Presidential Address

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Medical Governance: Are We Ready to Prescribe?

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Abstract

Federal and state governments in the United States play substantial and complex roles in promoting, subsidizing, regulating, and even providing health care in the United States. Financial pressures on Medicare and Medicaid, concerns about the translation of evidence-based findings into medical practice, and efforts to reduce the number of people without any health insurance are likely to expand governments' roles even further in the future. Although a large body of research seeks ways to improve the delivery of medical services, relatively little research addresses the advantages and disadvantages of the various governance arrangements that are or could be used to make better collective decisions about the allocation of medical resources. Assessments of the many types of governance arrangements already employed—advisory committees such as those employed by the Food and Drug Administration, menu-creating commissions with narrow mandates such as the Oregon Health Plan, and stakeholders trusteeships such as the Organ Procurement and Transplantation Network—should be an important topic for health policy research pursued by public policy and management scholars. Absent these efforts, the policy community may not be able to offer good advice about medical governance.

INTRODUCTION

Governments throughout the industrialized world make decisions that fundamentally affect the quality and accessibility of medical care. In the United States, despite the absence of universal health insurance, these decisions have great influence on the practice of medicine; because of the absence of universal health insurance, they occur in a great variety of institutional contexts. We see direct federal provision of medical care through the Veterans Administration, federal funding and regulation through Medicare, federal and state funding and regulation through Medicaid, federal funding of health services research, and state regulation of private group health insurance and entry into the health-related professions, to name just the most famil-

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iar ones. Each of these contexts employs a particular form of governance, which, following Laurence Lynn, Carolyn Heinrich, and Carolyn Hill (2000: 3), consists of the "regimes of laws, administrative rules, judicial rulings, and practices that constrain, prescribe, and enable government activity," broadly defined. It has become trite to say that institutions, and therefore governance, matters. Nonetheless, it is true. I believe that one of the central tasks of policy analysts and public management scholars is to understand the implications of various forms of governance, especially in fundamentally important areas of public policy such as medical care. Are we ready to offer advice, let alone write prescriptions, about medical governance?

In posing this question, I am connecting the first presidential address published in the *Journal of Policy Analysis and Management* with the most recent one. In 1987, John Brandl argued that we should pay more attention to institutional design, seeking to create arrangements "acknowledging self-interest while giving persons opportunities to practice other-mindedness" (Brandl, 1988: 423). Last year, Rebecca Maynard focused our attention on the promise and challenge of evidence-based policy-making, asking how we can get decision makers to care about evidence (Maynard, 2006). My question can be thought of as asking about our capacity to design institutions that can promote evidence-based decisions about medical practice and policy. I approach this topic humbly. Unlike John Brandl, I do not combine the experience of the legislator with that of the scholar; unlike Rebecca Maynard, who has had a long career in education research, I am a relative newcomer to the topic of medical governance, doing research on medical report cards and the organ transplantation system only in recent years. Nonetheless, I think I have observed enough of the health policy field to ask, if not fully answer, what I believe to be this fundamentally important question.

The opportunities for improving health through better governance are obvious to even the casual reader of the newspaper. Consider, for example, the recent Institute of Medicine report on medical errors, which reports that on average each hospital patient is subject to one medication error per day (Aspden, Wolcott, Bootman, & Cronenwett, 2007). These errors annually cause approximately 1.5 million injuries and inflict $3.5 billion in costs. Better medical governance could help reduce the frequency and cost of such errors by establishing realistic standards, promoting compliance through changes in professional norms or regulations, or advocating changes in relevant framework laws.

A few preliminary comments on medical governance are appropriate. Most important, I see medical governance not in terms of a single institution but rather as the collection of the particular institutional arrangements for governance that appear throughout the complex health care system. The nature of health care and our goals for the heath care system, however, make it useful to view these various institutions within the broad category of medical governance. Against a backdrop of changing knowledge about the possibility, efficacy, and safety of medical treatments, there is typically a large informational asymmetry between patients and providers that complicates market exchange. Because of the potential for medical care to improve health and to prolong life, many see fair access to it as important for a good society. Medical care is also very expensive, so that access has implications for the availability of other things people value.

These particular characteristics of medical care raise the importance of the sort of goals that we generally seek to achieve in all areas of governance: technical efficiency, democratic accountability, and economy. The challenge of technical efficiency involves finding arrangements that allow for the continuous integration of rapidly changing medical expertise, based on both scientific evidence and tacit

knowledge, into decision making processes. The challenge of democratic accountability involves finding arrangements that maintain appropriate oversight by elected officials and also promote authentic public participation in decision making. The challenge of economy involves finding arrangements that facilitate the consideration of costs and benefits in decision making. Medical governance deserves our attention because of the importance, and difficulty, of balancing these challenges.

My argument has three components. First, I make the case that we are likely to be confronted with demands for advice about medical governance. Second, our research enterprise is not well organized to prepare us to offer useful advice. And third, models of governance exist that can and should be studied to prepare us to offer useful advice in the future.

Looking Ahead: Three Possible Sources of Demand for Advice on Medical Governance

John Kingdon (1984) argues that major policy changes occur when there is a confluence of the "problem stream," the "policy stream," and the "political stream." That is, some events focus political attention on a problem for which a policy community, including people like us, can offer a solution. Unfortunately, this framework, and related ones like "punctuated equilibrium" that have followed, do not tell us when such opportunities are likely to materialize or how one might go about creating them. Nonetheless, these studies make a strong empirical case that instances of non-incremental change do occur (Jones & Baumgartner, 2005). As opportunities are transitory, it is unlikely that those of us working in the policy stream will be able to offer anything based on research not already completed or at least well underway. If we are not ready, then the opportunity will be lost or exploited using whatever ideas that happen to be at hand.

I can imagine three sorts of opportunities arising that would call for us to offer advice about medical governance.

First, and at the longest odds, a demand for advice about governance may arise in the context of serious consideration of universal health insurance. Perhaps consideration of universal health insurance will be prompted by concern among businesses about their growing employee health insurance costs. Perhaps it will follow a political landslide as did the adoption of Medicare. As no society can be rich enough to cover every possible medical procedure for every person, some mechanisms would have to be included in the design of universal health insurance to decide what is, and is not, covered. For example, imagine a system that emphasized the role of insurance in reducing catastrophic risk but also sought to promote preventive care. What medical interventions would be considered too risky or too costly? What routine diagnostic tests would be considered essential components of preventive care?

Second, within the current framework of government as a major provider of medical care for veterans and the co-purchaser of medical care for the elderly and the poor, demands may arise to put evidence-based medicine into practice as called for by many prominent health policy experts (for example, Cutler, 2004; Dranove, 2003). Already there is a small army of physicians, epidemiologists, economists, and other social scientists funded by the National Institutes of Health, private foundations, and pharmaceutical companies seeking empirical evidence about the effectiveness of various sorts of medical care. Some of this work even assesses some elements of the governance of health care delivery, such as the difference between the delivery of services by for-profit versus not-for-profit organizations (Forbes, Hill, & Lynn, 2006). While it is not clear if there is enough or the right kind of such

research, what is clear is the absence of institutional arrangements for effectively moving such evidence into medical practice.

Allow me to illustrate the current problem of bringing evidence into practice, and therefore the substantive opportunity it offers, with the case, developed by Alan Gerber and Eric M. Patashnik (2006), of arthroscopy of the knee. Unlike pharmaceuticals, which undergo extensive clinical trials before they are marketed in the United States, surgical procedures typically come into use based on the accounts provided by surgeons of their impacts on a series of their patients. There have been a few examples of random-assignment surgery studies in which patients in the control group receive an incision so that neither they nor the physicians assessing effects after surgery can tell whether they had the procedure. The most prominent of these "sham surgery" studies, published in the *New England Journal of Medicine* in 2002 (Moseley et al., 2002), assessed arthroscopy, a common treatment for osteoarthritis of the knee. Over a two-year follow-up period, the study of 180 patients found no statistical difference in terms of pain or function between the treatment and control groups. As there are at least 100,000 such surgeries every year in the United States at a cost of as much as $5,000 per surgery, the potential resource implications of this finding are large. The federal Centers for Medicare and Medicaid Services considered the study and even removed one type of the surgery from automatic coverage under Medicare, though local Medicare contractors could, and still do, cover it. Thus, in the face of actual opposition from orthopedists and potential opposition from other specialists, the finding has had little if any immediate impact.

Third, and most likely, a demand for advice about medical governance may arise from the fiscal pressure placed on the federal government by Medicare and the fiscal pressure placed on state governments by Medicaid. Many observers see explicit rationing of services in terms of their cost-effectiveness as an inevitable consequence of rising medical costs. Indeed, this is actually being done by the Oregon Health Services Commission, to which I return later. Henry Aaron and colleagues (2005: 147) argue that "[c]ontinued growth of health care expenditures will therefore force Americans to consider heretofore unthinkable ways to limit spending." If they are right, then shouldn't we be preparing ourselves to offer advice about how this can and should be done?

ADVICE IN THE FACE OF GREAT COMPLEXITY

I think scholars invest too little in the study of institutions of governance. The complexity of governance in an area like medical care poses a great challenge for researchers seeking to understand processes, assess outcomes, and draw transferable lessons about potentially desirable institutional designs. Unfortunately, the incentives within academia tend to discourage scholars from taking up this challenge.

Status in many academic fields derives heavily from the development of theory. We thus have a lot of it. Although it can support the study of institutions, and some of it is directly relevant to the design of institutions, it cannot substitute fully for the empirical study of actual institutions in operation that might serve as models for design. We cannot expect legislative staffs or public managers to make complex designs from first principles. They undoubtedly will, and probably should, copy working models that are perceived as functioning well in some other context. That perception and analyses of the essential components of the models can and should be informed by empirical research.

Economics now abounds with ever more sophisticated and precise models of decision making. These models certainly are valuable in helping us anticipate strategic behavior. They also reinforce some empirically based generalizations about the sorts of private governance that one expects to find as a function of complexity, asset specificity, and other aspects of the contracting environment (Vining & Weimer, 2005). However, these models are too narrow to offer much guidance about the nitty-gritty of institutional design beyond "Get the incentives right." Consider the most direct, and perhaps most successful, explicit application of economic theory to institutional design, the simultaneous ascending auction of radio spectrum conducted by the Federal Communications Commission. To create a well-functioning institution in light of the problems previously encountered in other countries and those suggested through extensive simulations, over 130 pages of regulations were required (McAfee & McMillian, 1996).

The design of public governance should be one of the primary concerns of political scientists. Much recent work has borrowed the principal-agent framework from economics to model the delegation of discretion to administrative agencies by Congress. I agree with Jonathan Bendor and Adam Meirowitz (2004) that these models suffer from the assumption that delegation is primarily about the control of discretion, ignoring the sincere desire by many, if not most, politicians for good decisions. Knowledgeable politicians generally realize the limitations Congress faces in keeping too tight control as well as the political risks it involves. Further, I think there is a recognition that, along the lines suggested by Eugene Bardach and Robert Kagan (1982) in the context of the inspectorate, professional norms can be a resource for countering self-interest. It is also consistent with the advice Alice Rivlin offered in her 1983 commencement address at the Rand Graduate School, "[T]he best rule for politicians for dealing with generals, admirals, and doctors may be this: put the money on the stump and run."

Political science should also be a major source of guidance on how to design institutions for achieving appropriate levels of representation, accountability, and responsiveness. Normative theorists write about these values, though, with only rare exceptions (Grogan & Gusmano, 2005; Goodin & Dryzek, 2006), usually in the abstract with little concern about real institutions. Public management scholars connect their work more closely to actual practice, considering especially values such as responsibility (Bertelli & Lynn, 2003) and accountability (Behn, 2001; Radin, 2006). Perhaps because of the more direct public role in medicine in the United Kingdom, our colleagues there have begun to devote attention to medical governance (Gray & Harrison, 2004). The cross-national comparative empirical study of institutions usually does so at the level of political regimes (Cheibub & Limongi, 2002; Powell, 2000) but less often in sectoral contexts (though see Bovens, 't Hart, and Peters, 2001). Nonetheless, the literature offers us relatively few comprehensive assessments of governance institutions that would be of immediate use to institutional designers.

Researching complex institutions is difficult and the incentives within the academy discourage public affairs scholars from undertaking it. Institutional research is typically very labor intensive and often requires considerable time to unfold—these factors make it a risky strategy for assistant professors and a difficult one for more senior scholars. Adding to the risk are the difficulties of finding comparable institutions to transcend single case studies, of making generalizations in the absence of convincing counterfactual arguments, of drawing implications beyond the particular substantive area, and of reducing the work to journal-length formats.

One way to get around the problem of comparability is to look at institutions with similar missions in different political jurisdictions. This is often done taking advan-

tage of variations across U.S. states, and it is likely to be especially important as a number of states move to provide universal health insurance for their residents. Researchers have also sought to make international comparisons, though these studies are difficult to execute (Riker & Weimer, 1995). Several such efforts in the medical area are exemplary. At one extreme, a specific substantive focus, such as policies governing assisted reproductive technologies (Bleiklie, Goggin, & Rothmayr, 2004), can facilitate comparison across a large number of countries. Broader comparisons are also possible though much more difficult to do well. For example, Carolyn Hughes Tuohy (1999) provides exceptionally rich accounts of the general evolution of medical governance in the United States, Britain, and Canada, and Kieran Walshe (2003) provides an explicit comparison of health care regulation in the United States and the United Kingdom. Obviously, comparisons of institutions cross-nationally suffer because it is not possible to hold constant differences in political institutions and national cultures. As Ted Marmor and colleagues (2005) insightfully discuss, drawing valid policy lessons from even the best international comparisons is difficult.

In view of the complexity of governance institutions and our limited cognition, it would certainly be desirable to be able to borrow working models from other countries as the starting point for our own institutional design. If we cannot do so confidently, then perhaps we can find working models of various sorts here within the United States. I very briefly consider three such working models: the advisory panel system of the Food and Drug Administration (FDA), the Oregon Health Services Commission, and the Organ Procurement and Transplantation Network—each warrants a fuller assessment in terms of technical efficiency, democratic accountability, and economy. Although these models apply to specific aspects of medical governance, they could potentially be applied in other contexts. My belief is that we should be studying these sorts of institutions more thoroughly as a basis for offering advice on medical governance when the opportunity arises.

AGENCY REGULATION WITH ADVISORY COMMITTEES

The most familiar form of sectoral governance in the United States is notice and comment rulemaking by a public agency. The agency publishes proposed rules, receives comments from interested parties, acknowledges the comments in a final rule, and responds to challenges to the rule in the courts. In sectors with rapidly changing technology, agencies whose hiring, firing, and compensation policies fall under civil service cannot hope to keep adequate expertise on staff. Inevitably, the agencies in these sectors turn to advisory committees, contributing to the approximately 950 (U.S. GAO, 2004) that operate across the federal government.

The FDA employs approximately 30 committees to advise on drugs, medical devices, and biological products. Most committees have consumer or patient representatives as voting members and industry representatives as non-voting members. The majority of members are relevant medical or scientific experts. Although the committees take votes, the votes are not binding on the FDA.

FDA decisions concerning the marketing of pharmaceuticals have been criticized by the press, scholars, and congressional oversight committees since implementation of the 1962 Kefauver-Harris amendments that gave the agency responsibility for assessing the efficacy as well as the safety of new drugs. More recently, the criticisms have included charges that the FDA has inappropriately allowed politics to enter its decision-making processes (Steinbrook, 2004). The most prominent case is

the failure for an extended period of the FDA to approve Plan B, a "morning after" pill, for over-the-counter sales, despite strong advice from advisory committees to do so. It has led to resignations of agency staff and advisory committee members (Davidoff, 2006) as well as senators blocking or delaying the confirmation of FDA commissioners. Although science and medicine under the current Bush Administration seem more politicized, we should also remember that one of the first executive orders of the Clinton administration instructed the Secretary of Health and Human Services to assess initiatives to promote RU 486, a drug combination that induces abortion (Jackman, 2002).

Having spent a lot of time with many outstanding political scientists throughout my career, I am not at all surprised that what is supposedly a scientific enterprise is actually politically influenced. After all, governance is inherently political and politics can enter in many ways. In highly technical policy areas, I believe that most politicians want the routine decisions to reflect the best expertise, reserving for themselves large-scale oversight. Indeed, they may wish to shift the political as well as decision-making costs away from themselves—what Morris Fiorina (1982) calls the "shift the responsibility" model. Agency regulation provides one degree of shift. Regulation by commission, with voting members holding fixed terms, provides an even further shift. In the case of allocation of things of value, such as medical care, where there may be clearly identified losers, politicians may desire to shift the responsibility even further. Cognitive psychology tells us that those who suffer losses are likely to feel more aggrieved and be more likely to act upon those feelings than those who suffer comparable gains (Kahneman & Tversky, 1984). Politicians are likely to see the opportunity for claiming credit as more than offset by the risks of accruing blame in situations of granting or denying access. In the political calculus of "credit claiming" and "blame avoidance," the latter is likely to dominate (Weaver, 1986). Especially when issues are both complex and salient, what William Gormley (1986) calls "operating room politics," politicians will seek a procedural rather than a direct substantive intervention. Therefore, I believe that politicians will want to find a way to tie their own hands with respect to the nitty-gritty of medical governance—in other words, follow Alice Rivlin's advice to put the money on the stump and run.

Our task as analysts is to find models that politicians can consider for tying their own hands in viable and socially desirable ways. Perhaps it will be through commissions with relatively narrow mandates, such as the Open Market Committee of the Federal Reserve. Or perhaps it will be through broad delegation to NGOs representing stakeholders through what might be called private rulemaking (Weimer, 2006).

MENU-CREATING COMMISSIONS

In 1989, Oregon undertook a multifaceted initiative to reduce the number of its residents who were uninsured. A bold element of the initiative was to confront explicitly the tradeoff between the number of people covered by Medicaid and the services that are covered in the face of a constrained budget. The legislature delegated responsibility to the newly created Health Services Commission to rank diagnostic/treatment pairs in order of priority. A contractor estimated the cost of offering each pair so that the legislature could move down the list with a running tally of how much the accumulated package of services would cost. The legislature imposed upon itself a closed rule—it accepts or rejects the list in its entirety. For example, the 2003 prioritized list had 730 diagnostic/treatment pairs and the legislature funded pairs 1 through 549 initially, and then through 546 the following year

(Oregon Health Services Commission, 2005). The commission created its first list in 1991, but federal approval through a Medicaid waiver was not granted until 1993 following several revisions to the prioritization methodology. The Oregon Office of Medical Assistance Programs implemented the list in 1994. Since then the list has been revised for each biennial budget.

The Oregon Health Plan, especially the prioritization of services, drew much national attention. One of the objections raised to it was that it substituted technocratic expertise for authentic public participation. The process for creating the initial list, however, involved substantial public participation: a telephone survey of residents to provide data for constructing a quality-of-well-being scale specifically for Oregon, 47 community meetings, and 12 public hearings (Garland, 1992). Since then the commission has continued to consult widely, and, according to one observer, receives good reviews from both producer and consumer groups (Leichter, 1999: 151). Tim Tenbensel (2002) argues that the commission has been very effective in interpreting and incorporating public values into the prioritization. If we avoid the Nirvana Fallacy that seems to plague many medical ethicists—comparing public participation in the activities of a real organization such as the commission with some ideal of public participation rather than with the sort of participation that would result in decision making by a regulatory agency or legislature—then I think the commission offers an encouraging view.

Another line of criticism centered around the initial intention to rank diagnostic/treatment pairs primarily in terms of the quality-of-well-being scale similar to quality-adjusted life-years (La Puma, 1992). As the methodology for applying these scores led to counterintuitive rankings, because it inappropriately assumed cardinal properties for the scale (Nord, 1993) and because of data limitations, the commission adapted its approach to draw on members' expertise to deal with rankings that appeared anomalous (Garland, 1992). This prompted some criticism from those who thought this reduced the legitimacy of the commission's rankings (Kaplan, 1992).

The strongest concerns expressed about the Oregon Health Plan were that it would deny services to the most vulnerable segments of the population. In fact, the cutoffs selected by the legislature appeared primarily to exclude services for which there was little evidence of effectiveness. Further, in implementation some of these excluded services were delivered by the managed care organizations that enrolled the majority of Medicaid participants and others were delivered by physicians as part of the diagnostic process (Bodenheimer, 1997; Leichter, 1999). As with the concern about methodology, the new criticism became not that the rationing was too strict, but rather that it was not very consequential and did not save much money (Oberlander, Marmor, and Jacobs, 2001). Nonetheless, the prioritization was a politically important component of the Oregon Health Plan that allowed Oregon to move from an uninsured rate above the national average in 1990 to below the national average today (Leichter, 2004). In particular, Lawrence Jacobs, Ted Marmor, and Jonathan Oberlander (1999: 175) see the prioritization as having strategic value to reformers by transcending the boundaries among health care actors and providing a forum for continuous negotiation, keeping stakeholders directly engaged for a protracted period.

I think even closer study of the operation and impact of the commission is warranted. What features of the commission would we recommend be emulated by other states seeking to ration medical care provided through Medicaid? What features should be avoided? Could the model be employed in other contexts of medical governance?

TRUSTEESHIP BY STAKEHOLDERS

It is not surprising that Lawrence Jacobs and colleagues see the protracted engagement of stakeholders as a strategic advantage of the Oregon Health Services Commission. Observers of the advisory process see committees that closely connect expertise to policy questions as most effective (Jasanoff, 1990: 230–231; Smith, 1992: 193). One reason is almost certainly that expertise includes much tacit knowledge reflecting direct experience as a scientist or clinician that cannot be easily tapped in the abstract, but can be in the application to concrete proposals. Another reason, which is also one of the rationales for negotiated rulemaking in public regulation, is the high level of engagement, and perhaps compromise and commitment, possible when those with a direct interest in the issue have a voice in policy formation. We have at least one example of broad delegation of policy formation to stakeholders in an important realm of medical governance: the Organ Procurement and Transplantation Network.

Before creation of the network in 1984, organ allocation occurred through a system of voluntary sharing among organ transplant centers coordinated by the nonprofit United Network for Organ Sharing (UNOS). The fiscal importance of kidney transplantation to the End Stage Renal Disease program and the highly visible appeals, supported by politicians and other prominent persons, for liver donations for children prompted Congress to seek more systematic arrangements for procuring and allocating cadaveric organs. Despite the literal life and death implications of allocation policy, Congress delegated the design of rules to the network, an organization to which all transplant centers, organ procurement organizations, and transplant-related laboratories must belong to qualify for federal funding. In other words, Congress delegated responsibility to the stakeholders themselves, leaving only a very broad oversight role for the Department of Health and Human Services. Congress effectively put the organs on the stump and ran.

The choice of private rulemaking over public rulemaking is at least consistent with the notion that in very obvious zero-sum situations, any credit earned from winners will be more than offset by the blame received from losers. Delegation to medical experts provides more political insulation from the consequences of zero-sum allocation than delegation to bureaucrats. The choice of private rulemaking also reflected a belief that the medical profession has the most appropriate expertise, and generally the most appropriate values, for making such decisions. Further, and relevant to my argument about the need for working models of complex institutions, Congress had UNOS as a working model of stakeholder cooperation. Indeed, the law was written in such a way that UNOS would almost certainly become the administrator for the network as well as at least initially for the Scientific Registry of Transplant Recipients, which created a database for assessing transplantation outcomes.

The network employs a variety of committees, both specific to the allocation of types of organs and dealing with more general issues such as minority access to transplantation, that meet regularly to consider changes in rules and policies. The committees include representatives from transplant centers and other providers as well as patients and their family members. The committee meetings I have observed, usually day-long gatherings, typically involve the presentation of research findings and data analyses drawing on the Scientific Registry of Transplant Recipients. They also involve much candid discussion of implications, problems, and concerns based on the wealth of tacit knowledge of the members. The continuity of the major committees, as well as the use of majority rule voting to

make decisions, allows them to propose and to agree to many incremental changes in allocation rules. Their recommendations are adopted only after review by other relevant committees and network regions, public comment, and a majority of votes from the board of directors. Although the rule changes do not gain the force of law until they are published as regulations by the Department of Health and Human Services, something that has yet to be done in any case, they become de facto law because transplant centers must follow them to be members of the network in good standing.

Although the network has generally operated without much public visibility, it became embroiled in a very heated political controversy over the geographic basis of liver allocation during the late 1990s that spilled over into the courts and Congress (Weimer, 2007). The episode urges caution in designing institutions that deviate too far from the pattern of influence that would prevail in the larger political arena—a particularly prominent and politically well-connected transplant center was consistently outvoted by the more numerous smaller centers so that its desire for national sharing of livers was frustrated. Instead, there were a series of incremental changes that gradually moved the network to regional rather than local sharing.

My own assessment of the network, based on the liver allocation controversy and its response to the conflict between antigen matching of kidneys and adverse racial access, parallels the assessment of private standard setting made by Ross Cheit (1990: 202): "[P]rivate standards-setting is prospective and ongoing, while public efforts are usually corrective and singular. Private standards-setters tend to intervene relatively early in the life cycle of an issue, adjusting the standard subsequently over time. Public standards-setters, by contrast, are likely to get involved later, often after a major disaster, adopting a 'one-shot' standard without the benefit of subsequent adjustments." In substantive policy areas like medicine, with almost continuous additions to knowledge and technology, private rulemaking like that of the network provides a more flexible response than traditional regulation. Its desirability, however, requires a more careful look at the outcomes it produces in light of the full range of relevant values. Its usefulness as a model for adaptation in other contexts of medical governance requires an understanding of how it operates and what aspects of its operation are essential to the outcomes it produces. In the absence of careful policy research that provides these normative and positive assessments, we will not be prepared to offer confident advice about whether private rulemaking should be considered as a form of medical governance.

CONCLUSION

Perhaps no policy window for considering universal health insurance will open. Perhaps fiscal pressures will not force states to redesign their Medicaid programs. Perhaps opportunities for advancing evidence-based medicine will not materialize. Yet, if these contingencies do arise, we will be much better prepared to offer good prescription if we include medical governance on our research agenda today. I have indicated several well-established institutions that I believe deserve more attention. There are certainly other domestic institutions that could be added to the list, such as private and public accreditation of hospitals and Medicare Part D. Cross-national comparisons may also be more promising than my earlier dismissal suggests. In any event, I believe that we need more careful thinking about how to assess the outcomes of alternative forms of governance, as well as more attention to how decisions are actually made. If APPAM members do not take up these tasks, then who will?

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