THE BROOKINGS INSTITUTION

A Brookings Health Policy Forum

"PUTTING THE LID ON HEALTH CARE COSTS:

AN INDUSTRY PERSPECTIVE"

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A G E N D A

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P R O C E E D I N G S

MR. TALBOTT: Good afternoon everybody. I'm Strobe Talbott, the President of the Brookings Institution. I'd like to welcome all of you here this afternoon for our health policy forum. Before I turn the proceedings over to my friend and colleague Hank Aaron, I'd like to give you just a word or two of background on this event.

The core mission of the Brookings Institution is to study, think about—that's why we're called a think tank, and come up with ideas about the major challenges facing this country. And it's the consensus of the staff here, the scholars of the Institution, our trustees, who are represented here by Leonard Schaeffer and Ken Jacobs, and we're very glad to have both of them.

And, Leonard, we're glad you're doing double duty, both as a trustee and as a think thinker and as a panelist. It's the consensus that if Brookings if going to live up to its mission, it's got to make a contribution to one of the biggest challenges facing the country, which is how to deliver decent health care to all American citizens.

With the leadership of Belle Sawhill, who is the Vice President and the Director of our Economic Studies Program, and with a great deal of assistance from our colleague, Martha Blaxall, we've been organizing a series of what we call brain storming sessions, with experts from around the country who have been helping us explore how Brookings can best address the challenge of health policy.

We're trying in the course of this to refine a research agenda, with the hope that next year, we might be able to establish a center on health policy here at the Institution.

Crucial to this effort has been Hank Aaron. He has established himself over many years as one of this country's leading experts on the issue that we're going to be discussing today and the issues of health policy, health economics in general.

He, like a lot of Brookings scholars, is always writing a book. And he has just produced another one, which is called "Can We Say No: The Challenge or Health Care Rationing." That book will be out in a matter of weeks.

Hank is, in addition to being a scholar, also a practitioner. He has served as an Assistant Secretary in what is now the Department of Health and Human Services. He chaired the 1979 Advisory Council on Social Security. And he's also a member of the Institute of Medicine, and Chairman of the Board of the National Academy of Social Insurance.

All in all, he is the perfect person to help us move forward in our effort and also the right person to be moderating this panel.

So, Hank, over to you.

MR. AARON: The thought occurred to me, Strobe, as you were making your remarks that perhaps the best way to deal with the problem of finding the personnel and the ideas for our new center would simply be to lock the doors right now and draw on those people here sitting in the audience.

I do have to say a special hello and thank you to the person whose name adorns the chair I'm privileged to hold, and that's Bruce MacLaury, our former Brookings President, who just came in the room.

Strobe has made clear the intention of his own and of the trustees to try to restore Brookings to something of its former luster as a source of health care policy ideas, both public

and private. And this event is the third in the series to which he referred earlier to help us to develop ideas for such a center.

As virtually everybody in this room knows, health care is the nation's largest industry. Health care spending is soon going to pass pensions as the largest single federal government activity. Growth is not abating, and it's not expected to do so.

A primary question is whether we're getting as much health care as we could from the hundreds of billions—and, in fact, now trillions—of dollars that we spend each year on health care.

I think most of us would say the answer clearly is no. We are not. But the practical question is how to do better.

Today, we have three leaders of the health care industry, who will give us their thoughts on this question; and two equally informed commentators to tell us what the first three got right, what they got wrong, and what they left out.

I'm going to introduce all five of them at the start, so I can sit down and simply listen along with the rest of you.

Each of the principal speakers will have 15 minutes, which in emcee jargon means that I have no hope of getting them to sit down in less than 20 minutes, and that's what we've allotted as a practical matter.

When they're done, the discussants will have 10 minutes each, and I hope we will have 40 minutes for discussion and exchange of views both among those here on the platform and between them and those of you in the audience.

Our first speaker today is going to be Sidney Taurel. He's Chairman and CEO of one of the nation's largest drug companies. He's held the first of those positions since 1999; the

second since 1998. He's a naturalized U.S. citizen, having been born in Morocco, educated in France, and then come to the United States, where he also attended an institution of higher learning.

He's been President and member of the Executive Committee of Pharmaceutical. And he is currently a director of both IBM and McGraw-Hill.

Our second speaker—he will be followed by—Leonard Schaeffer, who is the Chairman of WellPoint, Incorporated, the nation's largest publicly traded health care company. He's also Director of the relatively, more recently created WellPoint Foundation. Business Week named him as one of the top 25 managers in the year 2001.

Before helping to make WellPoint the really smashing success that it has been under his leadership, Len served as Assistant Secretary of Management and Budget at what was then the Department of Health, Education, and Welfare, and he was also Administrator of the Health Care Financing Administration, which is now CMS. I guess the name of the game is you change the names of agencies regularly.

As Strobe mentioned, he's a Brookings Trustee.

Then we'll hear from Bob Galvin. He's one of two MD's on the platform today. He directs Global Health Care for General Electric. They spend the tidy sum of $3 billion a year on health care in more than 20 nations around the world. Besides being an MD, he also holds an MBA, which is a terrific combination these days.

His career has emphasized efforts to make sure that every dollar spent on health care buys as much of it as possible. He's helped to found two organizations that are dedicated to that goal—the Leap Frog Group, which is a collection of businesses dedicated to improving health care quality; and another organization, Bridges to Excellence.

He's also an adjunct professor at Yale University, and a member of the IOM Committee on Redesigning Health Insurance Benefits, Payments, and Performance Improvement Programs. That's a long enough title for a Brookings book.

Our two discussants will first be Carolyn Clancy, who is the second physician on our program. She has been Director of Agency for Health Research and Quality for the last two years, and she acted in that capacity for the year before, but she's actually been with the agency for the last 15 years.

Before that, she got her medical training at the University of Massachusetts, served a fellowship at the University of Pennsylvania, and then taught at the Medical College of Virginia.

One of her jobs at our—was to direct the agency's Center for Outcomes and Effectiveness Research.

Our final discussant will be Nancy-Ann DeParle. Currently, she is a Senior Advisor at J.P. Morgan Partners. She's an adjunct professor also at the University of Pennsylvania, only in this case at the Wharton School. Like Len Schaeffer, she served as a commissioner of HCFA. She's a member of the Medicare Payment Advisory Commission.

She previously before coming to Washington served as Commissioner of Human Services in the State of Tennessee, and I hesitate to say, but I will, she's a lawyer, but because of her other services, we're going to forgive her.

So why don't we start with Sidney Taurel.

MR. TAUREL: Thank you very much, Dr. Aaron.

I think it's really exciting that Brookings is bringing its powers to bear on the vital matter of health care reform, and I'm really honored to be asked to contribute to your effort and particularly humbled to be in the presence of such a distinguished panel.

To begin with, I think you've framed your inquiry with exactly the right questions. What can be done about rising health care costs? How can we upgrade the quality of health care delivery in this country? How can we expand coverage for the millions of Americans who now have little or no access to the system? And finally, how can we address all of these issues and still preserve the incentives needed for continued medical innovation?

I'm delighted that you have included this last issue in your research, because many reform proposals never raise the question, while others seem to assume that innovation will continue under any scenario.

There is plenty of evidence to show that some approaches can kill innovation, at least in the case of the pharmaceutical industry.

So I'll fill in that thought in the course of my comments today and indeed I want to share my perspective on all of the key questions that you have posed for this discussion.

But before I start offering solutions, I think it's worthwhile to look more deeply into the questions themselves.

The concerns that you have highlighted—costs, quality, and access—really describe the consequences of chronic problems in our health care system. But they tell us very little about the causes. They are really symptoms essentially, and so to pick the best solution, we first need to understand the underlying pathology, the root causes, if you will, of the problems that we are trying to solve.

I suppose that there are many contributing factors, but I see three powerful drivers.

To stretch the analogy a little bit further, the disease analogy, I would say that the American health care system suffers from a metabolic disorder, an autoimmune disorder, and a cognitive disorder.

[Laughter.]

MR. TAUREL: Bear with me. That will become more clear as we go forward.

The metabolic disorder is really an economic problem. As the intake and utilization of food drives the performance of the human body, so does the intake and utilization of funding drive the performance of a health care system.

People with certain metabolic disorders may overeat because the chemical signals that usually tell the brain when to eat and when to stop are out of balance.

A similar malfunction is at the heart of the endless cost spiral in the U.S. health care system.

There is a breakdown in the economic signals between buyers and sellers, where normally price is the balancing mechanism. In health care that exchange, as you know, never happens because one party, the patient, needs and consumes the medical services while another party, the government or my employer or the insurance company, appears to pay for it.

And I say appears because economists would argue that one way or another, consumers do bear the costs.

But because we think of it as somebody else's money, we feel little inhibition about spending it. Feed me, the consumer says.

Conversely, the payers are driven to focus on costs above all else and cannot fairly or fully balance their concerns with considerations of the long-term benefits to the patients.

So stop eating is their message.

And the sellers—the doctors, the hospital, the drug companies, and all the other suppliers—are really caught between these conflicting signals.

But still, they are—we are—the sellers. And so in general, we will try to provide what the patient requests.

Consequently, like the over compulsive or the compulsive over eater, we as a society cannot seem to check our consumption.

Now, the side effects of this fundamental economic dislocation are pervasive. Harvard's Michael Porter, probably the world's leading authority on competition, has recently focused his analysis on our health care system and found that the very principles of competition have become deformed. He argues that competition in health care is really a zero sum game. As he puts it, and I quote: "The system participants divide value instead of increasing it."

He shows how instead of competing to increase value to consumers, health care payers and providers compete to avoid costs to themselves. So what we see is an endless cycle of cost shifting. Again, quoting Porter: "Costs are shifted from the payer to the patient, from the health plan to the hospital, from the hospital to the physician, from the insured to the uninsured." And those gains in one participant come at the expense of others and frequently with added administrative costs. It's obvious how such behavior powers the upward spiral of costs. It's also obvious that the root of it lies in the fracture that separates patient from payer.

When I say that another key pathology in our system is like an autoimmune disorder, I'm thinking of the impact of various kinds of government involvement.

The immune systems function is to protect the body, mainly by detecting and neutralizing harmful intruders, such as viruses and bacteria.

But sometimes the immune system runs out of control and begins attacking the body itself. That's the essence of an autoimmune disorder.

Most government regulations in our economic system are designed to protect citizens from potentially harmful practices. But in the case of health care, massive over regulation, while surely intended to protect us, has instead created a great deal of economic friction, tremendous waste, and inefficiency that is crippling the system as a whole.

Recently, one group of scholars attempted to compute the total economic impact of all the regulatory complexity in our system. Subtracting total benefits from total costs, they concluded that regulation in our current system imposes excess costs of at least $169 billion a year. That's about 10 percent of total health care costs.

In health care sometimes even the best intentioned act of government intervention can have unintended and undesirable consequences.

The split between patients and payers can be traced to a quirk of policy expediency during World War II, when the Roosevelt Administration allowed employers, as you know, to skirt temporary wage and price controls by offering health benefits to workers in lieu of higher wages.

What really locked the system in place and greatly amplified the economic dislocation it causes was the subsequent decision by the government to exempt these benefits from taxation.

All of us who receive our health care through our employers are dependent on this break, but it has pernicious consequences. In effect, it inflates our currency for buying health

care insurance, and, thus, compounds the third-party payer problem in weakening even further the price signal in health care transactions.

Consumers who enjoy this invisible subsidy are less sensitive to the true consequences of price, and, therefore so are suppliers. This is one of the keys to the perpetual rise in costs.

And, of course, it is a key to the problem of the uninsured. If you don't get health coverage through your employer, you don't get the significant discount. You have to pay full fare, and many simply can't afford that.

Now, this is not to say that all the friction, the wasteful friction in the system, can be laid at the door of government. A significant part of it arises from the third systemic disorder, which I compare to a cognitive disorder.

Our health care system seems to be plagued by a strange pattern of willful ignorance.

Many of the deadly medical errors and other quality problems that plague U.S. health care can be traced to a gap in the flow of necessary information. Too often, vital information is not available not because it does not exist, but because we do not allow ourselves to see it, share it, and act upon it.

Exhibit A is the general failure to fully adopt and implement the advantages of information technology. Though it's starting to change, too many people in health care are still living in the world of paper charts and hand scrawled prescriptions, and we all know how well physicians write.

We need a world in which our doctors have instant electronic access to our complete medical records. And for consumer-driven care to work, we need a world in which

consumers can go online and get reliable information about price and performance for health care products and services.

Now, some people look at the depth and the complexity of all of these problems in American health care and conclude the free market has failed here.

The only solution is to build a nationalized health care system along the lines of Canada or England.

I believe this is not the correct conclusion and certainly not the correct solution. The free market hasn't failed us here. It simply has never been given a chance to work.

On the other hand, government managed systems have been given numerous chances to work in various nations around the world, and the evidence suggests that they are far from ideal.

When health care is offered as a universal entitlement, free or heavily subsidized at the point of service, there is no economic check on demand.

To stay solvent, the socialized systems typically impose a check on supply, some type of rationing, in other words.

Often the logic behind the rationing choices seems topsy-turvy. To quote from one recent survey of nationalized systems, and I quote: "Not only are health care resources not allocated on the basis of need, these systems tend to overspend on the relatively healthy, while denying the truly sick access to specialist care and live saving medical technology."

The politicians and bureaucrats running these systems aren't trying to be cruel or callous. They are simply following the logic of social democracy, trying to produce the greatest good for the greatest number.

Good politics, but bad medicine.

Government-run systems also tend to impose price controls to hammer down costs, and use their regulatory powers to slow down the introduction of new and more expensive technologies. As a consequence, presumably an unintended consequence, these countries fail to provide adequate support for medical innovation within their own borders.

And my industry in the last 30 years has produced a steady migration of pharmaceutical innovation away from Europe and Japan and toward the United States. Even 20 years ago, European companies produced twice as many new drugs as U.S. companies.

By the turn of the century, the U.S. industry had caught up with and now outperforms European companies by more than 20 percent.

Moreover, one-third of European R&D, R&D conducted by European companies, is now made in the United States. When looking at products under development in total today, about two-thirds of all potential new drugs are now based in the United States.

The lure is not brain power or better science, but simply the relative freedom of the American market. But I have no doubt that if we were to adopt a system like those in Canada or the U.K., innovation would die back here as well.

A recent study from the National Bureau of Economic Research calculates that the drop in drug prices of 40 to 50 percent would create the corresponding decrease of 30 to 60 percent in R&D projects.

So I don't think that this is the kind of solution that Americans are looking for. I'm confident that if we can apply free market principles in a sustained reform effort, we can create a health care system to match our progress in medicine. And indeed I believe that continued progress in medicine depends on achieving free market reforms.

So let me just quickly sketch a few key principles for building a better system.

First and foremost in my opinion, we need to build a consumer-driven system. In order to instill a sense of personal ownership and to break the endless cycle of expanding costs and cost shifting, we need to heal this economic fracture at the heart of our present system and put the individual consumer back in charge of how money is spent.

That doesn't mean that people have to pay for everything out of pocket. There should be still a central role for insurance and indeed for government assistance. But no one should be allowed to think of health care as free completely or paid by others.

Congress has already taken a giant step in this direction by including authorization for health savings accounts in the Medicare Modernization Act. These HSAs are designed to be combined with high deductible catastrophic insurance coverage so that people meet first medical expenses from the HSA up to the deductible limit, after which the coverage kicks in.

This not only puts the purchasing power in the consumers' hands, it dramatically reduces the cost of insurance coverage. And most importantly, these accounts belong to the individual, not the employer or the government. They will be portable, from job to job, and eventually from employment to retirement.

Second, we need to restructure the system so that it is patient-centered. We need to end the continual tug of war between the many interests in our system and refocus decision making on a single question: What is best for the patient?

This doesn't mean that we create a system that indulges the patient's every whim.

On the contrary, a patient-centered system would begin with the idea that we as individuals bear primary responsibility and accountability for our own health.

The role of all the providers and the first objective of the system should be not merely to help us when we fall ill, but to work with us and teach us how to prevent illness in the first place. Doctors should play a key role in helping patients see the incentives for healthier living in terms of reducing both illness and costs.

A patient-centered system should be one in which providers compete on value and are measured on quality. But that can't happen unless physicians and other providers are also unshackled to act fully as agents on behalf of their patients. They, too, need to be cured of the cost-shifting disease and allowed to truly compete in an open market, where patients pay for results and use reliable quality measures to predict those results and chose their providers.

Ultimately, to really deliver value to patients, all provider services need to be restructured into a system of integrated care. Prevention, treatment, and health maintenance should all be provided and funded as a unified package, not as a disjointed string of treatment episodes as it is today.

Third, we need to bring health care into the information age. We need to step up now and build a nationwide medical IT system necessary to reduce errors, to promote consumer choice, and to integrate care.

And the good new is this is finally underway. The federal government, led by CMS, is working to establish standards and protocols for recording, sharing, and very important protecting patient information and it will use these new tools to bring Medicare, Medicaid, and the VA systems into the digital age.

Once that happens, it should create enough critical mass to pull in the private sector as well.

Number four, we need to work towards a system that is friction free. Government at all levels should work to weed and prune the regulatory framework now choking health care, preserving only those parts which truly protect the interests of patients, and eliminating those which create costs in excess of their value.

We should start with tort reform, which is long, long overdue. Reformers have come close but failed several times over the last decade, during which time tort costs have risen far faster than even health care inflation.

Medical torts now impose a net cost of about $80 billion per year on the U.S. system.

Another big policy target should be to get the states out of the role of regulating health insurance.

The large insurance companies have long argued that larger, more cost effective insurance pools could be formed under federal guidelines.

Fifth, and finally, we should build a system that promotes universal access. We must do everything we can to extend some form of affordable health insurance to all Americans. Free market reformers argue that the best way to deliver this is to replace the tax exclusion for employer-based benefits with a refundable tax credit available to all, provided it is used to purchase some form of health coverage.

The credit can be easily supplemented with additional financial aid to those in need.

And just this week, we saw reports that the President's Tax Advisory Panel will probably recommend capping the exclusion for employer-based health care at $11,000, granting

to employees who buy their own insurance a tax deduction of the same amount, and finally creating a refundable tax credit to help low-income families buy insurance.

So bringing the case full circle, we can see that changing the tax code is really vital to creating a consumer-driven system accessible to all.

To make sure that all consumers buy with the same currency, we need to create tax parity between those who buy coverage through their employers and those who want to buy it on their own.

And to make sure that all consumers spend those dollars carefully, we need to give them direct control.

Now, any of these measures, if enacted, would improve our system. All of them together can truly transform it.

But forward progress on something as emotional as health care is bound to be tough in this blue state-red state political environment.

So I can only hope that we can keep working, keep pushing, and take it one step at a time, if necessary.

But what we must do is to be very careful not to take further steps in the wrong direction, and enact measures that may temporarily ease one of the symptoms, but make the underlying pathologies worse.

It will take time for market-driven reforms to work their magic and realign buyer and seller in a conversation about value. But when it is done, and when we have made that journey, we will not have done merely a hard, but a necessary, thing and created a health care system worthy of the best medicine that the world has to offer. Thank you very much.

[Applause.]

MR. SCHAEFFER: We're going to attempt a technological feat here, where Bob is going to try and get my slides to come up. Okay. Super.

Don't turn out all the lights. There's—that's it? Super.

I think many of you know the secrets of getting ready for a public speaking opportunity. They were taught to me very, very long ago, and they are to arrive 10 minutes early, to immediately go to the bathroom, to comb your hair, and then to check on your slides.

And I did all of those. When it came to checking on the slides, I ran into trouble. I want to thank Bob for his help.

I also want to tell those of you who are newer and younger and involved in this that there's a new thing out there, which is they put mikes on you so you can walk around when you talk. They always put the mike on after you go to the bathroom, not before.

[Laughter.]

MR. SCHAEFFER: We're going to see if this works. Holy cow.

I'd like to cover these five topics before Henry does the hook, and gets me out of here.

I want to talk a little bit about the marketplace, and then we'll talk about value. I think this is the issue in health care, and it's ugly.

Then we'll talk about emergence of infomediaries, which I think is going to have a big impact on our health care system; and then the necessity for investment. We need more than just the market I'm afraid. We need more than just government. We need to make some big investments in this country, and they're not going to come easy. We need people to be willing to step up, and then, of course, there's a huge finish.

[Laughter.]

MR. SCHAEFFER: All of you are familiar with this data, so I won't take a lot of time. But the point is we have about a four percent, three to four percent inflation economy. Why are health care costs going up so dramatically?

Well, it's not doctors taking home more money. But it is doctors making—doing prescriptions and ordering tests and doing a bunch of other things that lead to very high costs.

In the good old days and before I knew that Sidney was going to be here, I would blame everything on the pharmas. You can't do that. He is too nice a guy, and it ain't true anymore.

You take a close look at pharmaceuticals, what you found is they were the very bad guys at the end of the '90s, down now to about seven percent in terms of inflation, and it's only about 10 percent of the action today, although it's going to grow dramatically over time. So we really can't say it's their fault, although still not at four percent.

However, if you look at the hospital world, what you find is in-patient care, at least since—the middle '90s, where it was going down, is now up and it's up at about a six percent rate.

So hospitals are growing and they're a much bigger piece of the action obviously than pharma and this is the real issue, which is hospital out-patient has grown at a very dramatic rate. For the last three years, the single fastest growing element of health care costs, and according to some analysis, taken together, hospital in-patient, out-patient was about half of the total increase in spending between '03 and '04.

By the way, in terms of hospital costs, utilization is going up very slowly. This is almost all price increase. So in my effort not to offend Sidney, I'm sure I have offended everybody from the hospital world.

Now, the point of this is not that hospital—that costs are going up. We all know they're going up. The point of it is how these cost increases are perceived by the players.

And if you take a look at how they're perceived, well, first, you have to see the national health expenditures as a percent of the GDP has grown dramatically. From 1970, we've seen it more than double, from seven percent of the GDP up to over 15 percent. And this is a period of time when our gross domestic product exploded.

So it doubled at a period of time when we had this incredible growth. So everybody knows costs are up.

From the point of view of employers, though, here's the more significant piece of information. Out-of-pocket costs borne by patients were about 34 percent of the action in the '70s. They're now down to about 14 percent.

So when viewed from the point of view of employers, they are shouldering the burden. Viewed from the point of view of patients and individuals, health care costs are going up, but most Americans have no idea how much they're going up, because, although they're only paying 13 or 14 percent, it's still a lot of money. But they are essentially shielded from the real costs. And so you have employers desperate to get out from under it, and I'll talk in a minute about what employees want.

From the point of view of employers, they want out. And it's not simply that the costs are going up too much. It's that they're being and have for a while to impact profitability. And here you have GM, the once greatest corporation on earth, whining about its huge loss being a function of the costs that they have to bear for their employees. It is a true fact that the cost of health insurance exceeds the cost of steel in American cars. You ought to ask who signed all those contracts and gave all those benefits. That's another question. But the point is they are in

trouble, and the degree of trouble is so severe that in an off-bargaining year, GM and the unions came to the conclusion where they think they can save about $3 billion. Trust me. That ain't enough, and they will be back.

So employers want out from under something fierce. That is not what consumers want.

Consumers want choice. They want to be able to choose their plan. They want to be able to choose their provider. And much more importantly, they want to be able to make choices based on cost and based on outcomes. In other words, they want to know how much it cost, and whether it's going to work or not. And we can't tell them. Okay. They do it—there's no place to go to get that information that's meaningful on the employee or the patient or the non-professional level. And that is the problem. So what we need in this country is both information and tools for decision making that individuals can use to make these choices.

I would say parenthetically that doctors need a lot of this information as well. Most physicians don't understand cost. Most physicians don't know how their outcomes compare to other outcomes in other parts of the country. There isn't a meaningful way to do that, either.

So it's not simply getting information to individuals when they need it to make a choice about a procedure or about a course of treatment. It's about having that information available for all the players, and making that information available for decision making. We got endless amounts of data—endless amounts of data. We have very little information for decision making.

So you're at Brookings and all these academics around obviously all we need is better information. Wrong. Okay. Because health care is not about information. It's not—it's a

little bit about science, but a little bit about economics. But in our society, it's a lot about social values. I'm going to spend a few minutes on this, because it's not that quantitative and people don't want to talk about it.

But what we've seen in this country is a consistent change in the definition of what is health, what is health care, and what should insurance and the government pay for it.

And I'm going to try to go through some examples that are provocative. The first one is alcoholism. Fifty years ago, you had Uncle Harry drank a lot. They kept him in the back room, and he kept drinking until it was all over for him.

Today, it's a 24-day in-patient stay, and if that doesn't work, they get another one and another one and another one. We have medicalized alcoholism. It may very well be good. I'm not against it. Okay. But that's a social transformation.

Take a look at drug abuse. Thirty years ago in this country, if you were dealing drugs, you went into the criminal justice system. Today, if you're white and if you're middle class, you go into the health care system, and it cost a lot of money, and it's another 24-day in-patient stay at other more interesting places. And you go again and again and again. We have movie stars on television comparing their rehab experiences.

A more recent one and really fascinating one—and we're facing a diabetes epidemic in this country, because of the number of people who are overweight and morbidly obese. Well, a weatherman went into the hospital and got his stomach stapled and now everybody wants that—everybody wants it. It is extremely expensive. Somewhere between two and five percent of the people who get it die from it, and in the good old days, your mother said stop eating. Lose weight.

We are transforming what the medical system is expected to do and the reliance we place on it and every time we do it, we raise the costs dramatically. Now, everybody is about to go to sleep, so I'll try one that you won't forget.

Let's all talk about erectile dysfunction. Now, that's a topic which 10 years ago if I tried to talk about, I would either be asked to leave or the ladies would be asked to leave or basically we would have a socially embarrassing problem.

Now, it's not necessary because drugs for erectile dysfunction are advertised on television every day, so we can all talk about it.

I'm very proud that WellPoint was the first company that said it would cover Viagra when Viagra came out on the market. Front page of the New York Times we said we would do it. Now, what we said was that we would cover Viagra when a person had another—had a diagnosed disease state, one of which's symptoms was erectile dysfunction. You just want a hot Saturday night, you're on your own. Okay. I was very proud of that.

It turns out it was the wrong question, the wrong issue. The issue is not do you cover it or not. The issue how many people is a one month's supply.

[Laughter.]

MR. SCHAEFFER: Now, I don't laugh at what you guys do. I don't. This is a serious insurance question. But it's a serious social policy issue, because we're talking in our society about a society that's plagued with chronic illnesses, and the issue is not cure. The issue is lifestyle.

What are we willing to pay for to get people back where they want to be, where they ought to be, where they can be as human beings?

I'll tell you briefly, I used to go to cocktail parties before Viagra came out. I would mention this topic. People were fascinated by it, and how would say how many pills is a one-month supply. Women always gave the same reaction. Let's see one month, that's four Saturdays, 31 days, three pills.

You asked men: 31 days, four Saturdays, 36 pills.

[Laughter.]

MR. SCHAEFFER: You won't forget this. It is a serious question. And what is an insurable event? What is health? And the answer is not scientific. The answer is in our social values. And that is driving health care costs. Well, he made his point. He should get off stage.

I'm going to talk about value. Very, very serious problem—value for money. Health care costs go up every year by X amount. Okay? Does the value we get go up by X amount? Does it go up at all? Are we getting anything of value? Okay?

Bad news, people. Fifteen percent of the GDP we do not know what we're getting for our money. According to the Dartmouth study, more care and higher spending do not result in better outcomes. Say that again. The more you get, the more it costs, the worst the outcome. In fact, there seems to be an inverse relationship that cheaper is better. That's not what people believe in this country. That's not how people behave.

There's huge variation in evidence-based care. In other words, if you saw Beth McGwin's [ph.] work, 45 percent of the time, you'd go to the doctor. You do not get evidence-based medicine. Eleven percent of the time, you get stuff that's harmful; that's bad for you.

There isn't another part of the American economy that would tolerate that kind of failure rate. We are not getting value for money. And the variation is incredible.

According to the, you know, GAO, the variation in hospital costs—259 percent for hospitals; 100 percent variation for physicians. No correlation with outcome. No correlation with quality of care.

So what's going on? We got trouble.

What's going on is people want information and particularly employers want it because they want to make decisions based on information, and increasingly patients want it because they want to do the right thing. You know, I mean it's their families. It's their bodies. Okay.

And what's going to happen I think is we're going to see what I call infomediaries emerge.

Now, what's an infomediary?

There's a lot of information around. In the good old days, the HMOs said we'll look at the information, and we'll decide what's right and what's wrong for you, and we will control your access to the health care system. It does not work in America, contrary to our social values and beliefs. Okay? What we learned was we got to make that information available to others.

There are intersections today of those key information flows. Health plans are important ones. But others are getting into the act, and you'll probably hear from GE and IBM and others about how they're going to get on top of that flow of information. They're going to capture it. They're going to integrate it, analyze it, and if they can turn it into—if they can take data and turn it into knowledge for decision making, helping people decide what to do, we could have a transformation in American health care.

We'd have a consumer with the information he or she needs to make decisions about himself, herself, or their family. We could have providers much more knowledgeable about not what is community standard, but what's going on all over the country and all over the world, and most of them don't know.

And we could have insurance plans, both government and non-government, that were based on what works. We ought to pay for what works and we ought not to pay for things that don't have better outcomes. Right now, it's very, very hard to know which is which.

One would hope with the right amount of information, we could improve products; in other words, make more choices that are more appropriate to people; that we could build networks of providers that were based on their ability and their quality and their outcome. We could generate pay-for-performance programs. We don't have time to go into it now, but one of the key problems in health care is you get paid for doing it. You don't get paid for doing it well. You don't get paid less for doing it worse.

One of the things that would be very helpful in health care is to reward people financially—physicians react very quickly to financial rewards and punishments. But we can't tell, and we can't tell in a meaningful way, so that would be very valuable I think.

We could also develop better medical and cost management strategies, and just generally information transparency in this very complicated would be very, very helpful.

Notice information. Not data. We got lots of data. It's almost impossible for the average person and certainly for the average insurance company CEO to understand what's going on.

I want to take a step back from all of this and talk a little bit about social investment. We—a 21st century in the health care system in America is possible, but it is not inevitable. The forces are not aligned to make good things happen.

You know in health care, Adam Smith's invisible hand writes inside out. Not backwards, but inside out. You get very odd outcomes. The source of supply controls demand. You have, you know, investment in plant, and it's clear that the more hospitals you have, the more people are in hospitals. There are a bunch of things that don't make the normal system work well.

So we got to do some things to help it work well.

And our company, we decided that our self interest is involved in trying to impact the health care system in these ways: changing the system, improving health, expanding coverage. Because it isn't going to happen just naturally, and it cost a lot of money given the size of the system.

I just want to briefly some examples of attempting to do this, and some lessons learned, because this is not a normal part of the American economy.

We spend about half a billion dollars on our own IT strategy every year, and one of our big problems is we get the doctors, and they're not online. They are doing, you know, on the back of envelopes.

So we said, okay, we will give you free for nothing, either a laptop or a handheld gizmo to do prescriptions and all you got to do is accept the gift. Okay?

We had to talk to 26,000 doctors to get 19,000 to take the free gizmo. And I got one of the nastier I've ever gotten from the California Medical Association accusing me personally of unfairly burdening doctors with gift packs.

[Laughter.]

MR. SCHAEFFER: I'm a well-known bad person. Okay?

What was very disappointing to me was that we only got about 2,000 doctors to accept the hand-held gizmo, and this thing, according to the IOM study and other studies, could save lives, could save time, would save time, and save a tremendous amount of money—over $4 billion. But most people took the laptop instead, and from what we can tell, a lot of those laptops went home, and, you know, people are doing whatever they're doing with it.

I was very puzzled why this thing didn't work, because there are no—it was totally hands off. You take it; do what you want with it—until Harvey, you know, Feinberg at IOM explained to me that if you're running your own medical practice, free is not cheap enough. And he wasn't kidding. In other words, what you're asking is for physicians to change the workflow in their offices. And if, as a result of that, the total health care system improves or maybe total health care costs go down. That's nice, but what's in it for me. I'm running a business. And it's not going to improve the quality of what I do, because what I do is pretty good.

So we've got to find carrots, I hope, and sticks maybe to change the way the health care system works. And on behalf of all the people I've offended from the hospitals, hospitals are worse.

We tried another approach. I don't know if this is going to work or not. But we gave some money to this REO [ph.] that's supposed to develop this, you know, automated information exchange. It's going to be confidential and all that other wonderful stuff. And I hope that that works. But that's third party, and the notion was maybe a third party will be more trusted.

I personally, because my background is in IT, I think this is big important stuff, but the question is will anybody use it. This is a lot of, you know, if you go build it, they will come. We'll have to see.

All right. So here's the big finish. Health care consumption in this country is going to grow because we're aging, and as we age, the good for human beings is we're living longer. As we live longer, we fall prey to chronic conditions. Lots of therapies are made available so that we can live even longer and get another chronic condition, so health care costs are going to jump as the baby boomers age.

More important, the baby boomers are I think the richest generation in human history. We do a lot of research. They want three things. They want to look good, and oddly enough they're depending on the health care system to do that. They want to feel good. They're depending on the health care system to do that. And they want to live forever. And they're going to give it a good shot, so health care costs are going to go up.

We're going to try all kinds of things. Sidney mentioned consumer directed. We're going to caution a lot of things we're going to try, but they ain't going to reduce health care costs. That is not going to happen in this country as long as our economy is vibrant.

Second, there isn't a simple answer. There ought to be. I thought put me in charge. I'll run HCFA. It will all be better. I didn't work.

We need leadership across the board. Nancy-Ann did a lot better than I did on that. We need leadership across the board. We need better data. We need to be able to turn it into information. We need new behaviors. We have to change the way doctors and patients act. We need political will, which we ain't got right now, and we need a culture of accountability—Personal accountability for your own health status.

This epidemic of diabetes is not going to be because doctors failed. It's not going to be because we don't have good IT. It's going to be because an awful lot of people in this country aren't just overweight. They're morbidly obese, and they're doing it to themselves, 'cause it is socially acceptable.

I think we have about a two-year window. My guess is the next presidential election is going to be all about health care unless terrorism is still at the top of the list. And it will be about different kinds of health care. One, how expensive it is—what we've been talking about today; two, what we're going to do in a pandemic situation; and three, what we're going to do for natural disasters and other rare, but devastating, catastrophes.

This country has never really looked at that. Okay. We need big investments in redundancies, and we don't have it. And that's going to be a huge issue I think.

But as I said earlier, health care systems reflect social values, not just the things we like to talk about—you know, the costs and the research, and I think those social values are going to have a huge impact on how this thing plays out.

So now, I will turn it over to Bob Galvin, an MD and an MBA. When a person has an MD, an MBA, and a JD, they're referred to as the complete catastrophe.

[Laughter.]

DR. GALVIN: Thank you for that introduction.

[Laughter.]

DR. GALVIN: [Inaudible.] of catastrophe.

MR. SCHAEFFER: I'm not a JD.

DR. GALVIN: Thanks to my kids for teaching me how to do this.

Did you see that message that came up? Here's one thing he taught me is ignore him. Just hit okay and keep going, which I think works.

Well, thank you for asking me to speak today. I actually went a slightly different route in my talk today than just talking about health care costs in general for a couple of reasons.

I think first I figured that Leonard would do a very good job, which he did. I've done a lot of work on that, as Henry mentioned, in terms of getting public release of information, driving consumerism, and the payment reform in Bridges to Excellence. And about a year ago or so, I started to direct a lot of my thinking to I think what I'm convinced is the largest driver of cost over the next decade and longer, which is new technology.

And so what I am going to do today—I don't have any answers, and so this is really a work in progress. I really took this opportunity to try and put together my thoughts after about a year of talking to a lot of the top people about trying to understand what this is all about and what we can do about it. So it's kind of a—it's a work in progress.

I did learn two things. I learned first of all it's incredibly complicated and awfully controversial. That's why I'm calling it the third rail. And you know the third rail comes from the railroad industry, where actually the two wheels of the rail, kind of you have two rails that the wheels go on, and then you have a third rail that provides the electricity. And if you touch it, you die. And that's what it seems like when you talk to either kind of suppliers or payers about what to do about tech assessments.

And the second one is that I really am convinced we need to think very differently. I'm really convinced we're in an old model.

But let me start and tell you what my thoughts are. First, this is a slide that I think is worth showing. This is one that Jeff Immelt, who is the CEO of GE, shows all the time, which

was we're in a very interesting kind of situation as a company. GE it's a big, big company. One of our divisions is the Health Care Division. It's about $15 billion. You know it makes MR machines, CT scanners. We're in IT now, and then I am on the cost side trying to, as Hank mentioned, trying to figure out how to spend well, and so he used to have the takeaway at the bottom. He used to call it a perfect hedge. And when he speaks to other CEOs, he would basically say I got better than most of you. He said 'cause at least when I walk in on January 1st, at least I'm not spending on health care. I'm making as much from the health care industry.

What it does for me is give me an opportunity to actually see the kind of innovator-producer-supplier side up close. I don't make any decisions based on what we cover based on the fact that we're in the same company. In fact, that business is frequently mad at me, because I don't. But I've learned a lot about how businesses like that operate; how they think; and how they look at it. So it's a nice opportunity I think to try and figure this out.

I think the first kind of conclusion that I came to is that we need to decide where innovation fits into the health care system. And I became convinced over the last year if you talk to patients, if you talk to consumers, if you talk to physicians, and if you talk to payers when they get sick, you will see that innovation is a core value. And so I wish I could have gone back at the IOM time when we came up with this step, you know, idea. This is what came out of the crossing the quality chasm a few years ago, where, you know, we basically said care was safe, timely, effective, efficient, equitable, and patient-centered, which I think is right. And I think innovation was somehow subsumed under kind of effective. But I think it exists separately. And so I don't know if you agree with it or not, but if you did, then I think it would change then a lot of what we do. If you look at what's happening around the country now, in terms of hospitals, physicians, and employers all the activity that's going into trying to reform the system based on

this steppe acronym, you would get a sense of, if you had innovation in there, we might be doing things differently. I might point out that one of my children, my daughter, is an English major, and she pointed out to me that it should be innovative. I guess it was a grammatical flaw I made. I didn't have time to change it, but kudos to Jennifer.

What does the kind of—kind of what's the state of technology assessment? I don't think this will be a surprise to anyone. I don't think it's working well for anyone today, because we have great innovations that aren't used soon enough.

I don't know how many of you had personal experience with it. I did with one of my kids who needed surfactant when she was born a long time ago. It hadn't quite passed all the hurdles. It passed the hurdles three months after the time she needed it. It was pretty clear that it was effective, but there was no opportunity to have any kind of flexibility about how it's used.

I think that's a frequent story. I think great innovations don't get there soon enough. And then innovations with minimal benefit are overused. And the story that we tell—I could tell a million of them from the $3 billion that we're spending that we're spending this year. But I mean Vioxx is a great story. Vioxx and all of those COX-2 inhibitors are pretty good anti-inflammatories. And a couple of them seemed to actually spare bleeding of the stomach. And our calculations, the same as Kaiser Permanente's and maybe WellPoint's, was about three or four percent of the population really needed it.

The usage in our population who was taking non-steroidals of any kind was 55 percent. And so—and that's typical. That was absolutely the way it was. This was before the safety issue. So you kind of—you see where payers get shy on this, and that leads kind of to the next kind of point, which is there's no clear accountability or leadership that I can find. If, you know, if we were to ask the question how well is the technology assessment and reimbursement

process that we have working to meet those two criteria, the answer is who could answer it and who would you report it to.

I don't know. There is no kind of leadership that I can tell.

And I think it's pretty clear—and this I've learned from the business we have at GE—that this whole—I mean we all are focusing on drugs, which I think is right. I think there's some fantastic things in the pipeline. But I think what's going to catch everyone by surprise is a lot of the imaging treatment combinations. The innovations and the revolution that's going on in imaging, to be able to see things at the molecular level, kind of guide treatment, combine it with medications, and then kind of all of the stuff we're learning about personalized medicine is just going to I think really horribly overtax our system.

So this is what I can—this is the brilliant result of my year of thinking about it—it was the cycle of unaccountability. And it is, you know, so I haven't gotten to the solution yet, although I do have a few more slides.

But I mean this is as much as—I went and talked to all the leaders I could find. And so from the pharma and device folks, what I heard—I think this is legitimate. I think this is how people legitimately see it. My job is innovation. It helps people. And they say, and that's hard enough to get that done, and it's very hard to do that.

It's really up to the physicians and the professionals to do the right thing once I've come up with the innovation. You then go talk to the leading clinicians, and their job is—they say, look, I'm not here to do anything but everything I can do to help my patients. And if I think there's an advantage, and the benefit outweighs the cost in my mind, I'm going to do it. And then, by the way, if I were to say no to anything that might help, I'm going to get sued, so I better do it.

You then go talk to the consumers or the patients, and I think Leonard summed them up, which is pretty much, you know, they do want the best of everything, but they don't want to pay for it, and we've conditioned to do that.

So you move around to say where are the regulators with this? And I think the FDA is trying hard to do a good job, but it's basically, hey, look. I'm about safety. These cost effectiveness and appropriateness is not what I do.

And then it comes to the payers, and I would include employers, like myself, and insurers, like Leonard, in that, and basically what I hear is well, we do want to pay for the right things, and this will be music to Hanks' heart, but saying no jeopardizes our relationship with consumers and clinicians.

And so you have this circus rhythm going around and round. I don't think that's news to anybody, but I think that's pretty much kind of the baseline from which we have to figure out how to do better.

And so here's what I think, and I didn't interview anyone for this. I just asked myself what I would like to see. And it's this—and I think this is pretty kind of commonsense. You know, we want to get the right new patients and treatments to patients as fast as possible, and we do not want to pay for new treatments that don't add value. And I think that's pretty simple.

And so just in thinking about how we could get there from here, I just came up with four ideas that I'm going to just percolate and hope we can have some discussion about them.

And the first one is that the people that ultimately pay for care, you know the employers and the employees whom they represent, need to change their mindset. Second, we

really need a lot more and better research about not only what's working and what isn't, but how we kind of can get that information a lot faster. I think the third is the relationship between payers and suppliers just couldn't be any worse—

[End of Tape 1, Side A; flip to Side B.]

DR. GALVIN: [In progress.]—think that put yourself now in the consumer or patient role, I don't think you'd want the relationship to be so adversarial for something that is going to produce something that could save your life or one of your family member's.

And I don't see how this thing gets solved except but by the payers. And I don't think the public payers—I don't think this is a regulation issue. I think it's going to be a partnership. I think it's going to be public payers, and I think Mark McClellan is doing a wonderful job of trying to push ideas through.

But I think the private payers have a lot more flexibility and a lot more freedom to drive, and I'll get to that in a minute.

So talk about employers or purchasers in the mind set. So I'll give you my confessions of a reformed cost cutter, because I've been managing this for a while at GE and when I first got there, 10 years ago, basically the issue was, you know, we're spending too much on health care. Get control of this beast, and, you know, cut some costs.

And so here's the lessons I learned. It all could be summarized by saying it doesn't work. And I think, you know, kind of sub lesson one of that is, you know, obviously one person's cost is another person's revenue, so, you know, we cut cost, someone is going to have trouble meeting their quarter. There's lot of smart people in every corner of this sector, and it simply doesn't work.

Second—and we learned this through the managed care era—if you focus on cost without quality, it's a dead end. First of all, you get some short-term benefits, but then look what happens. The backlash is pretty severe because I think down deep people know that that's not what health care is about.

So this idea of value that we're playing with, you know, kind of the best quality at the best price I think is what we all think now.

I think that we ought to get payers to get excited when they hear about new innovations. I have a pharmacy and therapeutic committee we do in GE because we spend about $750 million on drugs. So we meet every month, and I have my kind of team of health care managers in there, and then we have kind of an expert come in and talk us through the pipeline. And it's really amazing to watch.

As soon as a new blockbuster is about to come up, all my health care managers wince. You know, they just oh, my God, here comes another. I'm going to miss my numbers. And I think that that's wrong. I think the idea ought to be how terrific. There's a great new treatment, and a great new therapy that's going to help our employees and their families. And I think that would take a mind set change, because it has to be balanced by paying less for the unnecessary stuff. And I think that's kind of the balance. And I have put out the challenge many times to drug companies when they would come to me and say let's do disease management, and the disease management was always about getting our employees to take more of the drugs they should be taking, which I thought was great. And I say okay, but could we also have a program where we cut down on the stuff that they don't need to be taking. No, I don't have a take up yet, but I'm waiting.

Let me get to the kind of relationship, because I think that we all know, and this doesn't have to be health care, but if you have tow kind of groups of people that are critically important to kind of making a system work, and I think that would be true of the device makers, the drug companies, and then the payers, and they are absolutely at odds; and there's distrust, and there's kind of frequently hostility, it can't be the right system.

And this is kind of as I talked and I learned if I talked to the people in my own business, if I go to the pharma, I mean they are a dedicated group of people who are absolutely there to help patients and prevent and cure disease. They believe that innovations save money, bring people back to work sooner; and they're good for the economy. I mean, in fact, they employ a lot of people. And they think basically payers don't get it. They think, and as I told you about my health care managers, rightly so that payers are just trying to keep the costs down.

If I go over to the payers' side, they actually are very sincerely believing that they are trying to keep health care affordable and do the best they can to get the right treatments to people. They think some innovations are great, not all of them.

But many are absolutely unnecessary, and they think that the pharma and device makers don't get it. They're just driven by quarterly earnings and kind of just trying to drive up their product whenever they can.

So the current situation is clearly there is no constructive dialogue, and you can read it there's no planning, and the positive side is there's lots of opportunity. And I think it's led us to this slide, which I kind of—it helps me think through some of what I think we need to help solve.

And kind of what this slide—it's a cycle time slide. It's basically if—let's say there's a great new innovation. How long would it take for that innovation to get to a patient, and so what are the steps it needs to go through to get there.

And interesting, most of the literature and most of the policy community focuses on regulatory approval. So most of the focus is on fast tracking FDA—what can they do better, et cetera.

And what I found is that there's a whole other world of kind of inefficiency and waste in the cycle, and that's once you get a pre-market approval, what happens in terms of getting the right codes and getting the insurance companies to cover it, and to figure out the reimbursement.

And, in fact, it takes a long, long time to get there, and frequently up to five or seven years, which helps drive the cost of coming up a new innovation higher, which keeps drugs away or kind of innovations away from folks.

But it does protect costs, because it takes a long time to get there. So the question is is this cycle time right. And I think the answer is no. And the question is can we find a way to intelligently kind of shorten it. And the answer is I don't know. We'll see.

This is some ideas about that—I've been thinking and a group of us who have been thinking about this have come up with. And that is—and Astrozenica has actually come out with this idea, which I think is pretty interesting—which is that suppliers integrate payers much more upstream into the product development. And it's very interesting.

I was on a call today, earlier, with our health care business. And they have a—kind of a new product that they're really struggling to kind of get approved. It's had pre-market approval, but it won't get covered by the insurers.

And they were trying to figure out what—they asked me as a payer to come on it and give my views. So I listened to all of their plans. They were going to do this study. They were going to think about going that way. They were going to tap that database.

And I simply asked the question, did you ask any payer if what you're going to come up with is going to be valuable to them or help them make the decision?

And the answer was no, we didn't do that.

And I said why, and they said first of all, we don't know any. And said, second of all, we're afraid if we do ask the question, what they really want to do is not pay. So they're going to make the criteria so kind of—so high and so undoable that it will be worse off and better off.

So I think there's got to be a better way than doing that, and I think there's a lot of innovative payers out there who are interested in making this cycle better, too.

And I think the question is simply what would you as a payer like to see from the clinical trials? What answers would help you judge whether this is something you should pay for?

And then I think on the payer side, I think they've got to get much more creative, much more innovative, and much more flexible about moving away from the paradigm they're in now, which is essentially unless you have met what are really the legacy criteria of a couple of thousand patients in essentially a randomized control trial, we're not going to cover it. We consider it experimental, which in 99 percent of the plans across the country means it's not covered.

Well, think of that Catch-22. So you're an innovator. You have a good product. You've got enough to get pre-marked approval, but you can't get it paid for which would actually

help you give you the number of people you would get to actually see if it really works in large populations or not.

And so the idea is can you cover in a limited, smart way and develop evidence at the same time coverage with evidence development?

And this is an idea Shaun Tunis and Mark McClellan came up with, and I think it was in April or something they put it out for comments. I've been following the comments. And it's going to be a tough slog for them. I think that kind of a lot of the innovators are concerned about kind of some of the implications of it. They're moving forward with it, but I think the real potential is with the private payers.

Why can't a WellPoint who covers 25 or 30 million lives now, a United who covers 25 million lives, Aetna, 15 million lives, Signa, 15 million lives, why can't they see it as part of what they do to help contribute to this innovation value that I think we have?

And I think employers can do a lot better because, you know, most of the insurance is self funded in this country now, in expanding their own benefit design policy to make it much more flexible about paying for clinical trials.

So I think those are kind of two ideas. For this to work, and I mention one of them, I think again it's how we think about it differently. I think there has to be a mind shift. And I think payers really have to be willing, either through kind of their own kind of commitment or through pressure from employers and consumers to go it isn't okay anymore to simply say, no, the trial isn't quite right to me. Here are my criteria. Not quite there. Nobody gets it—to basically saying, look. If this is the right thing we want to know, let's figure out how we can cover it safely, certain drugs, with certain criteria, and deliver the—and get the evidence.

And I think the suppliers, the innovators need to go from kind of no news but good news to really a willingness to do head-to-head trials, follow the evidence, and in some cases have their innovations be for a much smaller population than they thought it was at first.

So probably impossible dream, but that was just as I'm thinking this through. And that is it. Thank you.

[Applause.]

MR. AARON: We've had three terrific presentations. I suspect like many of you I'm aching to ask some questions, but please hold that thought. We're going to hear next from Carolyn Clancy and then from Nancy-Ann DeParle.

MS. CLANCY: Well, good afternoon. I'm really delighted to be part of this discussion and like Sid a bit humbled by the present company up here at the table.

I'm pleased to see a lot of familiar faces out there. We have a lot to learn from each other. I want to say it was about 15 years ago that Rick Cronic and Allan Entovan [ph.] described our health care system as a paradox of deprivation and excess. And it would be hard to argue that that characterization doesn't still hold.

But I want to actually focus on some parts of the answers that you've been hearing from the discussants earlier today. We have lots and lots of slides and findings on our website that can describe the problems we're facing in greater detail, so I just refer you to arc.gov, if you need slides for similar sorts of presentations.

But what we're trying to get to is to achieve a common goal, and that is to find out how we can contain health care costs while continuing to improve quality, safety, efficiency, and effectiveness of health care for all Americans. And that's really the mission of ARC.

Now, Barbara McNeal [ph.] a few years back, who I think is here today, basically insisted that we were at a fork in the road. In terms of cost containment, we could either focus on blunt strategies, just cut everything by X percent or we could invest in a strategy, some of which Bob has just begun to sketch out in his presentation to be able to make informed decisions so that we could get to value.

Interestingly, it feels like we've been at that fork in the road for a long time, and while we're pondering which way we're going to go, the common denominator strategy seems to be giving consumers more incentives or more out-of-pocket costs.

There's been a lot of discussion here today on pay-for-performance as market-based solution that has the potential to control costs while improving quality. And last week in the Journal of the American Medical Association, there was quite a lovely study, funded by Karen Davis [ph.] at the Commonwealth Fund. So the researchers tracked 200 physician groups in two areas funded by Pacific Care, and they compared improvements in one group that had pay-for-performance incentives with those that did not.

Now, what they found was that in the group that did have the incentives, there were improvements in terms of the rates of delivery of Pap smears, so that's good news; a much smaller rate of improvement in the other group.

However, the quality of care for diabetes care and screening mammography was not statistically different. The good news, of course, is that the physicians who had the most room to improve not surprisingly in statistical terms actually improved the most. So this is good news I think.

On the other hand the Commonwealth Fund, which supported the research, concluded that the study shows that we still have some questions that need to be asked in what we can expect from pay-for-performance plans.

So a lot of excitement about this at CMS and policy circles and so forth, and I think a lot to learn.

And to better understand this, we're working very closely with the Robert Wood Johnson Foundation and its Rewarding Results Program, which I'm pretty sure includes an effort that Bob and his colleagues initiated a few years back, the Bridges to Excellence Program, which has become sort of the benchmark pay-for-performance program that many people turn to.

And I think that we'll learn a lot as we move forward. We have a lot to learn just as with any new clinical innovation about how to customize the application in a way that makes the most sense.

And, of course, the biggest payer of them all, CMS, with two former administrators sitting up here, is becoming more interested in pay-for-performance all the time. A sort of not so secret part of the Medicare Modernization Act is that in addition to covering a new prescription drug benefit, there are lot of very exciting demonstrations. And I see Stu Gutterman here, who still looks very successful having survived trying to launch a lot of these important initiatives.

One of the very interesting demonstrations that was just recently announced is Section 646, and this demonstration is actually going to call for integrated delivery systems either actually formal integrated delivery systems or those that can work together in that way to identify best practices to encourage better quality efficiency and effectiveness and to make payments more consistent with these practices.

Now, I just said a lot, but what I see this—this is going to be a very important opportunity to learn, and we're looking forward to working with CMS to be able to export some of the lessons learned as rapidly as possible.

One feature of this particular demonstration that's different that touches on some of the points that Leonard made is that there's a very strong focus on shared decision making between clinicians and patients, because there have been enough studies that show or that suggest that when given full information about the risks and benefits of alternative treatments might be far more risk adverse than their providers.

Another very important initiative that's coming out of the Medicare Modernization Act is Section 1013. Now, for those of you who don't follow every little section of the bill, let me just say that we have just launched this new program.

It's called the Effective Health Care program and it actually directs the agency to provide information and research on comparative effectiveness and effectiveness of interventions broadly defined, to include drugs, devices, HIT for that matter, programmatic interventions of relevance to the needs of the beneficiaries of Medicare, Medicaid, and the state child health insurance program.

And what's actually new here, because that sounds a lot like what we've been doing or we thought we were doing, is that the researchers don't define the priorities. Actually, the people who administer those programs define the priorities. So the Secretary actually sets the priorities available, and that we're going to be addressing rather.

And there's a very strong focus on effective dissemination. Again, turning to Barbara McNeal's really terrific Shattuck Lecture a few years ago, she made the point very, very clearly that it's not just enough to invest in research about what works and for whom.

We need to make sure that that information is available, whether that's through infomediaries, websites, trusted intermediaries, I don't know what the right strategy is, but I know it's an area we've underinvested in pretty significantly.

So the purpose of the new program that we're launching is to provide clear, authoritative, and unbiased information about the effectiveness of existing treatments, including medication therapies.

And our aim, consistent with the legislative language, is to make that information available to clinicians, payers, other decision makers and consumers so that everyone can make informed choices.

I think Bob's sense of what we would all want for ourselves is rapid access to new innovations that would help us. No one wants to be waiting for a regulatory cycle.

At the same time, I don't think any of us want people to have rapid access to new innovations that are likely to be either of limited value or actually lead to harms.

So the first round of topics has already been chosen for this program and includes treatment options that touch the lives of millions of people and involve billions of dollars.

So some of the questions that we're going be addressing include management strategies for gastroesophageal reflux disease, the use of epoetin and darbepotin for management of anemia in patients receiving cancer treatment, off-label use of atypical antipsychotic medications—a huge big ticket item for Medicaid, therapies for localized prostate cancer. We've noticed in the history of the agency, it's always very important to keep prostate disease on the agenda, given the makeup of the U.S. Congress.

[Laughter.]

MS. CLANCY: Oral medications for diabetes management, medications for treating depression and drug therapies and behavioral interventions for osteoporosis and osteopaenia. I think I may have just covered a lot of direct to consumer advertising and other information on health.

To make sure that we cover all the bases, this new effective health care program is going to have three components that work together to disseminate the most accurate, up-to-date and useful information.

The first part of this structure is our network of evidence-based practice centers across North America. If you ever click on the National Library of Medicine's MedLine Plus, what you find is that you can find information from individual studies. It's very hard to get an integrated picture, and the whole focus of our evidence-based practice centers is to actually organize a body of work to answer very specific questions.

The second part of the structure is called the DECIDE Network. This is an acronym for developing evidence to inform decisions about effectiveness. And what this is a network for research centers working under contract that can generate findings quickly and test different alternatives to randomized clinical trials and answer questions that don't require clinical trials. I'm not saying we want to get rid of clinical trials. They're an incredibly valuable approach, but for many areas of innovation, they're simply not that practical.

It's not practical to have a randomized trial of a new device that's being continuously improved while the trial is ongoing. That would be a methodologist's nightmare.

We need some better approaches. And a very clear focus of this new network is to take advantage of those organizations that have made substantial investments in health information technology.

And then finally, the last part of the challenge is to make sure that the information is comprehensible. So to do that, we're actually funding a new center named in honor of John Eisenberg [ph.], which is the Clinical Decisions and Communications Science Center. Some might say it's the English to English translation Center. I don't care what it's called. The point is that good information has to be impossible to avoid or we're not going to be able to achieve the goal that we're aiming for.

So the activities performed by this program reflect the g general principle that clinicians and patients should have the best evidence available to inform how they deliver, receive, and chose health care products and services. And I think that's a theme you've heard from all of the presenters.

I think many people don't understand that their clinicians are often just as clueless as they are, because we have not made the investment in organizing evidence-based information in a way that it's easily accessible at the point of decision making. So our evidence-based practice centers are currently hard at work on the first set of priority topics, and we look forward to delivering the first series of comparative effectiveness reports later this year and early 2006.

The Internet and health information technology have come up across these presentations as well as cost containment tools. And there's no doubt that we have just begun to tap the power of IT to transform our health care system.

And the one person that really needs no convincing at all is Secretary Levitt. He's made that very, very clear. There's a very strong focus on electronic health records for most Americans by 2014 and a very near term focus on electronic prescribing and the rapid reporting of adverse drug reactions.

So ARC has had a really important opportunity in this transformation. We've supported much of the research so that we'll define how computers will be used in everyday clinical practice so that the next time Leonard tries to give away free software and hardware to reduce errors and to improve the quality of care, we're hoping that we'll have good information so the clinicians will know how to make this a part of their workflow, and he won't have to keep telling us that free isn't cheap enough.

To that end, we've actually created a national resource center, whose clear focus is to export the lessons learned from our current investments as rapidly as possible.

A lot of clinicians want to do this. And they want to do it right. They're terrified of the upheaval in their practice. I have a good friend who's a clinician at Penn and if anyone lives in Philadelphia, let me know if you have a serious medical problem, because she's the person I would recommend more highly than anyone else I know.

And she told me for the first six months of working with an electronic health record, she felt really stupid every day. That's a lot to ask. And we're trying to make that transition a lot easier for clinicians.

A year and half into it, she tells me she's never been able to work as effectively as she has now. But six months is a long time. That's a lot of behavior change without any gratification.

We still don't have enough knowledge about knowing how much our health care system will save when it converts to computers, and we very urgently need the answers, and a number of our projects are focused on estimating the return on investment at multiple levels of health care decision making.

But the final point is just as the question about HIT, how much is it going to save? What are the benefits and what are the potential downstream costs or harms? As a nation, I think that we have an opportunity to invest more in effectiveness-related research, especially during the next few years when we're making far reaching decisions about the future of health care, how we're going to pay for it, and in particular as we anticipate the baby boomers joining Medicare.

There was a paper published in JAMA last month that said that the U.S. spends six cents out of every health care dollar on research, but only one-tenth of a penny on longer-term evaluation of which drugs and treatments work best at the lowest cost.

So I think this confirms what Don Berwick [ph.] told Bob Galvin in an interview published earlier this year in Health Affairs. Don said we spend less than a fraction of one percent of the money on understanding on how to configure care systems as we do on providing the pipeline of biotechnology that those care systems supposedly deliver.

That's a misallocation of resources. It would be as if GE worked only on components and not products. We need to create an aggressive and well-supported national agenda for research on better health care systems.

So with that in mind, I'll simply close by suggesting that taking the lid off of effectiveness-related research budgets may be one of the best things we can do to keep a lid on health care costs. Thank you for your attention.

[Applause.]

MR. AARON: Nancy-Ann.

MS. DEPARLE: All right. Well, first let me say it's an honor to be here at Brookings this afternoon. The people here are really smart. Alice Rivlin, who hired me to work in the Clinton Administration, is here, and she's one of the people I look to as being really smart,

and I can't help but wonder, Henry, if it was not coincidental that Brookings stepped back and took a bit of a pause from its focus on health care right when things started to get really ugly.

So that said, I'm—

MR. AARON: Well, the answer is it was when Karen Davis left and went into the Clinton Administration.

MS. DEPARLE: Well, there was that. There was—

MR. AARON: I mean in the Carter Administration

MS. DEPARLE: There was that.

That said, I'm very glad that Brookings is recommitting itself to trying to address some of the really thorny issues and I get the pleasure this afternoon of trying to land us after this lofty discussion.

And I think that's somewhat appropriate because if the question is can health care spending be restrained, my answer would be yes, but, with a capital "B."

I think I'm here to supply the realpolitik, because I presided over the Medicare program, which spends—I don't know $40 million or so every hour on 42 million beneficiaries during the time in its 40-year history when spending actually declined year over year.

Real spending in 2000 was less than it had been in 1997. And that was due principally to two things: first, the Balanced Budget Act; and second, and perhaps when the story is finally told, even more so the attack on waste, fraud, and abuse—the program integrity efforts—at the Department of Justice and in particular the prosecution of HCA.

What I learned from my experience in the government and running the Medicare and Medicaid programs is something that Bob Galvin pointed out very aptly earlier today and I think all of our speakers would agree with, which is that one man's excessive health care

spending is another man's life-saving procedure or more to the political point, since we are here at Brookings and in Washington, his indispensable revenue source.

Cutting the rate of growth in Medicare spending by $123 billion over five years I can tell you was a wrenching, miserable experience for me, for everyone in the Administration, for the Congress, and for the millions of hospitals, physicians, home health agencies, and all the rest who saw their reimbursements reduced or at least not increased for the first time after years and years of double-digit growth.

There are number of ways I would argue that we can help to restrain health care spending. I've listed some of the options here—lowering payments to providers and suppliers is one, and that's the one that I'm talking about right now, the Balanced Budget Act.

The Medicare cuts did help balance the budget. They reduced the deficit, contributed, in fact, significantly to that; indeed helped to produce a surplus; extended the life of the Medicare Trust Fund Part A or the hospital side of Medicare through I think the estimates were a the time 2029.

I think it was good economics, Alice. I hope you agree, and I could certainly defend a number of the individual 350 or whatever policies in the Balanced Budget Act as decent health care policy.

But it was terrible politics. Beneficiaries weren't hurt by what occurred, but trust me going around telling beneficiaries at senior centers that we are working hard to strengthen the Medicare Trust Fund by moving to a prospective payment system for home health is not as much fun as telling them they're getting a prescription drug benefit.

Providers hated it just to be blunt. And Congress then went forward and undid parts of it in successive give back bills, as they came to be known here in Washington.

So I'm here to tell you that it can be done. We can restrain health care spending. We've tried to do that, and we've done it in at least one instance with the Medicare program.

But I'm afraid, despite the fact that we have 150 people in this room on a fall afternoon in Washington, there is no real constituency for restraining health care spending. And I think that point has been aptly made by all of our speakers here today. Our perhaps I should say no real constituency with any real influence without offending everyone who Leonard hasn't already offended this afternoon—all of us in this room I suppose.

So whether it can be done, I think is a very different question than whether it should be done or will be done.

And there are, of course, a lot of reasons why we spend so much in the United States, some of which frankly I would not want to change; one being the fact that we're a richer country, and richer countries simply spend a greater proportion of their income on health care; one being technological improvement, which has been a wonderful thing to behold, and as a consumer, I want all of it.

But the level of spending doesn't concern me nearly so much as what we're getting or not getting for it. And I think all of my colleagues today have spoken eloquently about that, in particular Carolyn Clancy, who's doing such a terrific job at ARC.

What terrifies me is that we could easily be spending 25 or 30 percent of GDP on health care by 2030, and still have poor quality relative to other countries and a lot of waste to show for it, and that is what is really terrifying.

It seems to me that a number of the approaches that have been suggested this afternoon will help at the margin in putting a lid on health care costs. Clinical information

systems, more information generally available to consumers and translated to them, better transparency, ideas suggested by both Sid and Leonard will certainly help.

I must confess that I find a great deal of the enthusiasm about the new consumer empowerment approaches as a little bit gilding the lily. We are mainly shifting costs here, if we're honest. But Leonard is correct in pointing out that for much of this century, Americans have paid a lower percentage—a lower proportion of their health care costs than may be optimal. And we shall see whether at the margin, shouldering them with more of the decision making and making them open their pocketbooks a little wider will slow the growth in cost a little.

I'm a big fan of the approach that Bob Galvin articulated so thoughtfully today. And I would point out—I don't want to get Bob in trouble—but you know he is a leader in one of the biggest health care technology innovators in the country, and for him I think to think publicly and so thoughtfully about how do we get better value for what we're spending on health care technology is very bold, and I found it exciting.

Figuring how to pay more for great new stuff is how he put it, and I think that is really essential. Assessing clinical effectiveness and making decisions based on clinical effectiveness is critical, and I believe we're way behind in moving forward aggressively there.

In fact, it occurred to me if the industry people sitting up here and some of the others in the room could just get together and work towards some kind of a public-private approach like the National Institute for Clinical Effectiveness, NICE, in the U.K., that would be a great step forward, and all we'd have to do is just give Carolyn the money and I think she could run this.

And without it, without something like that where we have an entity that is helping to guide decisions about what works, what doesn't work, not just looking at new

technologies, but looking at the old things that we're paying for, too, and determining which ones of those are still worth paying for, I worry we'll be left with debates like the ones that are shaping up in the Congress right now, where you have floor time being taken up with members arguing over whether or not the Founding Fathers would have approved of Medicare coverage of Viagra. That is not the place to make these decisions, and I would hope we'd be able to figure out something better than that.

And I should say, as others have, the federal government and CMS is moving forward I think to begin paying some hospitals and doctors based on the results they get rather than just for doing the service, the so-called P for P approach, and I think that is promising.

But in the end, I think I would have to say that I believe even if we do all of these things, and we must do them, they will only make a small difference.

We are spending so much on health care that even a small difference could be significant. I mean how many points of GDP growth, how many points above GDP growth that health care is spending today could this—could all these efforts shave off. So it's not trivial. It's something that we should really work toward.

But I don't see that without a major change in our values, our deep commitment to patient choice—almost unfettered patient choice, and physician autonomy in decision making that we will make a major change here in health care spending growth.

So I guess I would conclude by saying that I think we have to be resigned to cycles here, as in so much else in life. In fact, is this what they mean by intelligent design? I'm not sure. But periods of unsustainable growth that are followed by periods of cost-containment initiatives.

So as we saw bundled payments and prospective payment systems and capitation in managed care and now consumer-directed care and HSAs, all of those things kind of going in cycles as we go from one period of what many of us say is unsustainable spending.

I would conclude by saying that perhaps one step at a time, which was Sid's line, in the right direction as opposed to in the wrong direction may not only be the best we can do, but it's certainly good enough for me as opposed to where we've been.

And I think all of this made me think today, and I promise I won't sing, because I couldn't carry this tune, but of Chris Kristofferson's song, Let the Devil Take Tomorrow, Just Help Me Make It Through the Night. I think that's where we may be resigned to be here for awhile and concerning health care spending. Thank you.

[Applause.]

MR. AARON: Thank you, all. It is your turn now. There have been a few people whose names have been invoked repeatedly in the course of talks. If any of them would like to say something. Barbara McNeal. That's who I had in mind.

MS. MCNEAL: I have one comment. I enjoyed everybody's talks tremendously. Bob and Carolyn and Nancy all talked about new technologies, and I think that really is where the money is. But I'd like to make a couple of comments that Bob heard me make I guess when Jeff Immelt was in Boston, and you were there a couple of weeks ago. It's really easy to say let's just do the evaluations better and quicker. But the devil really is in the details. And let me give you a couple of examples of that.

The first regarding getting the data, there are very few Gleevecs [ph.] acts around, and, as many of you know, that's one of the drugs that just a miracle drug for patients with

leukemia and that, in fact, got approved by Novartis after I think only two clinical trials. They didn't even have to go the whole nine yards. It was so miraculous.

But when you look at technologies which would be a lot of Bob's business, I'll give you two examples. For example, digital mammography, which was recently written up on the Wall Street Journal a couple of weeks ago, it took actually four and half years to do that study of 70,000 women. That's a lot of women, and it would be really hard to imagine how you could have gotten 140,000 to do it in two years.

And another example is screening for lung cancer, where it's going to take seven years, again 70,000 people. Again, how could you get 140,000 to cut it in half?

So the issue there is really very, very difficult for lots of what we do. The example that's frequently given is registries. Registries are really going to help a lot. We're going to dump all of our haphazard sample of patients into a registry and then we'll get the answer.

The problem there I think is really profound, and I don't think it's been talked about quite enough in this city. It's the following: Suppose you have a registry of all of the patients that come in to wherever, getting whatever technology it is or whatever drug it is, and the result comes out positive. It's shown to be better than whatever the other thing is. The public is going to be happy. The manufacturers are going to be happy. Everybody is going to declare success, because we've had an observational study with a relatively modest investment in few patients.

However, suppose it comes out negative or inconclusive? That's when everybody is really going to say, lousy study. Who would have ever believed data from an observational

database anyhow? Forget it. We shouldn't have done it in the first place. It was money down a rat hole. So I think we just have to worry about that.

And then the final comment about technology is interpreting the results that you get and the value equation that I guess every speaker spoke about.

I've been on MCAC and both the Blue Cross tech for a number of years. And that comes up at almost every meeting.

I'll give you the perfect example of how I don't think we know how to define what we mean by value. The example there is the drug for adult macular degeneration, Verteporphin, which I'm sure Sid knows about, even though it's not his drug. And that's a drug that was developed by Novartis, and it came to MCAC about a year and a half ago.

And the issue was should Medicare pay for this drug, for patients with macular degeneration, when the treatment costs are thousands and thousands of dollars per patient, and each treatment takes place every three or four months.

Well, it turns out at the end of the day, the data that were presented showed that the average patient with adult acute macular degeneration ended up saving two lines of vision on that Snellen Eye Chart that we all see when we all see when we go to the eye doctors. So instead of dropping from 15 to 18 lines, they dropped from 15 to 17 lines.

So the question at the end of the day was what does it mean to save two lines? And that was never part of any clinical trial, even though the trials that were done were very careful and expensive randomized trials. That wasn't part of the output of the trial. So we were left with saying what did two lines mean? And this was in the face of obvious political and patient pressure to get the drug approved.

So I would just say it's an extremely important problem, very difficult, and the devil is in the details for all of these things.

MR. AARON: I want to take that comment and turn it into a question for our panelists, which is that Len said that we should pay for what works. Bob said we should pay for great new stuff and not pay or pay less for unnecessary services.

The force of what Barbara has just said is that we are talking about a multi-dimensional smooth continuum of efficacy of alternative procedures. In that environment, what does it mean to say that we pay for what works? And what does it mean to say we pay for great new stuff and pay less for unnecessary services?

MR. SCHAEFFER: I think you have to start with what the FDA does. Historically, the FDA requires drugs and certain devices to pass a test, which is safety and efficacy. And all that means is that it's got to be safe and efficacious. It doesn't mean that it has to be better than anything else.

So there's a long tradition in the drug and device and certain parts of the industry of saying this thing is approved, and, in our opinion, says the salesman, who is out there detailing, you know, all these doctors, you ought to try it because it's good and it's sexy, and we think it's better.

We need head-to-head comparisons. Not is it safe and efficacious, but is it better than whatever the current standard of care is.

Now, we also need to recognize that there usually isn't a standard of care. There's a community standard. All the dermatologists on the West Side of L.A. do certain things. They do it a little differently in Orange County, but that isn't a standard of care. That's just how those people tend to operate.

So I think we need head-to-head comparisons, and we need the ability to say that we will reimburse government and private sector for those things that come out better.

Now, that is not to say it isn't very hard to come to these conclusions. It's very hard to come to them. But right now, that data does not exist, and it doesn't exist conveniently.

And some of the things that I think, you know, Mark is doing at CMS are great. These registries may not solve all the problems, but they're going to give us some sense of something that's better or worse and whether something adds or subtracts.

One other comment: We're talking about innovation. I think it's important, but I don't think it's the ballgame at all. Health care is one of the few areas in our economy where something new comes in and we continue to do the old thing and just add the new thing in. There's an awful lot of stuff that is being done that may not be valuable at all. There's an awful lot of stuff that's being done that may work wonderfully well.

The two things that are most shocking to me was the study done on blood pressure control mechanisms, and it turns the old fashioned way is the best way. Okay. And if we hadn't moved all this other stuff, you know, maybe we'd be in as good or better situation.

The hormone treatment for women, what was that about? Okay. So we need to take a real close look at whether something new is better and whether we're doing old stuff that's bad, and we need to make comparisons.

MR. GALVIN: Sure. Well, I'll look at Barbara is the best at this. And those were great comments. And I agree with Leonard in the sense. You've picked the most difficult, the most charged issues. And I think there are no simple answers to those. Those are social issues about what we want to spend and what we don't.

So I think holding that hoping we can have a dialogue about that in this country, you have a mass of other issues that Leonard brought up about other technologies where you can do head to head and we don't do them.

So I'd kind of stratify it. And I would say let's start with the easy stuff. Lots of data on stuff that we're using, and let's have an intelligent dialogue. And that' kind of what I was getting to in that cycle of unaccountability chart.

I don't know anywhere where that discussion is occurring about what's working and what isn't.

MR. TAUREL: And I would agree with what both my co-panelists have said with a couple of caveats. Number one, I think it will be a bad idea to have these cost-benefit analyses done prior to approval of drugs, in other words make a fourth hurdle after safety, efficacy, and quality, because you find out a lot of things after a drug or a device is on the market.

And the second thing is given the heterogeneity of patients that there should be some kind of safeguards whereby a doctor can still not go with the formulary or with the conclusion because he has a patient with certain characteristics, who will be best helped by a drug which may not have come out as the best in the survey of thousands of patients.

MR. AARON: Additional questions? Karen Davis, Commonwealth.

MS. DAVIS: My question is can we get there without fundamental payment reform of the fee for service payment system? All of you have kind of touched slightly on that. Carolyn Clancy talked about the recent study in JAMA on pay-for-performance, where Pacific Care gave five percent bonuses if you improved Pap smear screening, but that's—given that

Pacific Care was only 15 percent of the medical group's revenues to start with, a five percent bonus didn't add up to a whole lot of financial incentive.

And most of the hundred or so pay-for-performance plans that Bob Galvin's Leap Frog Group has analyzed are fairly modest and the whole incentives within fee-for-service are doing more things—hospitalizing patients, doing more procedures, doing more tests.

And the Dartmouth Group has found that the number of physicians involved in the care of a hip fracture patient varies two-fold from one academic health center to another. The number of doctors involved in treating a heart attack patient varies two-fold from one place to another.

So are we going go get there without moving in a more fundamental way away from the way we pay? Mr. Taurel mentioned Michael Porter's article in the Harvard Business Review, where he really recommends paying a lump sum for care over an entire episode of care, and rewarding quality and efficiency on the entire episode of acute care or maybe over a year's time for somebody with chronic conditions.

So that's my question.

MR. AARON: Anybody?

MR. SCHAEFFER: I'm in violent agreement, so I won't be helpful.

MR. GALVIN: I am, too.

MS. DEPARLE: I am, too, and we do have some evidence of that, empirical evidence from the Centers for Excellence demonstrations that were done a number of years ago. Cabbage surgery and other things where they showed that you can get better quality of care. Medicare can save money. The beneficiaries can save money. But those were—have been mightily resisted by providers as far as expanding that to more fee-for-service Medicare.

So it will be difficult, but I agree.

MR. AARON: Let me just point out that unless there is a real kicker for measurable quality, there is an incentive to stint in that kind of a payment arrangement. For that reason, Joe Newhouse [ph.] has suggested that a blended payment scheme, which consists of an element of prospective payment based on episode or capitation, with a fee-for-service kicker that's well below true marginal cost, but still positive, may be better than either the straight fee-for-service or the full prospective payment arrangement.

MR. GALVIN: Yeah. I think we're going to have to change the reimbursement mechanism, but there—I think there are a couple of points that are important. If the devil in the details is tough on the quality, you can't believe how tough it is—the mechanics of changing reimbursement methodology, and it is politicized, and it is very complicated. I think we give it a shot, as I said in my remarks, I think that will happen at the next presidential election. But don't kid yourself. Any system, once in place, you know, is manipulated and gamed.

And what we really have to do is get to the—in my opinion, get to the underlying behavior of physicians. And there has to be a mechanism that shows them what is the desirable, you know, way to practice. I think we need to go to the specialty societies and ask them to work with the other organizations that are developing evidence-based protocols and endorse one or another of these protocols when they think the evidence exists. And then we pay for someone who abides by the protocol.

Now, there's a big argument about, you know, the conventional wisdom, you know, preventing innovation, et cetera, et cetera. And I think that is an important argument. But we're trying to change physician behavior. And the way physicians are taught in this country is you do what you learned in medical school. And different medical schools give you different

approaches to doing certain things, and you get these ridiculous variations across the country, and they're enormous variations in practice patterns that aren't related to quality at all.

So we need some academically, intellectually, clinically, medically, legitimate players to help say this is a better way of doing it. I don't know what percentage of the delivery of care would be covered. My guess is it wouldn't be more than 50 or 60 percent, because life is so complicated in the real world.

But I think we do need to have some standards, and then we need to have a reimbursement system that reinforces those standards.

The notion of saying we'll pay you after the fact if it works, you know, sounds good. But you have to determine whether it worked or not. Then what about the people that tried hard and it didn't work? An awful lot of this going on.

So I think it's both having standards, where they're appropriate, and reimbursement that provides incentives to either use those standards or to achieve good outcomes.

MR. AARON: One more question. We'll take this lady over here.

MS. : [Off mike.] [Inaudible.]

MR. AARON: There you go.

MS. : And I would suggest a psychiatric disorder is a delusion, and it's a delusion that all sectors share; that we're going to cure everything. And this is a major problem. And as a practicing physician, I think all of you understand a lot about health care, and it is a real major problem when we all are on the same track all the time, talking about how we're going to cure things overnight. And as far as great new stuff, every patient comes in saying I want to know what the new great new stuff is, and I want it.

And they're not at all sophisticated to figure out the idea of there being a risk-benefit ratio and that not every new emerging therapy is going to be good for them as a matter of fact.

What I really want to ask the panel is about how do we make the public more aware. We are talking about them being more informed consumers of health care. But they're so far from that. The understanding that there's not going to be a breakthrough overnight and that medicine is all gray. It's not black and white; and that there is a lot of risk and benefit out there.

And how do we transmit that information to them?

MR. TAUREL: I think you raise a very, very important issue, which affects all of us and where all of us have a responsibility—I think all the medical community, the research community, the supplier community as well. Just talking about, you know, what's been in the press in the last year about pharmaceutical products, I think there is a general delusion that there is such a thing as a totally risk-free pharmaceutical product. This is called the placebo. If it works, it has side effects.

MR. SCHAEFFER: And it works very well.

[Laughter.]

MR. TAUREL: And it's cheap, too.

MR. SCHAEFFER: I wasn't thinking about that.

MR. AARON: I would like to point out that there is abundant research evidence about a medical intervention that does produce beneficial effects, and that is one drink. So we're going to adjourn now, and you have an opportunity—somebody is shaking their hand at me. We're adjourned.

[Applause.]

[END OF RECORDED SEGMENT.]