OPERA – fiche sociographique - santé

Prénom, Nom:
John M. Eisenberg

Contact :

Catégorie : Exécutif

Dates de naissance / décès :
Né en 1946. Décédé le 10 mars 2002

Lieu de naissance :
Atlanta, Georgia

Genre : Homme

Lieu de résidence (si DC avant l'accession à un poste retenu, avec si possible l'année de l'emménagement à DC):

Formation :

BA/BS	Princeton University 1968
MA/MS	MBA University of Pennsylvania
PhD	MD University of Washington 1972
Law degree (JD…)	
Autre	

Profession initiale :

Carrière :

- Held many key positions in academic and clinical medicine and was widely recognized as a leader in both medicine and health services research
- 1986-1992 : chief of the Division of General Internal Medicine at the University of Pennsylvania
- 1992-1997 : Chairman of Medicine and Physician-in Chief at Georgetown University
- 1997-2002 : DHHS, Agency for health care policy and research, Administrator,

Sources biblio/bio, articles, divers.

Health Services Research

Tribute to John M. Eisenberg

Ann Barry Flood, PhD, Coeditors-in-Chief, HSR and Harold S Luft, PhD, Coeditors-in-Chief, HSR

This issue is dedicated as a tribute to John M. Eisenberg, M.D., M.B.A., in recognition of his lifelong achievements in health services research. We have selected six articles, described below, which represent areas where John made significant contributions, either as a researcher and administrator or as a champion and mentor.

In addition, on behalf of the entire Editorial Board of *HSR*, our publisher, and the leadership at AcademyHealth, we would like to announce the establishment of an award for excellence in health services research, designed to recognize exceptional articles from *HSR* which advance our understanding in an area championed by John. Selection of these awards will be announced periodically in *HSR*, beginning in 2004. We also gratefully acknowledge support for the publication of this tribute provided by a grant from The Robert Wood Johnson Foundation in Princeton, NJ, and funding by W.K. Kellogg Foundation in Battle Creek, MI.

John Meyer Eisenberg was born in Atlanta, Georgia, in 1946 and died from a brain tumor on March 10, 2002. From 1997 until shortly before his death, John served as Director for the Agency for Healthcare Research and Quality (AHRQ; formerly called the Agency for Health Care Policy and Research) of the U.S. Department of Health and Human Services (HHS). He also served as the Senior Advisor to the Secretary of HHS on Quality; cochaired the Department's Data Council; chaired the Federal Quality Interagency Coordination Task Force; and served as Principal Deputy Assistant Secretary for Health and as Acting Assistant Secretary for Health.

Although this partial list of his titles illustrate the breadth and importance of his many contributions to the nation's health care system, it fails to capture the charisma, enthusiasm, and strengths with which he tackled these roles and policy areas. He was a champion of policy-relevant research in order to increase the "value" of health care services by improving its appropriateness, safety, and effectiveness while also monitoring and improving its accessibility to all. In taking on these challenges, he managed to engage researchers, clinicians, and policymakers alike in his vision for excellence in research to improve the nation's health care. He recognized that such efforts required continuous encouragement and mentoring of those who would undertake them.

He was a magna cum laude graduate of Princeton University (1968) and the Washington University School of Medicine in St. Louis (1972). He was also a Robert Wood Johnson Foundation Clinical Scholar, earning a Master of Business Administration degree with distinction at the Wharton School. A clinician and researcher from the beginning of his career, John held many key positions in academic and clinical medicine and was widely recognized as a leader in both medicine and health services research. His positions included Chair, Physician Payment Review Commission; President, Association for Health Services Research (now AcademyHealth); President, Society for General Internal Medicine; and Vice President, Society for Medical Decision Making. He was also a member of the Institute of Medicine of the National Academy of Sciences and published over 250 articles and book chapters on topics such as physicians' practices, test use and efficacy, medical education, and clinical economics, as well as writing a seminal book that influenced how many of us view medical decision making: *Doctors' Decisions and the Cost of Medical Care* (Eisenberg 1986).

John dedicated his career to ensuring that health care is based on a strong foundation of research. He challenged the field to address topics important to policymakers—both inside the clinic and inside the "Beltway"—with research that was methodologically sound, grounded in the "real world" and accessible to a broad audience. The first six articles in this issue were selected as a tribute to his contributions in these arenas:

Primary Care and Workforce Issues

John had a long-standing dedication to improving primary care, examining these issues from the perspectives of various providers but also insisting that quality should reflect the needs and perspectives of patients. He also worked to increase research in areas that have been relatively neglected in the past, such as addressing disparities in health care.

The article by Michael Seid and his colleagues (2003)—funded in part by AHRQ during John's tenure there—illustrates these concerns. The authors examined the relative importance of language, race, and insurance status for accounting for the quality of primary care received. They focus on care of the very young who are also disproportionately likely to be poor, of color, and uninsured or insured in public programs. Despite the greater vulnerability of children, prior research has tended to focus on adults and it suffers from problems in disentangling race from other social indicators and from the outcomes used to measure quality. This project attempted to address these problems.

Using parents' reports about the quality of care experiences received by their grade-school-aged children, they found that language and improved access through insurance were consistent predictors of better quality of pediatric primary care, even in multivariate analyses. In contrast, race and socioeconomic status (SES) as measured by maternal education were not consistently significant predictors. More surprisingly, with the exception of non-English speaking Asians, all minority and language groups had significantly higher comprehensiveness of care scores than whites. These findings point to the need for more research to understand the relative roles of SES, race, access, and language in pediatric primary care quality.

Eric Larson and his colleagues (2003) investigated a different aspect of primary care: how best to assess the total workforce engaged in delivering generalist care and its deployment in rural and urban settings. Policymakers and researchers alike, when examining the workforce and creating policies to deal with provider shortages, have tended to make strong, but questionable, assumptions about the productivity of nonphysician practitioners relative to each other and to generalist physicians who in turn are typically not distinguished by specialty. The authors use data about productivity to create a standardized measure of "full-time equivalent family practitioners" to compare across types of practitioners. They then demonstrate the impact of these measures, illustrating how we currently misestimate the supply of general health care available to a population and discussing the more subtle ramifications of factors such as professional and geographic distribution of women in the workforce in shortage areas.

Cost-effectiveness Research and the Importance of Drugs

John also had a strong conviction that limited health care dollars should be used wisely, arguing therefore that clinical practice should be evidence-based and address the value of the care delivered. He argued for a pragmatic perspective, using evidence from a multitude of data sources and aimed toward improving the safety and quality of care. He was also particularly concerned with how to include pharmacy benefits into Medicare and Medicaid so that the incentives for the most cost-effective care were appropriately aligned. The article by Michael Fischer and Jerry Avorn (2003) illustrates these interests with a fairly straightforward but powerful example of the potential cost savings that could attend a shift to generic drugs. They compared the total amount paid by each state Medicaid program for brand name prescriptions with the amount that would have been paid for generic versions of the same agent, and estimated that the savings in the year 2000 alone would be $450 million. Not too surprisingly, most of the unrealized savings were concentrated in a small group of medications, including clozapine, alprazolam, and levothyroxine, suggesting that concentrating efforts on a few therapeutic agents may be the most productive policy.

Physicians' Use of Services and Response to Incentives

Much of John's own early research, perhaps reflecting interests that led him to earn an M.B.A. from Wharton, involved the examination of why and how physicians make clinical decisions. This research included evidence and theory gleaned from basic medical sciences, experience, available choices of services, and an understanding of the economic incentives faced by physicians and patients.

Hal Luft's paper (2003) in this issue illustrates a solution to an important and vexing methodological problem in assessing the care of Medicare enrollees in fee-for-service (FFS) and health maintenance organization (HMO) settings, that is, the claims data that allow analysis of FFS patients are often lacking for HMO enrollees. His paper addresses a costly clinical issue of great importance to patients and policymakers alike: Do Medicare patients receiving care for acute myocardial infarction and who paid via FFS insurance experience better outcomes than those in HMO settings? Using California hospital discharge data to avoid the problems of noncomparable claims data, Luft's evidence suggests that HMO patients experienced identical or better

outcomes on average than did FFS Medicare recipients. More importantly, he found substantial variability among the HMOs in terms of outcomes that seems related to their patterns of treatment, suggesting that we need to focus on what leads to differences in quality rather than obsessing about whether HMOs provide worse care than FFS settings.

Improving Measurements of Quality and Outcomes

The last two articles gathered together for this tribute, by Claire Spettell and her colleagues (2003) and Sebastian Schneeweiss and his colleagues (2003), illustrate what many people credit as John's most important achievement for our field. This is the redirection of health services research and AHRQ's mission in particular. We no longer focus on propounding clinical guidelines, instead addressing how health services research can "marry" its continuously evolving science and evidence about what works well and safely to the practice of medicine so that practitioners, patients, and payers are rewarded with ever-improving health care. John was *the* champion for insisting upon excellence in evidence and methods, with the dual goals to advance our scientific knowledge and to make a difference by improving our health care. Spettell's article focuses on the importance of identifying problems in how well health plans identify depression. Recognizing that depression is one of the most underdiagnosed serious health problems, this article deals with the potential misidentfication of quality problems in plans as a result of our intent to improve the detection of depression. Similarly, Schneeweiss and colleagues tackle an important methodological problem: improving the performance of existing comorbidity scores to predict mortality in Medicare enrollees.

John Eisenberg had an enormous impact on research and policy in his lifetime. His example and his dedication to training and mentoring helped build new cohorts of researchers and policymakers ready to use research. We hope that future issues of *HSR* will be replete with articles worthy of his memory.

Support for the publication of this tribute was provided by a grant from The Robert Wood Johnson Foundation in Princeton, NJ, and was also founded by the W.K. Kellogg Foundation in Battle Creek, MI.

References :

- Eisenberg JM. Doctors' Decisions and the Cost of Medical Care. Ann Arbor, MI: Health Administration Press; 1986.
- Fischer M, Avorn J. "Economic Consequences of Underuse of Generic Drugs: Evidence from Medicaid and Implications for Prescription Drug Benefit Plans." Health Services Research. 2003;38(4):1051–63. [PMC free article] [PubMed]
- Larson EH, Palazzo L, Berkowitz B, Pirani MJ, Hart LG. "The Contribution of Nurse Practitioners and Physician Assistants to Generalist Care in Washington State." Health Services Research. 2003;38(4):1033–50. [PMC free article] [PubMed]
- Luft H. "Variations in Patterns of Care and Outcomes after Myocardial Infarction for Medicare Beneficiaries in Fee-for-Service and HMO Settings." Health Services Research. 2003;38(4):1065–79. [PMC free article] [PubMed]
- Schneeweiss S, Wang PS, Avorn J, Glynn RJ. "Improved Comorbidity Adjustment for Predicting Mortality in Medicare Populations." Health Services Research. 2003;38(4):1103–21. [PMC free article] [PubMed]
- Seid M, Stevens GD, Varni JW. "Parents' Perceptions of Pediatric Primary Care Quality: Effects of Race/Ethnicity, Language, and Access." Health Services Research. 2003;38(4):1009–31. [PMC free article] [PubMed]
- Spettell CM, Wall TC, Allison J, Calhoun J, Kobylinski R, Fargason R, Kiefe CI. "Identifying Physician-Recognized Depression from Administrative Data: Consequences for Quality Measurement." Health Services Research. 2003;38(4):1081–1102. [PMC free article] [PubMed]

Source : http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360928/#b2 consulte le 24 nov. 13

Sources additionnelles :

First Street, AHRQ, Health Services Research