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INTERVIEWER: The American Medical System is reputed to be among the most advanced in the world. But many common treatments from medications to surgery are not based on sound science. Every year, patients receive too many procedures or too few treatments that really work.

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Eric Patashnik is an expert on public policy and policy reform and co-author of the new book, *Unhealthy Politics.* Mark Peterson is a specialist on the role of evidence in policymaking, including as it pertains to national health care policy. We sat down with them recently to try to understand why efforts to improve the evidence base of US medicine continue to cause political controversy and public trepidation.

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I was shocked to learn that less than half of medical care in the United States is evidence-based.

ERIC PATASHNIK: It is. It's a really important thing that many Americans are unaware of. We certainly were unaware of it when we began our research. And what people, I think, are not fully cognizant of is that many treatment options have never been compared head to head with alternatives.

For example, let's say you have back pain. Well, you could be treated for back pain with surgery or physical therapy. Or maybe there's a drug you could take-- what works best. The reality is that we often don't have the hard evidence that we need to answer that question.

And as a result, physicians often have to fall back on their medical training, on conjecture, what other doctors in their community are doing. And we may not actually have the best information we need to make sure that patients get the most effective treatments for their conditions.

We have, of course, have the Food and Drug Administration, the FDA. That's a key regulatory agency. It reviews before they're marketed medical products and devices. But the FDA-- and I

think this is another thing that many Americans are unaware of-- isn't set up to determine the most effective treatments for different conditions.

INTERVIEWER: It's not comparing.

ERIC PATASHNIK: No, it's not usually comparing. It's usually looking, does drug A work better than a sugar pill? Does it work better than a placebo? Not does drug A work better than drug B versus surgery C.

INTERVIEWER: On this kind of patient.

ERIC PATASHNIK: Exactly. And that's really the information you would want as a patient to learn with Becks. Also, there's no FDA for surgery. A physician can invent a new surgical operation. And that procedure can diffuse wildly into practice without undergoing any kind of review.

As a result, invasive and risky operations can become very popular before they're rigorously evaluated. And then even worse, once a procedure like that becomes the standard of care, it can become very hard to retrench, even if medical studies later show that the operation works much less well than effective.

INTERVIEWER: Yeah, you do point out that it's hard to conduct clinical trials on a treatment that's already in practice.

ERIC PATASHNIK: It is. And it raises the importance of figuring this out before we start using patients as guinea pigs. And so all of those reasons is to say that it's not that there's no evidence in the American health care system.

But we often are missing the information we need to answer the most important questions for patients. And when we do have information about what works best, the uptake of that information is much slower than many people realize.

MARK PETERSON: I think there are two other contextual matters here. One is a historical context. Medicine spent a very long time developing its cultural authority on those issues and worked very hard to suppress anybody else who had any claims to having that kind of professional expertise and scientific basis. And that has permeated itself throughout our culture and through out to populations--

INTERVIEWER: And that we as the public sort give into that--

MARK PETERSON: We do. And even often I do. We naturally assume our own physician is a very talented individual with all the training that's necessary to give us the best possible care, given the information that's available. Most people are not even thinking about these issues and, therefore, not providing any kind of political pressure in that direction.

The second thing is-- and this is another part of the story in which I think medicine and physicians are unique. Most people think of their worry is, I'm not going to get the medicine I need-- the treatments I need. They're not thinking about, I'm going to get treatments or could be harmful to me.

And that imbalance-- the fear of, I'm going to be denied something because of somebody else's economic calculation, versus, I really shouldn't have all these interventions, because they could potentially be a lot more harmful than whatever benefit might drive from the treatment leads to this real paralysis around this whole issue about generating more information and having mechanisms for physicians to use that information more effectively in their work.

INTERVIEWER: OK, so that we've brought up two actors-- physicians and the public-- where we need to move the needle and also politicians.

ERIC PATASHNIK: Yeah, so let's unpack those, because in the book, *Unhealthy Politics,* my co-authors and I, Alan Gerber and Conor Dowling, look at three sets of actors-- the public, physicians, and politicians-- that we argue are the key to understanding the lack of countervailing pressure to improve the evidence base of medicine.

So what do we find for each of them? For the public, we did a series of public opinion surveys. And what we found in brief is that the public is extremely nervous about any outside group interfering with the doctor-patient relationship. The public views doctors as very trustworthy. Actors who have their best interests at heart that they're experts.

INTERVIEWER: --that they know best.

ERIC PATASHNIK: --that they know best. And, in fact, of course, most of the time, doctors do know best. I certainly look to my own doctors for advice. They know much more about medical conditions than I do. It's a completely understandable situation.

The public, then, also, is not fully aware of the way in which, for example, medical societies sometimes function, like, economic lobby groups that when a study comes out that suggests

the treatment used in their practice area is less effective, that those medical society sometimes can resist the use of evidence in order to maintain the discretion of individual physicians to continue practicing as they wish.

Although the public does have some appreciation for the need for better evidence, they're very, very concerned that the evidence will be misused. That's one part of the problem. Physicians, I think, are absolutely critical, because, as Mark Peterson was just saying, American health care essentially rests on a social contract.

We look to the authority of the medical profession to protect the interest of the patient. But the question is, what happens if the medical profession is not fully upholding its end of the social contract, is not using its authority to identify best practices and to make sure that patients always get the best treatments for their conditions?

We performed a national survey of physicians. And we found that many physicians, first of all, are not well-informed about the scope of some of the inefficiency in American health care. And also, we found that there was actually a lot of desire for medical societies to continue protecting the economic interest of physicians.

There was a lot of comfort with that. There's not a lot of tension between the leadership of the medical societies and the rank and file, even though doctors, of course, believe in evidence-based medicine. Everybody does. They, nonetheless, are comfortable with the posture of societies that often play a defensive role rather than embracing evidence actively and using their cultural authority to push the system to a more evidence-based system.

The role that the actors play in maintaining physician discretion to prescribe as they wish, trying to push for generous coverage and reimbursement of treatment used in that area, that's something that is sort of widely understood among doctors and accepted.

MARK PETERSON: Yes, and as Eric and his co-authors write very explicitly in the book about, as he says, the physicians want to practice according to evidence. But there is a sense of trust around physicians. And more than that, there is a sense that every person is an individual.

And evidence-based medicine is largely predicated on doing very sophisticated studies that are meant to be kind of population-wide. And that is the job of the personal physician--

INTERVIEWER: --to particularize it.

MARK PETERSON: --to particularize it, put it in the context of that individual who's presenting that set of conditions and all those comorbidities-- very complicated task. And I think people, including politicians, are worried that a movement too far in this direction would be in a kind of cookie cutter approach to medicine and really worries people that are going to be denied something.

An interesting thing about politicians, though, there's another side of the medical equation. Look what's happened over since the Roosevelt administration in the funding for biomedical research-- the founding of the National Institutes of Health and the continued funding that set of institutions get, even during periods of budget constraint.

And when the current administration proposed a budget that looked like it was going to cut dramatically, NIH funding, everybody knew that wasn't going to go anywhere. There is very strong support for a major government role in providing the public good of continuing advanced biomedical research and innovation.

The question comes, how do you apply that in particular individual cases? How do you direct it to these kinds of medical decisions? And if it gets mixed at all in the United States with the potential of a financial balancing of benefits, then people get very concerned.

INTERVIEWER: Mm-hmm. It almost seems like a public education, a vast effort at public education about the value of evidence and the nondangers of it is necessary.

ERIC PATASHNIK: It is. And so we've seen a recent effort. Actually, you talk about physicians and the need for public education-- so there's an important initiative recently called Choosing Wisely, which was an effort to identify treatments that are overused that are less effective in different areas of medical practice.

And it was pushed by a physician group, which is fantastic, as well as, I think, co-sponsored by *Consumer Reports.* In fact, in our public opinion surveys, we found that Americans want information about the safety and effectiveness--

INTERVIEWER: Right. We're always--

ERIC PATASHNIK: --services. Absolutely.

INTERVIEWER: And rating them.

ERIC PATASHNIK: We're nothing but good shoppers in America, right? We, of course, want to know if a particular

treatment might be dangerous, or if there might be a better treatment. Everybody does want that. But what we've seen is that, that effort is really laudable. But it hasn't had much impact so far.

Why not? Well, the different medical societies in each of the different practice areas-- some of them took the effort extremely responsibly. And they said, OK, here are some treatments that are widely used among physicians in our area. And we should not be doing them so much.

But what some other societies did was, they pointed out this treatments that are hardly used at all. Or they're not very expensive. They don't really generate very much revenue. Or some of them even went so far as to say, here are some inappropriate treatments used by other physicians not by us.

And so there was a sort of unwillingness on the part of some medical societies to fully embrace this. And then you had the question of, well, what would happen once this effort was made? Would it actually change practice? Some early empirical work has shown not so much.

So there was one careful study that looked at seven treatments that were listed as being overused, inappropriate. And it found that two of the seven use of it went down very marginally. Two of them went up, marginally, and that the others had no change at all.

Part of the reason here is, because of the way our health care system is set up, there is still a tremendous delegation of authority to the individual physician. That is how our system is based. No national group will easily be able to tell your doctor what to do. The guidelines are usually just advisory. They don't necessarily require the individual physician to practice a certain way.

And also, there are financial incentives that can push toward overuse. It can be concerned about malpractice and litigation. A lot of doctors are very worried that if they don't perform a treatment or procedure, even if it isn't necessary, that, perhaps, you could expose them to a potential malpractice claim. And so all of those forces-- policy forces, economic forces, the inherited organizational inertia-- can make the system extremely sluggish.

MARK PETERSON: And I think one of the interesting things here is, again, grappling with how to use this information effectively without creating fear in people. At this point in time, we've almost forgotten that we had a history from around 1994 to around 2005 of the managed care revolution. And to a very large extent, the marketing of managed care was managed care.

And that didn't mean denying care. It was supposed to mean, we're going to do a better job of identifying the physicians and hospitals who are the best providers. We're going to do a better job of helping to guide them in their decision-making based on evidence-based research.

And we had a mass rebellion against managed care. There was a huge backlash. They were getting denied treatment that they thought they should have. Or, at least, they thought they were being denied that treatment. And insurance companies all pulled back.

And what's interesting about this-- in a way it was saying, if government does this directly, there is going to be real pushback. It's just very hard for government to play that kind of role. But if we turn it over to the private sector, increasingly for profit private sector, which is supposed to be making highly efficient decision-making in a competitive marketplace, then, government will be protected from that kind of concern. And the marketplace will flourish.

It did for a while. But then it created the same kind of backlash. And now almost everybody has insurance, even if it's called managed care-- actually has a lot of escape valves. And many opportunities to go to providers are going to give them the kind of treatment they want.

ERIC PATASHNIK: I think what's important to see is, we don't have a fully government-run system, of course, in United States. We don't have the kind of systems they have in some European countries. We rely heavily on private employer-based insurance systems. Nonetheless, the Medicare program, which Mark Peterson's written a lot about, is still the foundational statute of the American health care system.

And by design by law, the Medicare agency is really has a difficult time denying coverage or changing reimbursement rates for low-value services. And once Medicare sets policy, that sort of shapes even the private insurance market-- can be very difficult for private insurers to say to the people who are in their plans, this treatment is really not very effective. We don't want to cover it if Medicare is covering it, because the patient can say, well, I don't understand why I can't get it. It is widely used. Maybe the patient's own doctor is also recommending it.

So it's difficult to reshape even the effectiveness and cost effectiveness of care in the private sector as long as the foundational statute of the American health care system, the Medicare Act of 1965, is still built on limited statutory authority to make these kinds of decisions.

MARK PETERSON: It's a fabulously important point. And I think something that most people don't appreciate is, Medicare has been a driver of massive innovation in the health care system.

INTERVIEWER: No, I don't think most people think that.

MARK PETERSON: They think, oh, that's government. It can't possibly have done anything new and different. But the whole way in which hospitals are paid through prospective payment-- now, the whole way in which physicians are paid based on relative value scales-- that all in the United States came through the Medicare program.

And it fundamentally transformed the financing of the system, because, ultimately, those same mechanisms were picked up by private insurers as well. So now the question that Eric brings up is, well, here's an important innovation. Everybody should be doing it.

There are a lot of incentives one would think for it to happen. But even Medicare has been extraordinarily hesitant. And part of the reason there is, in the end, the overseers of Medicare are congressional committees.

INTERVIEWER: Right.

[MUSIC PLAYING]

What's interesting about your book-- and I know, Mark, you're a political scientist-- is that this is not about health economics as much as it is about political science.

ERIC PATASHNIK: It is. The problem that we write about, about the uneven use of evidence in health care, about the slow uptake, about the geographic variation in utilization across the United States, meaning you could have two patients with the exact same medical condition. And one lives in Providence-- one lives in Los Angeles. And they receive entirely different treatments without any mechanism in place to figure out what works best.

INTERVIEWER: And also going back to the slow uptake, you say that it can take up to a decade for something that is known to work to be adopted?

ERIC PATASHNIK: Or no, not to work. Yeah, to be retrenched, yeah. All of those problems-- we're not original in pointing to those problems. The book rests on extensive research by public health scholars, the kind that are here at Brown, at health economists.

There's a large body of work that documents the problem. What this book is about is trying to understand, as political scientists, the reason for the government's failure to actually tackle the

problem.

INTERVIEWER: And you talk about the status quo and how stubborn--

ERIC PATASHNIK: So back, for example, in the 1990s, there was an agency that pointed out that back surgery was being overused as a frontline treatment for low back pain. The back surgeons were unhappy about this. They went to Congress. They lobbied Congress.

And essentially the agency was defunded and reduced its authority. And that example shows why so many politicians are so concerned about giving an agency, like the new Patient Centered Outcomes Research Institute, which is an innovation created in the Affordable Care Act.

But the agency has no real authority to make policy decisions to say to the Medicare agency, we believe that this treatment is actually not worth funding. Or, perhaps, this very expensive treatment doesn't work better than an alternative. You can still have it. This is United States.

We're not going to tell you what you can do. But you're going to have to pay more for it if you want that choice. All of those things we're very concerned about doing we haven't done. So we're beginning to generate some of the information, which is a first step.

But in terms of using that information to actually ensure that patients get the best possible care to ensure that our scarce taxpayer dollars are used in the most cost-effective way and the most equitable way, those kinds of decisions we are still have not yet made.

INTERVIEWER: Well, in that institute that you mentioned is going to go away in 2019, isn't it?

ERIC PATASHNIK: It has a sunset date. Yep, it remains to be seen. The idea of improving the evidence base of medicine was not a democratic idea. It wasn't an idea of the Obama administration. It was a bipartisan idea.

Actually, some of the leading advocates originally were health economists associated with the George HW Bush administration. What happened, however, in our recent politics in the debate over the Affordable Care Act was so polarized and contentious was that even an idea, like, let's figure out what works best for patients, that became highly politicized.

And so that's really one of the casualties of our current political moment that not only are politicians disagreeing over things, like, how high should taxes be on the wealthy, but they're

also fighting over things where, actually, there's an underlying consensus that there is a problem and that we should be doing better.

MARK PETERSON: Eric has raised-- but there is also something that I always wanted to be cautious about. We come from policy school institutions. We have faculty that focus on policy analysis. Our whole theme is to bring evidence to decision making and informed that there's a decision making in a powerful way.

A lot of the issues that we're dealing with here even in medicine or, perhaps, particularly in medicine aren't easy to identify in these terms. Some are that the sham surgery for orthoscopic knees surgery is remarkable. But there's a lot of medicine that it's a lot more ambiguous.

And, for instance, we do have things, like, the US Preventive Services Task Force. And they do look at the body of information. And they do come up with recommendations on things, like, who should have a mammography during the course of a life. A very big story was about the PSA test for prostate cancer in men.

And the Preventive Services Task Force looked at the evidence, came up with recommendations. It looked like it was not the kind of tool that people thought it really was. And so there was really pulling back from that. Then there was backlash from people. So, no, you're going to kill people.

And I don't mean people on the street. I mean people in the physician community who were very earnest and sincere. And that decision is going to kill people. Take my own situation-- my personal physician is on the US Preventive Services Task Force. We have a lot of, obviously given what I know and given her experience.

We have a lot of discussions about how to think about these issues. And on the PSA in the end was, well, should I have a PSA test or not? And in the end she said, if we do decide to go back to doing the testing, I just need to let you know as a physician if we see the metric that shows there is a real elevation in your PSA score, we're going to go aggressively after that.

INTERVIEWER: Wow.

MARK PETERSON: So that was her clinical training in the context of knowing that that metric is problematic. But if you get the number, you can't just say, oh, it's problematic. You have to act. That's the complexity that makes it so difficult to move forward on this issue.

INTERVIEWER: OK, so quickly, where is health care working? And where can we go from here? And what's the policy recommendation?

ERIC PATASHNIK: Well, first of all, there are aspects of the American health care system that work extremely well, actually. I think, for example, there are groups, like Kaiser, that are much more evidence based. We are seeing some private entities are beginning to use evidence more efficiently.

So those are sort of islands in efficiency and rationality in the American health care system. And they can serve as examples. I also think that they're going to be pressures to do better. It's slow. But there is a growing awareness among if not the public as a whole, the educated, sophisticated public that reads magazines, like, *The Atlantic Monthly,* for example. They have been publishing articles more and more about this problem.

There is a growing recognition among the public that medicine has both benefits and costs that there are risks and that it is important to understand the trade-offs of different medical services, especially as we age as a population, as very sophisticated consumers themselves become in need of greater medical care and also caregivers for their parents.

There are also other reasons that may be pushing us to do better-- fiscal pressures. We are going to be facing budget constraints. That can lead over time for the desire to figure out how do we eliminate waste so that we can make health care as effective as possible?

And there is also a vanguard movement within the medical profession that wants medicine to do better. It's still small. There are some public intellectuals, like, Atul Gawande and others. But it's an emerging voice within the medical profession.

Ultimately we argue in the book that we're not going to be able to improve the health care system, make it more effective work better for patients without the leadership of doctors. They're going to be absolutely key. And we do see some leadership emerging there.

Nonetheless, I think they're going to have to be other changes that will be important. We're going to have to see more far reaching cultural changes in medicine. We're going to need medical societies to view themselves as promoting the interests of patients and that they have a responsibility to stay informed about these issues and to husband the use of scarce clinical resources.

We're also probably ultimately going to have to realign economic incentives to create less

tension between what doctors want to do, which is care the best for their patients and the economic pressures to provide services that are really either useless or offer low value for money. And that will require some policy changes as well.

MARK PETERSON: One of the things that's happening right now is tremendous pressure on the federal budget in programs, like, Medicare and Medicaid. And the Republicans in Congress right now-- less so the president. But the Republicans in Congress keep viewing this as an unsustainable growth path for Medicare and Medicaid.

What I always want to say in response is, it's unsustainable in the private sector as well. The health care system is just going to get massively more expensive. And people are going to be grappling with that. Right now, the solution that some on that side pushes the whole notion of if individuals have more skin in the game, then they're going to make wiser decisions.

If they're going to make wiser decisions, they need to be informed. If they're going to be informed, then they need to have an evidence base for that to happen. So there will be a market way in which that transpires. I'd be a little bit skeptical of that.

And actually working out in quite those terms, I think, mostly, it becomes a redistributive element where the informed patients get what they need and want. And those who don't simply don't have the finances to go into the system.

So there is that. But it's going to create those kinds of dynamics in different changed incentives for people. But it's hard to envision the exact pathway, particularly a policy-driven pathway through government anytime in the short term.

ERIC PATASHNIK: Yeah, I think picking up on what Mark said, what's important to see is, this problem has to be solved independently of our overall choice that we make as a country about the future direction of the health care system. If we move to a Medicare for all system, which will be very expensive, government will need the tools to identify cost-effective treatments or else that kind of program will be unsustainable.

If we move to a more individualized health savings account system, which is something that a lot of conservatives would like to see, consumers will need this information to use their own dollars to make those choices effectively. So having a better medical evidence base is important, whether we move to a more individualistic system or more collective system. We have to get this right regardless of what we decide about those other--

INTERVIEWER: That's such a good point.

MARK PETERSON: There is one other possible aspirational or hopeful pathway here. And that is, there's an increasing integration of health care in a number of respects. If you go back to the 1950s, we think of the doctor or the office on the side of his house and putting up his shingle and seeing the patients and not being connected to the health care system in a Broadway.

Now, practices are getting bigger and bigger, more and more doctors together, more and more specialties together. One of the reasons why Kaiser works so well, and why they use evidence effectively is the doctors and the other providers are all in the same complex. And they talk to one another about their patients. They share information.

So they get a more holistic view of the evidence and the patient and how they move forward. As the system moves more in that direction, then there are elements of the Affordable Care Act that some of our colleagues refer to as aspirational. They're not really evidence-based.

But they're creating demonstrations to try to identify whether or not we can create an interconnected health care system where information flows more effectively among providers. And they can collectively make better choices that are both good for the patient, as well as preserving the resources and using them effectively.

ERIC PATASHNIK: And I think it's important to see the problems that we're talking about and the kind of solutions that we say we need are really about improving the quality and the safety and the efficiency and the cost-effectiveness of American health care.

This is not the full agenda if we want to control the costs of American health care. This is only a small piece of it. American health care is very high prices. We have high administrative waste. So we have a full panoply of problems that we will have to tackle to bring down the costs of health care.

We in this book are focused on the problem of making American health care more effective for patients. In some cases we would argue, we need to spend more money on health care if there are treatments that are effective that are being underused. This is really a question about how much we decided society to spend on health care. There are a lot of trade-offs there-- more on health care is less on education is less on--

INTERVIEWER: I was going to make that point too.

ERIC PATASHNIK: Those are separate issues about the allocation of overall social resources. Here, we're focused on whatever we spend on health care. Let's, at least, make sure we're getting as much good health from our investment as we possibly can.

INTERVIEWER: Got it-- excellent point. Well, it's been so interesting to talk to both of you today and fascinating book. Thank you both for coming in.

MARK PETERSON: Thank you.

ERIC PATASHNIK: My pleasure.

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