. Now it's possible that everybody is exactly equal, and that all physicians are equal to the mode, the median, and the mean of quality, but, in fact, we know that's not true. We have this Lake Woebegone view.

That's what Marcus Welby medicine was all about. Patients loved it. They didn't know about the quality stuff. I'll talk more about that soon. We do know about the biggest problem with Marcus Welby medicine. It was really expensive. What is the moral hazard? The hazard lies in the problem of insured patients buying things that they might not buy if they had to pay for it themselves. This is estimated to drive health care costs up by 20-30%. You probably have better numbers than I do about this. Demand inducement is the idea of a physician being paid on a fee-for-service basis, therefore doing more things for their patients. There are physicians who are capitated, which is also documented to drive up health care costs. There are no checks on the use of costly new technology. Technological change has been a common driving force behind health care cost inflation throughout the world for the last 50 years or more. Marcus Welby medicine certainly did nothing to check the cost implications of new technology. The result was double-digit annual inflation in the health care economy for nearly three decades.

Maybe we don't care. We are paying more for automobiles today than we were a few years ago, but they're better. Maybe we're getting better quality. The quality is just out of this world. We're willing to pay the price. Everybody believes that the quality of health care is extraordinary, but is it? Is it high, but is it as high as we can get? There have been lots of studies from the field of health services research suggesting that there are a lot of ways in which Marcus Welby medicine has fallen down on quality. We know from studies that appeared in the 1970s that there was a tremendous over-diffusion of technology. Physicians who are doing 10 or 20 open heart surgeries per year are not being driven from the marketplace, and they continue to do 10 to 20 per year, even though study after study shows that there's a tremendous learning curve. You're really taking your life in your hands if you don't go to somebody who has tremendous experience in that intervention and in many others.

The evidence of medical practice variations that emerged in the 1980s showed that the services you received depended on where you lived. The probability that you were going to be discharged from a hospital on an aspirin regimen following a heart attack, (something that the literature says you're supposed to be told), depends on where you live. That kind of variation is unacceptable to the medical profession, yet it persisted under Marcus Welby medicine. Last year, the National Institutes of Health released its now-famous, if not infamous, study on the magnitude of medical mistakes that have been permitted to persist in the health care arena.

But what the National Institutes of Health told us in 2000 should not have been new to people who are following the health care world. In 1997, Robert Brook, who is largely credited with founding the field of outcomes research, published an editorial in the *Journal of the American Medical Association*. The title of the editorial was "Managed Care Is Not The Problem. Quality Is." I think this is a profoundly important observation. He said, "Thousands of studies have shown that the level of quality care provided to the average person leaves a great deal to be desired, and perhaps, more importantly, the variation and quality of care by physician or by hospital is immense." Thousands of studies around the world, though the disproportionate share are from the United States, are saying that we are not at the best we can be on average, and there is great variation. There is not a justification for saying that all doctors are the same, let alone all doctors are above average. We are not getting the best medicine we can get. Marcus Welby medicine has fallen down on the competence dimension.

When things don't work, there's always pressure on them to change. Marcus Welby medicine wasn't working. We didn't know about quality back in the 1970s, but we certainly knew about cost. Concerned about cost, legislators imposed a variety of regulations here in the U.S.—there are price controls, quantity controls that centralized planning through a certificate of need and other planning mechanisms, quality oversight through professional standards review organizations, and what have metamorphosed into utilization review today. All were efforts to

deal with the cost of care, all efforts that unambiguously failed to control the cost of care. We tried the regulatory and planning solution. It didn't work. Been there, done that.

By the 1980s, there was an acceptance of market principles—the idea that incentives might be important and if we changed incentives, we might change the course of the health care market. So the Health Care Finance Administration took the plunge first by introducing the prospective payment system that reimburses hospitals on the basis of diagnostic related groups (DRGs) that you all know about. The private sector, which had been anxiously waiting for the government to fix the problem of rising health care costs, turned instead to another solution: managed care.

Before we talk about what managed care has and has not accomplished, and what it will accomplish, we must derive a lesson from it. It is that neither unfettered Marcus Welby medicine, nor regulation, was able to balance the American public's desire for cost containment and quality assurance. Both failed. So we've tried something else—managed care. The phenomenal success of managed care is well-known certainly in terms of the market test. It has succeeded beyond anybody's expectations. Managed care organizations of various shapes and sizes dominate all metropolitan markets. There is some regional variation in which types of organizations dominate, but you're hard-pressed to find the community in which more than 10% of the private sector insured population is in something other than a PPO, an HMO, or another three letter variant.

The hard evidence is also suggesting that managed care has succeeded on the first dimension that people were looking at—costs. There is good anecdotal evidence suggesting that it has been wildly successful. There was a consensus emerging around 1990. If you go back and take a look, it's really incredible. The experts and the futurists of that time, so to speak, claimed that health care in the year 2000 would consume 20% of the gross domestic product. That was unsustainable, and, in fact, the market changes took place to take us off that track. We now spend less than 14% of our GDP on managed care. Prior to 1999, the entire moderation in expenditures was in the private sector. Through 1999, we still had double-digit annual increases in the public sector. If you work it out, you'll find \$1,500 per year per person that has been saved. It would be a bit extreme to attribute all of this to managed care. That's an extraordinary savings. If you look at the difference between the private sector growth rates and the public sector growth rates, you'd be hard-pressed to come up with another reason for the disparity.

There's also more systematic research. The systematic research compares the rates of growth of health care cost in markets that have seen a lot of growth in managed care through the 1980s and mid-1990s versus markets in which managed care did not come along until the late 1990s. This research shows that managed care has saved a lot of money, on the order of 1-2% per year. It is not

as much as the numbers I was throwing out a minute ago, but it is certainly a substantial savings. It's not because the managed care organizations are enrolling healthy patients. Once you have 95% of the market, you're basically enrolling everybody. It's because managed care really has saved money, and, on top of that, managed care has passed the savings along to employers that have, at least in the recent tight labor markets, passed those savings along to employees. These are genuine savings being passed along to every man, woman, and child in this country.

I should note that there is considerable debate about exactly where the savings are coming from. Managed care organizations pay lower prices to providers. That might be the biggest savings. There is the reversal of economic incentives, a term that the Kaiser people invented 50 years ago. By going to capitation, doctors now have incentive to do less, and the evidence on the effectiveness of utilization review is much less convincing and might explain why United Healthcare has already dropped utilization review (UR). Others are considering doing it.

So managed care is terrific on cost, but we were defending Marcus Welby medicine because we thought it had good quality. How has managed care done on the quality dimension? The anecdotal evidence is certainly unfavorable. There are these wonderful surveys with a list of 20 types of organizations. People must rank them in terms of how trustworthy they are. Why anybody would want to rank the trustworthiness of the tobacco industry? Managed care ranks at the low end with the tobacco industry. In fact, in the most recent survey I saw, they asked whether you expect these organizations to be ethical. Only 9% of the public thought that managed care organization managers would behave ethically, and that's a sad statement about public opinion.

I should note, however, that the hard data is quite different from the attitudes. Is it really necessary for managed care to be of lower quality? It's not obvious that it has to be. After all, managed care has been very influential in the promotion of practice guidelines in disease management. Some managed care organizations have been highly innovative in assembling provider and specialist networks, taking far more care in scrutinizing the quality of their networks than Marcus Welby apparently ever did, if you believe the studies of how networks used to be formed.

On the other hand, there's always the concern of whether it is cost containment or cutting corners. You have to be especially worried about managed care organizations doing the latter when, in fact, it's so hard to really know what it is they're doing. It must be that temptation to cut corners when the consumers don't know. So while the theory is ambiguous, the systematic evidence is unambiguously ambiguous. Give me 30 studies. Pull them out randomly from the various journals, and I'll show you ten that find that managed care is doing better, ten that find that managed care is doing worse, and ten that find no statistically meaningful differences between the two. There are no systematic differences. The only place

where people start to find some systematic differences is that Medicaid managed care appears to be worse. Those are so woefully under-funded it's a wonder that they can deliver any kind of quality at all.

People judged Marcus Welby medicine on the trust scorecard. They loved it. They want to return to it because they trusted it. Managed care is being criticized because it fares poorly on the same scorecard. Certainly we've seen that patients don't trust managed care organization compassion. Patients certainly don't trust managed care organization control. I'm reminded of a story of a patient in North Carolina who needed a liver transplant, and his local health insurer wanted to send him out of state for that procedure because it had contracts nationwide with the 20 best liver transplant centers in the country. The centers in North Carolina were not on that list. The patient sued, claiming it was simply trying to cut corners, and this is going to compromise quality of care. The patient lost in court when the evidence came out that, in fact, they were more likely to die if they went to the provider in state than if they went to the one out of state. Patients don't trust it. They equate control with restrictions on access, and they equate restrictions on access with low quality.

Patients have been ignoring the evidence on competence. We are going to talk in a minute about health care report cards, the rankings that show that some providers are better than others—rankings that have some semblance of truth behind them. Some of the really low-ranking providers in these report cards really do stink. Patients ignore them almost entirely. What happens is we believe that managed care can't possibly solve any of our problems because there weren't any. The only problem is costs, and that's not a real thing for managed care to be claiming they're solving because, after all, managed care doesn't keep all the money for themselves. They put it in the hands of their shareholders, which is demonstrably false because they're all losing money hand over fist. They can't make money. We have a call for re-regulation. Before we re-regulate, I'd like to say six nice things about managed care and then talk about where we're going from here.

First, Marcus Welby got lousy fees from his patients. Managed care organizations get good fees. They negotiate. Marcus Welby permitted demand induced, moral hazard, and practice variations. Managed care organizations have tried to eliminate excessive and wasteful utilization, though they've potentially crossed the line and are very far. The evidence is ambiguous. The cost savings are real. The quality does not appear to have diminished in any persistent, demonstrable way. Managed care has forced providers to worry about efficiency, and, in many places, it forced them to worry about quality as well. These are things they didn't have to worry about under Marcus Welby medicine. Finally, for those who are in the let's-regulate-managed-care side of the argument, be careful about what you wish for. As we regulate managed care out of existence, the forces that kept health care costs under control disappear. Health care costs naturally increase. The last time we had health care costs spiraling out of control, we tried regulation, and not just regulating

managed care. We tried it all. We might try it again.

Where is managed care going, and what will it take for it to survive? Managed care organizations have to remember the fundamentals. The reason we have managed care to begin with is the shopping problem. Marcus Welby medicine tried to solve it and failed. If managed care organizations are going to succeed in the long run, they have to do a better job of solving the problem, and patients have to believe it. What will that take? First, we have to have dissemination of more and better data about quality. It's wonderful to believe that your doctor loves you. It's another thing altogether to find out that your doctor is incompetent and is loving you to death. Managed care organizations, if they have good data, can assemble their networks based on quality and cost. Many Blue Cross organizations, for example, are actively trying to do this, and I've worked with some of them. Managed care organizations cannot do this very well with the kind of data that's currently available to them. Provider outcomes research, for example, is woefully limited. For a heart patient that has just had open-heart surgery or for that prostate cancer patient who has just had his prostate removed, we could figure out from publicly available records whether they've lived or died. Life and death is certainly an outcome of interest, but there are other outcomes of interest that are more important when you think about the frequency with which they arrive. Incontinence and virility are two examples. No data has been collected on those two outcomes that could possibly be combined with other medical information so that we could determine which prostate surgeons are doing a good job and which hospitals are doing a good job in delivering that surgery.

At the same time, even if managed care organizations were to get their act together and measure some of these data, they'd have to go out and prove to the public that they were doing a good job of delivering quality. We have to measure the quality of managed care organizations. That is being done today by the National Committee for Quality Insurance (NCQA), with its Health Care Employer Data Information Set (HEDIS). HEDIS is available to the vast majority of employees in the United States. They can go to their benefits manager at their firm and take a look at the HEDIS reports for their managed care organizations, but nobody does it.

How are we going to get the job done in terms of data? We certainly are going to have to have some kind of standardized data so that the data in the physician's office can be linked to the data in the hospital. Then we can put together the equivalent of an electronic medical record. We're now also going to have to collect outcomes data electronically and tie that in. There is something like the SF 36, which is a survey instrument that takes ten minutes to complete. This would look at functioning status and other health outcomes for individuals. This is a standard tool that's used in research. There are also instruments known as SF 10s that are disease specific that could be administered, that have been administered on a regular basis. We can now keep track of which HMOs are keeping their patients

healthy and which surgeons are doing a good job with their procedures.

The continuity of data in the long run could be as important as the continuity of care as we could construct a seamless electronic medical record that really helps us do the kinds of evaluations that I think are essential. Without them, we're never going to be able to assure quality through managed care, and we're never going to be able to assure the quality of managed care. A big complaint that is raised is regarding concerns about confidentiality. Would an electronic medical record lead to the danger that people will find out that you have some unwanted disease? I think this concern is ill placed. Right now the managed care organizations already have enough information through their billings, through their administrative claims data, and through employers. If an employer wants to know who has AIDS within its work group, that data exist now electronically. Linking that from one provider to the next and creating a common I.D. is not going to enhance anyone's ability to do these kinds of nefarious things that the American public fears.

There are a lot of benefits to collecting these data. We can restore trust in the competence of both providers and managed care organizations. We could assemble better networks and reinforce our trust in provider control because we'll know that our providers are choosing their referral networks based on real quality, not just social networking. Finally, what is most important is that providers will have an unprecedented incentive to improve their quality because if they improve it, somebody will see it. Somebody will measure it, and that will translate into better business, more patients, higher revenues, and so forth.

There are two other things that I think have to be done if managed care is going to succeed. I think the data issue is the thorniest, though let me mention two others. The first is we have to have more vigorous antitrust enforcement. There has been ongoing consolidation among providers, but depending on what market you're in, some time in the last six months you've probably seen a newspaper headline along the lines of local hospitals increasing rates 20-40%. If you'd read the smaller headlines a year or two earlier, the smaller headlines would have been local hospitals merged.

In every major metropolitan area competing hospitals are merging. They then approach managed care organizations and require 30% price increases, and the managed care organizations have to deal. In the Cleveland market, there are only two major players. The entire metropolitan area now has only two firms selling hospital services. The consolidation has tilted the power in the direction of the providers. Of course, in response, the managed care organizations try to enhance their power through consolidation; suddenly, you're left with an industry in which winning and losing isn't dependent on delivering value and solving the shopping problem. Winning and losing is dependent on having the most power, and that serves nobody's interests, not even the providers' and the insurers' interests, because it's a zero-sum game.

Finally, I think we need to help reinvent the primary care physician. I don't believe that patients will ever solve the shopping problem on their own. Two years ago, I had to listen quietly as people were talking about new products like Web M.D. and drcoop.com, and so forth. I had my students soak it all up, and they concluded that this is the end of the world as we know it. From now on, everybody is going to do his or her own doctoring. There is a reason you go to medical school for four years and do a residency for six years. The next time you go to a teaching hospital, make sure you don't go the week after rotations change. You do not want a resident who has never treated somebody with your illness. It's bad enough being your own lawyer. It's worse being your own doctor.

We're also now seeing how bad these Web sites are. Somebody has to guide us through this thicket of information. That somebody, I believe, will continue to be our primary care physician, and it will be our primary care physician who will have to evaluate (HEDIS) and look at the outcomes data, the marketing claims, and so forth. The Marcus Welby of the future will have to be a master not just of medicine, but also of statistics and economics and spend more time as a consumer advocate and less as a direct care provider.

Here's where the final obstacle to making this all happen shows up. It won't work unless payers find a way to make it in the physician's interest to do this. Physicians have to get paid for all the time they're going to take being the patient's advocate, and that payment system has not been invented yet. But if it is, and if we can keep the mergers from proliferating, we can provide the data necessary to finally evaluate quality. Dr. Welby can combine good bedside manner with his expertise in the future of medicine to be someone that patients can continue to trust to guide them through the future health economy. In turn, patients will trust the system, not just their doctors, including the managed care organizations. The system will fully realize its potential to solve the shopping problem.