1 FEDERAL TRADE COMMISSION

2

3

4 JOINT FTC/DEPARTMENT OF JUSTICE HEARING

5 ON HEALTH CARE AND COMPETITION LAW AND POLICY

6

7

8

9

10

11 Tuesday, May 27, 2003

12 1:30 p.m.

13

14

15

16

17 601 New Jersey Avenue, N.W.

18 1st Conference Room

19 Washington, D.C.

20

21

22

23

24

25

26

1 FEDERAL TRADE COMMISSION

2 I N D E X

3

4 Welcome and Introduction - David Hyman, Federal
5 Trade Commission 3
6
7 Carolyn Clancy, M.D., Director, Agency for
8 Healthcare Research and Quality 5
9
10 Elliot Fisher, M.D., Professor of Community
11 and Family Medicine, Dartmouth Medical School 27
12
13 Karen Ignagni, President and CEO, American
14 Association of Health Plans 48
15
16 Martin Gaynor, Professor of Economics and
17 Public Policy, Carnegie Mellon University 66
18
19 Regina Herzlinger, Professor of Business
20 Administration, Harvard Business School 83
21
22 Michael Millenson, Visiting Scholar, Kellogg
23 School of Management, Northwestern University 102
24
25 Roundtable discussion 122

1 **P R O C E E D I N G S**

2 MR. HYMAN: Good afternoon. Welcome to the
3 Federal Trade Commission. It's an honor to have you here
4 for one of our continuing hearings jointly hosted by the
5 Federal Trade Commission and the Department of Justice.
6 I'm David Hyman, special counsel at the Federal
7 Trade Commission. And along with Chairman Muris and
8 Cecile Kohrs we'd like all collectively to welcome you
9 here, including the people who have phoned in or are
10 watching by video link.
11 We have a stellar panel to hear from today.
12 And rather than talk myself, I'll let them talk. So very
13 briefly, we've put together a set of bio's that are
14 available outside. And so I will give our standard, one-
15 sentence introductions for each of the speakers. And
16 then we'll more or less get right to it.
17 This is part of a series of three days of
18 hearings that are being held today, the 27th, the 29th,
19 and the 30th on quality and consumer information issues.
20 And the individual speakers will speak in the
21 order they are sitting, from right to left, although I
22 suspect most of them are going to go up to the podium.
23 But individual preferences will be scrupulously observed.
24 That is to say, we won't force you to speak at the podium
25 if you don't wish to.

1 The first speaker to my far right is Dr.
2 Carolyn Clancy, who is director of the Agency for
3 Healthcare Research and Quality, also known as AHRQ.
4 She's been there since 1990. She had the benefit of
5 becoming director after the name changed. It used to be
6 called AHCPR, which no one liked.
7 Next speaking will be Elliot Fisher, who is --
8 Dr. Elliot Fisher, who is a professor of medicine and
9 community and family medicine at Dartmouth Medical School
10 and the Center for Evaluative Clinical Sciences.
11 Then following him is -- well, I wrote it in
12 the wrong order apparently -- Karen Ignagni, who is
13 president and CEO of the American Association of Health
14 Plans.
15 Then immediately after Ms. Ignagni speaks,
16 Professor Martin Gaynor, who is the E. J. Barone Chair in
17 Health Systems Management and Professor of Economics and
18 Public Policy in the Heinz School at Carnegie Mellon
19 University.
20 Professor Gaynor wins the frequent flier award
21 for the hearings because he has -- at least on this panel
22 -- been the only repeat player, clearly he has yet to
23 learn to leave well enough alone.
24 Then Professor Regina Herzlinger, who is the
25 Nancy McPherson Professor of Business Administration at

1 the Harvard Business School.
2 And then finally Michael Millenson, author of
3 Demanding Medical Excellence, Doctors and Accountability
4 in the Information Age, and the Mervin Shalowitz Visiting
5 Scholar at the Kellogg Graduate School of Management at
6 Northwestern University.
7 And so essentially the framework here is we're
8 going to let each of the speakers talk. And then,
9 depending on our relative stamina, we'll take a break
10 somewhere toward the end of that or when everyone has
11 spoken. And then if we have time left, which we are
12 hoping to do, as is our fashion we'll have a moderated
13 roundtable, where the panelists can comment on one
14 another's work.
15 And, as I tell everybody, although these are
16 called hearings, that's not the nasty Washington version
17 of adversarial oversight hearings. This is more like an
18 academic conference, where everybody gets to beat up on
19 one another rather than have the key person moderating
20 beat up on them.
21 So, with that in mind, Dr. Clancy.
22 DR. CLANCY: Thanks for the introduction,
23 David.
24 Well, good afternoon. And thank you for the
25 opportunity to be here. Since I had the opportunity to

1 be first, I have a couple of objectives that I want to go
2 through today.
3 First is to talk very broadly and briefly about
4 some of the current challenges and contexts for assessing
5 and improving quality of health care.
6 The second is to focus on the federal role,
7 both what AHRQ does and what the Department of Health and
8 Human Services is doing right now more broadly, then to
9 focus most of my remarks on recent developments and
10 issues and let you know about some future directions.
11 I also know that some of my colleagues will be
12 testifying at some upcoming hearings, so I don't want to
13 steal their thunder by any chance. I have someone here
14 watching me to make sure I don't do that.
15 So just by way of assessing quality of care,
16 the holy trilogy for, I guess, at least the last 30 years
17 as presented by Avedas Donabedian has been looking at
18 structure, process, and outcome.
19 And even very shortly before his death within
20 the past couple of years he was still urging us to make
21 sure that we understood more and continued to learn more
22 about the relationships between these three dimensions.
23 Historically the healthcare system, of course,
24 has relied much more on structural measures. Now, by
25 structural measures we just mean: Are the right elements

1 in place to be able to provide quality? Do you have the
2 physical plant? Do you have the people, and so forth.
3 Fairly simple, but easily verified measures of what is
4 part of the healthcare system.
5 Now, by process we mean, are the right things
6 done to the right people at the right time in the right
7 way, and so forth. And recently with an emphasis on
8 patient safety we also mean, did the right patient have
9 all that stuff done for them.
10 And then outcome is the result -- is the result
11 as good as it should have been given current medical
12 knowledge. And in recent years the concept of outcome or
13 end results has also come to incorporate a patient
14 perspective, that is to say, results that people
15 experience and care about.
16 So, now, by way of context let me just say that
17 while structural measures are easy to verify and easy to
18 describe, they don't reliably predict quality, which is
19 too bad because we've invested many years of effort in
20 being able to tell you a great deal about structure.
21 Over the past, I guess I would say, 15 years,
22 there has been growing demand for evidence or performance
23 in public reporting of the same. Now, different people
24 would describe the history of this movement in different
25 terms.

1 Some people would say that this was a reaction
2 to managed care and the growth of the number of Americans
3 enrolled in some sort of organized delivery care system.
4 Others would say, quite rightly, that indeed
5 those delivery systems are the only parts of our
6 healthcare system that have the capacity to assess the
7 type of care that they're providing.
8 And other people would say that in response to
9 rising costs purchasers of healthcare wanted to know from
10 their healthcare suppliers, if you will, much more
11 specifically what the return on investment was for the
12 very large investments that they were making.
13 Regardless of which version of the story you
14 prefer, the net result is the same -- that both
15 purchasers and consumers are increasingly demanding more
16 evidence of public reporting of clinical performance.
17 Now, in general outcomes, I think, are
18 considered the best possible type of report. However,
19 they're not actionable. That is to say, if you find that
20 the outcomes in one healthcare system or provider are
21 less good than those of another healthcare provider, then
22 it's hard to know what to fix exactly.
23 So, for example, if heart attack care is worse
24 at one hospital than another, there are many steps in
25 that process leading to lesser outcomes. It's a little

1 bit hard to know which of those steps needs to be fixed.
2 If, on the other hand, you are measuring
3 different steps in the process, where we have a very
4 clear evidence about the relationship between processes
5 and outcomes of care, then you can see very clearly.
6 There's also an efficiency argument here for
7 some of my economist colleagues. There was a very nice
8 study done looking specifically at heart attack care,
9 showing that it's actually much more efficient to measure
10 processes than outcomes because you don't have to go
11 through as much rigorous work to adjust for severity of
12 illness and other factors to make fair comparisons.
13 Now, again, just by way of introduction for
14 those of you who are relatively new to the field. Where
15 do we get the data for these measures?
16 One source, of course, is administrative data.
17 And many states actually collect hospital discharge
18 abstracts. And there's also billing data. And we're
19 really, really good at collecting lots of billing data
20 given multiple payers and everyone's common interest in
21 making sure that they only pay for the services for which
22 they are responsible.
23 The problem there is that while there's a great
24 volume of information, there's very limited clinical
25 detail. So our researchers have learned many, many

1 tricks about how to adjust for that problem, but you do
2 reach a point of diminishing returns.
3 Now, clinical information systems, as they
4 begin to diffuse throughout the healthcare system, do
5 offer the power of much more clinical detail. And that
6 would be very, very helpful. And I'll come back to that
7 theme at the end.
8 The only problem is the uptake and penetration
9 so far has been highly variable. I did hear a statistic
10 recently that says that just about two-thirds of
11 hospitals either have clinical information systems or
12 have commitments to get involved at that level. However,
13 the statistics for outpatient care, where an increasing
14 proportion of healthcare is provided, is about eight
15 percent. I can't verify either of these, but again I'm
16 just trying to give you a sense of the context here.
17 Now, two other sources of data are surveys.
18 And surveys, of course, are the only source of
19 information for patients' experiences as well as patient-
20 reported outcomes -- what I meant when I said before
21 about end results the people experiencing care about.
22 Surveys -- and they are a lot of very good, valid, and
23 relatively short tools and instruments available now to
24 use for surveys. They are not inexpensive.
25 And chart reviews, of course, are another

1 source because that, after all, in some ways is the bible
2 of what happens in healthcare. The only problem with
3 chart reviews is that they are fairly expensive and
4 they're also subject to lots of errors of omission. That
5 is to say, different physicians, for example, have
6 different habits of recording. So some doctors will
7 write for every single patient "ask patient if they
8 smoked" and write that down. Others have their own
9 internal shorthand for "I ask everybody, but I only make
10 a note if they do smoke," and so forth. And trying to
11 identify the right data, given that sort of highly
12 individual variability in recording habits, gets a little
13 bit challenging.
14 Now, also by way of context let me also just
15 say that most efforts in this country as well as other
16 countries have focused on specific conditions. There's
17 no particular reason for that. One might imagine looking
18 at overall health status --
19 (Interruption to the conference audio system.)
20 DR. CLANCY: Well, this is great. In contrast
21 to congressional hearings, where I sometimes imagine
22 those, you know, imaginary balloons over different
23 congressmen's heads as to try to guess what they're
24 thinking, it felt like it was just being beamed right in.
25

1 Much of the literature in this country that has
2 looked at practice variations -- and I know that Elliot
3 Fisher is going to talk a lot more about this -- has
4 found consistently that the same healthcare institutions
5 and organizations that can produce very high performance
6 for one particular type of condition often do not do so
7 for another.
8 So there is, as far as I can tell from reading
9 Elliot's work, no such thing as a high-performing
10 institution or an institution that always gets it right.
11 Some organizations that do very well in one condition
12 don't do so well in another. Similarly for communities.
13 So that's sort of a post hoc rationale, if you
14 will, for a condition-specific approach. One can also
15 argue that specific diseases have a great deal of meaning
16 to advocacy groups and others who have some sense of what
17 a patient with diabetes is like, whereas just thinking
18 about overall health status is too global a measure.
19 Moreover, the way we collect data in
20 healthcare, most of our efforts to assess and improve
21 quality of care are highly setting specific. Now, on one
22 level this makes a lot of sense. Why not find out about
23 the quality of care in the hospital?
24 Our problem is that we have very little
25 opportunity to look at what happens across transitions in

1 care or to follow one patient from one setting to
2 another. And that remains something of a challenge and
3 limits what we'd like to know.
4 Now, I know in economics that the use of
5 aggregate or composite scores is one way to deal with a
6 lot of these data problems. So far the relevance of that
7 to healthcare has not been tested in great detail.
8 Our efforts to look into this a little bit have
9 not been incredibly encouraging, but that might be
10 another way to think about some of the data limitations.
11 And then, finally, if one were going to start
12 from scratch to think about how do I assess quality of
13 healthcare, one might develop a strategic plan looking at
14 what are the conditions most likely to lead to mortality
15 and serious declines in functional status and so forth
16 and develop the data and evidence based on that.
17 However, so far developing quality measures has
18 been a highly evolutionary exercise. What this means is
19 that in some areas, depending on the extent of clinical
20 knowledge in a particular area, we've got a lot of
21 measures and a lot of very good measures. Cardiac
22 disease would be one example.
23 In other areas like the quality of maternal
24 healthcare we have almost no measures whatsoever. And
25 most of those tend to be -- what measures we do have

1 focus on the outcomes as assessed by the outcomes for the
2 infants, very little that looks at the health of the
3 woman herself.
4 So this wasn't by design. This is just an
5 indirect reflection of the state of our knowledge.
6 In general within the broader array of
7 healthcare stakeholders there's growing impatience for
8 the rate at which the knowledge that we do have has been
9 translated into practice. And I think that that's
10 another factor underlying a very strong and growing
11 interest in public performance reporting.
12 You can pick your condition, and by and large,
13 we've gotten much, much better at developing precision
14 and consensus about how to manage or diagnose that
15 condition than our capacity to translate that information
16 into practice. This is a theme I know that Karen Ignagni
17 is going to pick up on.
18 Most of the successes we do have tend to be in
19 settings that are geographically based. That is to say,
20 a hospital or a closed-model health plan, although the
21 good news is I think that picture is starting to change.
22 And most of our successes have focused on the
23 underuse of effective treatments. Until very recently
24 there's been less focus on misuse or overuse of
25 treatments.

1 And the next frontiers are clearly going to
2 involve linking incentives with improvement, information
3 technology, and our clinical leadership. This is clearly
4 an issue of growing attention for the public. These are
5 just a few select headlines from recent newspapers. And
6 this comes from a New York Times editorial on December of
7 2002. So it's not as if this is a sort of academic debate
8 that the public isn't engaged in. Far from it.
9 So having given you just sort of a 10,000 foot
10 overview of quality of care and strategies for measuring
11 the quality of that care as well as our growing challenge
12 of learning better how to move from measurement to
13 improvement, I want to talk a little bit about the
14 federal role here.
15 Now, if one wanted to think about what are the
16 roles of the government in healthcare quality, I've
17 listed some on this slide. The federal government is a
18 very large and significant purchaser of healthcare
19 between the Medicare and Medicaid programs, the Office of
20 Personnel Management, Departments of Defense and
21 Veterans' Affairs.
22 In some cases the federal government also
23 provides healthcare. And there is a broad expectation
24 that the government will assure access for vulnerable
25 populations. How well we're doing that we don't need to

1 go into. But I'm just presenting general principles.
2 To some extent there is also an expectation
3 that the government monitor healthcare quality,
4 particularly for those populations that it serves. So
5 probably the best established infrastructure that exists
6 in this country for assessing quality of care is
7 Medicare's quality improvement organizations, which were
8 established in 1986.
9 When we changed -- we paid hospitals for
10 Medicare patients. Of course, obviously, regulating
11 healthcare markets is something that the government can
12 also do as well as informing. It needs to be affordable.
13 If it's available and affordable to meet an individual's
14 needs, the providers and services need to be covered by
15 various policies. Many people would say in addition that
16 informed choice in a consistent source of primary care
17 should also be part of the package.
18 Given all of those steps met, access to
19 appropriate specialists is also a part of the package
20 before you can get to really examining whether quality of
21 care is provided.
22 And many of the current discussions I would say
23 they were having in the public domain broadly tend to
24 confuse various points in this continuum. So you'll hear
25 people talking about quality on the one hand and on the

1 other hand someone making reference to the fact that we
2 have 41 million people uninsured.
3 Ultimately those two facts are connected, but
4 not quite as close as they sometimes seem to be in public
5 debate.
6 Now, where AHRQ fits in here is that we focus a
7 lot of research on looking at the relationship between
8 processes and outcomes of care as well as efforts to
9 strengthen quality measurement and improvement. And our
10 research also focuses on cost, use, and access to
11 effective services.
12 And across the top part of this map, if you
13 will, you see our -- the three groups that we
14 approximately think of as the main customers for our
15 work: clinical decision-makers being patients and their
16 families and clinicians obviously; health system
17 decision-makers, being those in the private sector who
18 lead large healthcare organizations or who purchase
19 healthcare, whose decisions very much influence the
20 landscape on which clinical services are delivered; and
21 then public policy decision-makers.
22 Well, we are in Washington, D.C. I don't think
23 I need to elaborate a great deal here.
24 So I wanted to spend just a few minutes next
25 describing some recent developments. And I think that

1 this will complement some of what a couple of the other
2 speakers are going to say as well.
3 One of the great opportunities that the agency
4 has had -- and I know that you're going to hear more from
5 Chris Crofton about this, so I won't spend a lot of time
6 on this -- was to actually develop a survey tool for
7 assessing consumer experiences with care that has become
8 a de facto standard, if you will, within the healthcare
9 industry.
10 About 123 million Americans now have access to
11 what is called the consumer assessment of health plan
12 survey. Or that's what it used to be called. Now, like
13 IBM, it's just CAHPS.
14 Now, in terms of like what is the importance of
15 this survey, very broadly one can imagine two categories
16 of care that we are assessing in terms of trying to
17 identify how high the quality of care that's being
18 provided is.
19 One is technical care, the application of
20 science and technology of medicine. And the other is
21 interpersonal care, which is very much about the
22 interactions between individuals, organizations, and
23 individual practitioners.
24 Both are critically important. In fact, for
25 most Americans, the overarching currency of healthcare is

1 time, communication, and information.
2 So the core instruments of this survey consist
3 of a core survey of 46 items. And then there are various
4 modules or supplemental topics that organizations can use
5 to supplement that key information.
6 And this just gives you one overview of how we
7 might think about ratings of healthcare. This is just a
8 graph showing that, overall, most consumers rate their
9 overall healthcare highly. So you see for Medicare about
10 52 percent of beneficiaries surveyed here give their
11 healthcare a rating of 9 or 10, which is the best
12 possible, compared with Medicaid, interestingly, where 53
13 percent give it that kind of rating, and commercial plans
14 a little bit lower than that.
15 And this is just a map to give you some sense
16 of the penetration of this instrument across different
17 types of insurance models.
18 And we also have constructed a benchmarking
19 data base so that any organization or state that's using
20 this survey as a way to assess quality of care can have
21 some perspective on the ratings that their consumers are
22 giving to their plans.
23 Now, recent developments in the department have
24 been very exciting. I was just saying to one of my
25 colleagues up here that Secretary Thompson has been quite

1 an activist in the quality of care area.

2 So within the past year the Centers for

3 Medicare and Medicaid Services have taken some new steps

4 to produce public reports on nursing homes. And shortly

5 we'll be launching the same kind of effort for home

6 healthcare.

7 In late 2002 the American Hospital Association

8 and American Association of Medical Colleges, the

9 Federation, and other hospital groups got together to

10 announce that they would be reporting publicly on 10

11 items of clinical care for hospital care.

12 Now, this is information they are already

13 collecting and reporting to the joint commission. What's

14 new here is that it will now be in the public domain for

15 individual consumers and purchasers to see.

16 In addition to the 10 clinical measures they

17 will also be reporting on a new measure of consumer

18 experiences of care in the hospital, for which we don't

19 have a single measure right now. We have multiple

20 measures, but not one that's predominant. And that will

21 be called, oddly enough, HCAHPS.

22 In addition to that I can tell you Secretary

23 Thompson is incredibly excited about a recent initiative

24 to promote bar coding of pharmaceuticals, which will be

25 incredibly helpful for those systems that have the

1 information systems to be able to read that
2 (right now institutions that have made that kind of
3 investment have to create their own bar codes), and also
4 adopting IT standards to promote the adoption and
5 diffusion of information technology in healthcare.
6 Nevertheless, this graphical depiction comes
7 from an overarching review of quality of care done by
8 Mark Schuster and his colleagues at the RAND Corporation
9 and gives you a sense of the translation and
10 implementation challenge here.
11 On the right-hand side you see the proportion
12 of the population that is estimated to receive excellent
13 quality of care on a routine basis. And the rest of us
14 are in that other, much larger bar.
15 And that, quite specifically, is the big
16 challenge before us right now.
17 Now, the agency also funds a lot of research,
18 which then becomes the basis for potential decisions made
19 by other stakeholders in healthcare, policy-makers, and
20 so forth.
21 So this is a study conducted by some of
22 Elliot's colleagues at Dartmouth last year, published in
23 the New England journal, looking at the relationship
24 between volume and surgical mortality in the U.S.
25 What you see here in this slide are the

1 differences in mortality rates at 30 days for Medicare
2 beneficiaries for the two procedures for which the
3 distinctions were most marked, cancer of the esophagus
4 and cancer of the pancreas.
5 Clinically these are really complicated
6 procedures so it's not incredibly surprising that there
7 would be such a difference here. The reason question in
8 policy terms is what do you do with that information?
9 As a couple of my colleagues at the agency like
10 to remind me, simply providing more business to low
11 volume institutions is probably not the answer to the
12 problem here.
13 Learning from high volume institutions what it
14 is that they do well is clearly, I think, a better
15 pathway. And to be honest, a lot of these high volume
16 institutions sadly are not uniformly distributed across
17 the geographic boundaries of the U.S., which would create
18 some very severe travel problems for many people.
19 Some other findings. Looked at characteristics
20 of hospitals that are more likely to prescribe beta
21 blockers and found that strong physician leadership,
22 shared goals across healthcare professionals, and
23 hospital leaders were very, very important. And very
24 specific strategies for monitoring progress were also
25 common to those institutions that did well.

1 We've also done some work on the relationship
2 between nursing staff and patient outcomes, a topic that
3 has received a lot of discussion in the media, so I won't
4 elaborate here. And very importantly, and I know that
5 Karen Ignagni will be speaking to this issue as well,
6 we've also begun to take a look at organizational
7 strategies. Since we know the right thing to do for many
8 particular areas, how is it that that gets translated
9 across the team of healthcare professionals?
10 What to do to detect and treat patients who
11 might be infected with chlamydia is not rocket science.
12 The evidence has been long well established.
13 The question is: Since adolescents often don't
14 come in for healthcare, how can a healthcare organization
15 take advantage of those opportunities when they do come
16 in for another reason? To try to catch them when they're
17 there and so forth.
18 So it's not just knowledge. It's also the
19 organizational strategies that are in place.
20
21 The agency also works with the American Medical
22 Association and the American Association of Health Plans
23 to make available an Internet-based repository of
24 clinical practice guidelines and recently just launched a
25 new resource, a data base of the most current evidence-

1 based quality measures, which many people have told us is
2 a very important resource for them, particularly looking
3 at internal efforts and improvements.
4 And Irene Fraser will be speaking to you at a
5 subsequent hearing about our efforts to use hospital
6 discharge data to construct tools to help people identify
7 potential quality problems, or the QI's as they're fondly
8 known in the agency.
9 Now, some of the issues I just wanted to
10 highlight for your attention. With all of our enthusiasm
11 right now for public reporting, the unspoken question of
12 the elephant on the table is, will all of this public
13 reporting lead to improvements in care? And there are
14 really two schools of thought here. One is absolutely.
15 And the other camp says, well, reporting and measuring is
16 step one, but the domino theory doesn't really apply
17 here. We have a lot to learn about how do we translate
18 measurements into improvements.
19 The literature to date suggests modest,
20 although a growing impact on consumer decisions and a
21 slightly more impressive impact on individual providers.
22 I don't know if that's because many of these providers
23 were trained from a very young age to be highly
24 competitive or how that works. We actually don't
25 understand the mechanism very well.

1 A great deal of enthusiasm right now about
2 paying for quality -- and I think most people at 10,000
3 feet above the ground would say, "Absolutely, we should
4 do that."
5 The real trick is how do you that and how do
6 you do that in a way that rewards the right type of
7 behavior and improvements and doesn't create perverse
8 incentives. And I think most people would agree that we
9 are a little distant from that at the moment.
10 One of the issues that we struggle a great deal
11 with is: If quality improvement, like politics, is all
12 local, what is the federal role? To a large extent we
13 see that as making available evidence-based measures and
14 strategies for improvements. But where that exact
15 interface comes into play and where the efforts of local
16 champions are -- clearly what's most important, I think,
17 is an ongoing area of discussion.
18 And then I just also wanted to highlight for
19 your consideration that the source of legitimacy for
20 guidelines and many other standards is one that I have
21 found most fascinating in terms of developing quality
22 measures.
23 Identifying what problems our nation is facing
24 and identifying sources of evidence to be able to
25 articulate which processes of care are likely to lead to

1 the outcomes of interest is pretty easy.
2 Trying to make sure that there's a professional
3 consensus that accompanies that evidence can be a much
4 trickier problem and one that no single party in this
5 interesting mix of federal and private payers is willing
6 to take on in any big way.
7 In the interest of time, I think I'm going to
8 stop here because I think that these are the most
9 important questions.
10 I wanted to highlight one other one for your
11 attention though. And that relates to information
12 technology.
13 As information technology spreads throughout
14 healthcare delivery and as medicine finally catches up to
15 other industries and slowly approaches the information
16 age, that will make a lot of this much, much easier.
17 We'll be able to measure what's important with
18 much more precision in a way that's simply not possible
19 now. All of our conversations now about the feasibility
20 of collecting data to a very great extent will either
21 diminish or disappear altogether. And that's a day I
22 think many of us are looking forward to.
23 One of the specific policy issues that's been
24 highlighted for our attention relates to the Stark law,
25 which really focuses on anti-kickbacks. And the issue

1 here is if a hospital wants to purchase information
2 technology for practitioners who refer many patients to
3 them, is that forbidden? Or is there a safe harbor?
4 And I think that that's one that you might want
5 to bring up with your colleagues.
6 So with that I will thank you for your
7 attention and stop here.
8 (Applause.)
9 MR. HYMAN: Thank you, Carolyn. We're going to
10 take 30 seconds to throw things around and to try and
11 reconnect the phone line, which I disconnected. You can
12 tell my technological aptitude is not all it could be.
13 DR. FISHER: David, thank you very much.
14 It's a treat to be here and a wonderful
15 introduction to the challenges we face from Carolyn. I
16 can't resist though, given the scope of the challenges we
17 face, starting off with a couple of points that she
18 really didn't make.
19 The first is about the magnitude of the costs
20 we face. The undersecretary of the treasurer, who's my
21 brother, reminded me of this problem.
22 Think of the United States as a gigantic
23 insurance company, he said. This particular insurance
24 company has made promises to its policy holders that have
25 a current value of 20 trillion, give or take a few, in

1 excess of the revenues it expects to receive.
2 It's an accident waiting to happen. Of course,
3 we all, who are involved in healthcare, know that two-
4 thirds of the shortfall, the excess of liabilities over
5 projected revenues, comes from federal healthcare
6 programs. Most of that's from Medicare. And our
7 children and grandchildren will be paying the bill.
8 We're also well aware of the problem of the
9 uninsured in the United States. One in three were
10 uninsured at some point in the two-year period, which
11 really was startling to me when I went back and tried to
12 find that number.
13 And analysts, of course, expect renewed growth
14 given the cost increases that we face. And then Lucien
15 Leap has made us well aware that 747's have a different
16 use as a point of metaphor in healthcare.
17 Errors result in the deaths of thousands. And
18 his estimate is that it's the equivalent of three jumbo
19 jet crashes every two days, dying from a consequence of
20 errors.
21 I think it's an overestimate. But I don't
22 think it's off by more than an order of magnitude.
23 So let me give you an overview of the argument
24 that I'm going to make this afternoon. And it goes
25 basically as follows.

1 And I think the problems that I've outlined are
2 connected. And I want us to think about the connections
3 between them.
4 The underlying causes of poor quality and high
5 costs I will assert are a flawed understanding of medical
6 care -- we think of it as science -- inadequate
7 information to support wise decisions, and flawed
8 incentives.
9 It will be clear that we all tend to agree on
10 the general approach to the solutions.
11 First of all, though, I want to emphasize an
12 expanded model of medical care that accounts for the
13 various categories of services that are involved:
14 organizational accountability for both quality and
15 causes, I think is the only way out of the box that we've
16 gotten ourselves into. And then that will allow us to
17 provide better information about organizational
18 performance and to fix the incentives.
19 First thing I'm going to tell you about some
20 research we recently published. And then I'll come back
21 and tell you about the causes and remedies.
22 But I think the research has important
23 implications for how we think about healthcare and the
24 importance of thinking more specifically about things
25 other than underuse of effective care.

1 The motivation for our research, which was
2 published in February, is basically what most of us have
3 known since the 1970's -- that there are huge disparities
4 in per capita spending across regions of the United
5 States.
6 Wennburg, with whom I went to work about 15
7 years ago had noted two full differences across Vermont
8 in per capita spending on Medicare. And subsequent work
9 had shown pretty well that although there are differences
10 in health status across regions, the two-fold differences
11 in spending persist after you adjust for any differences
12 in the price or illness levels across regions of the
13 United States.
14 What that means is that there are huge
15 differences in the quantity of care and the overall
16 intensity of services provided to different populations.
17 And that really was the focus of this research.
18 The key questions we asked was what does the
19 additional buy? What kind of care? And what are
20 implications for health and health policy?
21 We looked at about a million Medicare
22 enrollees: 167,000 patients with heart attacks, 200,000
23 with colon cancer, 600,000 with hip fractures, and a
24 representative sample of the Medicare population drawn
25 from something called the Medicare current beneficiary

1 survey.

2 We made the following basic comparison: We
3 assigned each group into quintiles. We broke it up into
4 fifths according to the practice intensity in the region
5 where they live, in the region of the United States where
6 they lived.

7 Regions were defined using some hospital
8 markets for tertiary care services, of which there are
9 306 in the United States. We used two different measures
10 of intensity to make these assignments.

11 We did a bunch of different ways of doing the
12 study. It all came out exactly as I'm going to show you,
13 so we don't need to pay much attention to intensity
14 because intensity predicts spending.

15 This is a map of how the regions of the United
16 States were assigned to different quintiles of spending.
17 Twenty percent of the Medicare population lives in
18 regions where they're spending $3,900 in 1996 per capita.
19 And another 20 percent live in regions where they're
20 spending $6,300 per person per year on healthcare
21 services.

22 So we thought this offered us the opportunity
23 to carry out a natural experiment. That was the basic
24 notion -- that we would find that patients in the red and
25 the pale areas were similar in terms of their health

1 status, but that they would be treated very differently
2 and we would then be able to say, well, what are we
3 getting for the extra (in this case, $1,400 per
4 beneficiary) that we're spending in the higher spending
5 regions compared to the lower spending regions.
6 We had a lot of clinical information. You
7 don't need to -- you know, a lot of detailed information
8 with which to adjust for case mix.
9 But the first question we needed to ask was
10 whether the patients were similar in different regions.
11 And I'll just show you, I hope -- we calculated predicted
12 one-year mortality in each of the study groups and took
13 the average predicted one-year risk of death in each of
14 these regions as a measure of how sick are the folks in
15 those communities.
16 For example, in the general population the
17 predicted mortality rate in one year was 5.1 percent in
18 the lowest spending region. And it was exactly the same
19 across the other five -- four levels of spending so that
20 the predicted risk of death was identical in the higher
21 spending regions compared to the lower spending regions.
22 Heart attack patients were, of course, much
23 more likely to die than were representatives of the
24 general population with about a 31 percent mortality.
25 Hip fracture patients had about a 25 percent more risk of

1 death. And colon cancer patients had about a 21 percent
2 risk of death.
3 But, again, across regions of different
4 spending levels there was absolutely no difference in
5 their predicted risk of death at the time they were
6 entered into the study.
7 They were, however, treated very differently.
8 That is, they got about -- if you are looking in terms of
9 the total amount of physician and hospital resources
10 provided to these populations, if you were a colon cancer
11 patient, you got some yellow -- the yellow dots -- you
12 got about 80 percent more care during the follow-up
13 period than those in the lower spending region.
14 Even in the general population you got about 50
15 percent more care if you were in a higher spending region
16 than the lower spending region.
17 Well, that now lets us ask the question: What
18 do you get for spending more within the context of the
19 U.S. healthcare system? What's the content of care that
20 people receive? And what are the outcomes associated
21 with it?
22 So we had lots of measures. And I'm going to
23 focus in terms of content on a framework for thinking
24 about the categories of care that my colleagues and I --
25 Jack Wennburg, John Skinner, and I -- think are

1 particularly important and useful for thinking about
2 fixing the healthcare system, thinking about reform.
3 Effective care refers to those services that
4 all patients should want. It's the aspirin at the time
5 you go into the emergency room with your heart attack.
6 Everyone should get these things. There's no issue of
7 patient preferences. Patients should want it. There are
8 few risks, no tradeoffs. Patients would want that
9 particular treatment.
10 It's not a particularly large fraction of
11 medical care services. Best estimate is probably
12 somewhere near 10 percent.
13 Preference-sensitive care are those procedures
14 where there are some tradeoffs involved and patient
15 choice should matter. That is, if there's some risk of
16 an adverse outcome with one treatment alternative
17 compared to another, it's patient values that should
18 dominate the decision-making.
19 There's been substantial work over the last 20
20 years, mostly by Al Moley, Jack Wennburg, and others,
21 starting with the patient outcome research teams that
22 were funded by AHRQ in the early 1980s, then AHCPR.
23 Actually then I think it was -- now what were those
24 initials?
25 Twenty years of research has demonstrated well

1 that patient preferences are not being respected in most
2 of the clinical decisions that are being made for major
3 treatment alternatives like whether to have treatment for
4 prostate cancer and what kind of initial treatment to
5 have for breast cancer. So those are preference-
6 sensitive services.
7 Supply-sensitive services -- my economist
8 colleagues will cringe, but we use the term "sensitive"
9 explicitly.
10 What we mean by these are services such as
11 visits, hospital stays, whether you go to the intensive
12 care unit or not, where it has been shown quite
13 empirically that there's a very strong association
14 between the availability of that resource, that is, the
15 number of physicians per capita in your community, and
16 the frequency with which that service will used.
17 We'll go into this in a little bit more detail
18 in a minute. We also looked in the study at access to
19 care satisfaction and health outcomes.
20 But let's look at effective care. If you're
21 spending 60 percent more, as they are in the higher
22 spending regions, the question is what do you get for it?
23 This slide will introduce you to the way I'm
24 going to present the information. And the first dot
25 shows the proportion of patients who got the right

1 treatment for their heart attack within 12 hours of
2 getting to the emergency room. That is, did they get a
3 clot-busting drug or a catheter stuck in their coronary
4 artery in order to reverse the blockage?
5 And what the graph shows is that in the lowest
6 spending region, quintile one, 56 percent of the patients
7 got this treatment, whereas in the highest spending
8 region only 50 percent of them got it.
9 So quality of care, in spite of spending 60
10 percent more on this particular measure, was worse. The
11 same was true for four of the six measures of effective
12 care for acute myocardial infarction and three out of the
13 four measures of preventive services for the general
14 population.
15 So in terms of what you get when you spend 60
16 percent more on medical care services across U.S.
17 regions, we see no evidence that those in the higher
18 regions get better care. If anything the care looks
19 worse.
20 In terms of preference-sensitive care, again we
21 saw that spending 60 percent more did not buy you any
22 more of the procedure that we think of as beneficial in
23 offering improvements and quality of life.
24 Following a heart attack patients were no more
25 likely to undergo angiography, no more likely to get

1 bypass surgery. And for all of the major surgical
2 procedures we found no difference essentially in the use
3 of services in high and low spending regions. Doctors
4 were providing just as much of this stuff in the higher
5 spending regions as in the lower spending regions.
6 It's important to point out that for each of
7 these measures, there are three-fold or greater
8 differences across U.S. regions. That is, there are
9 tremendously different rates at which people undergo
10 bypass surgery and cholecystectomy. However, those
11 differences are not related to differences in spending.
12 Well, where does the money go? Here's where it
13 goes. People in higher spending regions have about 30
14 percent more office visits.
15 But most of the difference is in care in the
16 inpatient setting. They get 2.2 times as many inpatient
17 visits during the year, during their follow-up period.
18 Initial inpatient consultations were two and a half times
19 more frequent in the higher spending regions.
20 And the percent of patients seeing 10 or more
21 different physicians was almost three times higher in the
22 higher spending regions.
23 What's important to recognize here is that
24 ratios apply to each of the cohorts. That is, heart
25 attack patients see physicians much more frequently than

1 hip fracture patients after their initial event.
2 However, across regions of different spending levels the
3 ratios were identical. That is, there is, we believe, a
4 threshold effect of living in a higher spending region
5 that whether you're a heart attack patient or a hip
6 fracture patient, you get three times as much of this
7 stuff in a higher spending region than in a lower
8 spending region.
9 Of course, if you spend a lot of time seeing
10 physicians, we're going to do something. We tend to
11 order tests. They spend much more time in the hospital.
12 Discharge rates were 30 percent higher but lengths of
13 stay were substantially longer, so total inpatient days
14 were over 50 percent higher and patients spend much more
15 time in the ICU.
16 The most remarkable difference across regions
17 were the intensity of treatment at the end of life.
18 Patients were much more likely to get rescue in terms of
19 feeding tubes and emergency intubation -- attempts at
20 rescue.
21 Well, what about -- so, we've seen what
22 happened with content of care. We looked at access to
23 care. It was no better or worse on all the measures that
24 we looked at. Satisfaction was no different. Functional
25 status was no better. Declines in functional status were

1 no different.
2
3 And mortality let's look at it in detail. If
4 you compare the highest to the lowest spending regions
5 what you see here for the second -- quintile two -- is
6 that the risk of death was slightly lower. That is,
7 spending more was slightly but not significantly --
8 resulted in slightly lower mortality, but not
9 significantly lower mortality.
10 But as you moved up to the highest spending
11 regions there's a two and half percent higher risk of
12 death in the highest spending regions compared to the
13 lowest spending regions.
14 And the same was true for the two other cohorts
15 although there's a little more noise. That is, it's a
16 five percent greater risk of death in the higher spending
17 regions compared to the lower spending regions.
18 So what did we learn from this study?
19 The first is that increased spending across
20 regions is largely devoted to what we term "supply-
21 sensitive services." Higher spending and higher use of
22 supply-sensitive services is associated with lower
23 quality, worse access to care, and no gain in
24 satisfaction. And it's associated with a small increase
25 in the risk of death.

1 Well, what's going on? What are the causes of
2 what we're seeing here?
3 I think the first point I'd like to make is the
4 costs reflect the capacity of the system. Local supply
5 is substantially greater in the higher spending regions.
6 There are 32 percent more hospital beds per capita. And
7 the numbers of medical specialists are 62 percent higher
8 in the higher spending regions than the lower spending
9 regions.
10 What this translates into is if you group the
11 regions of the United States, each of these regions,
12 according to the numbers of internists and medical
13 specialists on the one hand and hospital beds on the
14 other, you can explain half of all the variation in per
15 capita spending across U.S. regions.
16 And what you see is that there's a greater
17 effect the greater the levels of capacity that is
18 present. Now, our theory about this is that it's easier
19 to manage patients in the hospital for physicians.
20 There's a lower cost in-my-colleagues-who- are-
21 economists' language -- there's a lower cost to providing
22 that service for the physician and for the patient when
23 there are more beds available and it's easier to get
24 there.
25

1 It's easier to get a consultation when there
2 are more specialists. And visit frequency depends
3 directly upon the physician supply. If you have twice as
4 many -- if you double the office visit time, the routine
5 office -- reschedule visit for a cardiologist on average,
6 they could see twice as many patients.
7 Or, to put it another way, if you reduce the
8 average visit interval from three months to six weeks,
9 you could accommodate twice as many cardiologists in our
10 healthcare system as we currently have.
11 The alternative theory, held by some of my
12 economist colleagues, is that patients in higher spending
13 regions are demanding more care.
14 And that's perfectly plausible and some
15 preliminary data that we have suggest that patients in
16 higher spending regions do want more care, as do the
17 physicians believe that they should get it.
18 But if they're demanding it, why are they
19 demanding that care? I think the premise is that that
20 additional care offers some benefit. But that's the
21 underlying goal and the visits are the means to that
22 goal.
23 And our study suggested that is not correct --
24 that that assumption that providing more care leads to a
25 health benefit is wrong.

1 Why was quality no better or worse? Quality
2 improvement as we all know from lots of work that
3 Carolyn's agency and others have done -- quality
4 improvement requires an infrastructure, a system that can
5 monitor and link processes and outcomes.
6 That is, you have to know what is it about the
7 process that leads to the bad outcomes in order to be
8 able to change the process and improve the outcomes. And
9 the spending more on visits doesn't result in improved
10 infrastructure. And, of course, currently we have
11 incentives for more care, not better care.
12 Why might outcomes be worse? Well, treatments
13 of clear-cut benefit are relatively few. I mean, all of
14 us would recognize that it's a handful of measures that
15 we now have where we can say definitively that patients
16 ought to receive these specific treatments.
17 And, interestingly, they are provided at
18 similar rates in high and low spending regions. I think
19 physicians are doing their best in settings of real
20 complexity to deliver care that they know should be
21 delivered. They're failing at relatively equal amounts
22 in high and low spending regions.
23 Mortality may be worse because complexity leads
24 to errors. If there are more physicians involved in the
25 care of a patient, there are more opportunities for

1 slips.

2 It's harder for us to know who's going to be
3 responsible for writing the discharge medications to make
4 sure that they receive the therapy that we know they
5 ought to receive. I will believe that it's my
6 cardiologist colleague. He's going to say, "Oh, Elliot
7 will take care of it when he gets to the outpatient
8 setting."

9 Finally, hospitals are dangerous places as we
10 all know.

11 I just want to remind ourselves and the
12 audience about the distribution of healthcare services
13 and what physicians spend their time doing. Most of us
14 think about healthcare in terms of the scientifically
15 driven, highly beneficial, highly expensive major
16 procedures like bypass surgery, hip replacement, knee
17 replacement -- things which we did not see vary across
18 regions in terms of their spending levels.

19 But what you see is that a large fraction of
20 physician activity are devoted to these supply-sensitive
21 services, are devoted to evaluation and management
22 services. Those are physician visits. That's how many
23 specialists you see and the diagnostic tests, imaging,
24 and minor procedures that go along with them.

25 Well, what are the remedies?

1 I think poor quality reflects failure to manage
2 unwarranted variations in practice. And choosing the
3 correct remedy requires a clear understanding of the
4 causes.
5 We've summarized this work in an article in
6 Health Affairs a year ago -- Jack Wenburg, John Skinner,
7 and myself -- and let me go briefly through it. And I
8 think I've got about five more minutes.
9 In terms of effective care and patient safety
10 we have a very simplistic view of healthcare right now,
11 which sees the physician as the captain of the ship and
12 the only thing you have to do is have a physician come by
13 and write some orders.
14 And a lot of the work that Carolyn's agency has
15 done has clarified that these are complex systems and we
16 need a systems approach to thinking about care. And we
17 know something about processes. We can measure outcomes.
18 But the fundamental gap is linking processes
19 and outcomes in order to learn what is the failure within
20 your current system that is leading to the outcomes.
21 I'm working with a hospital system right now
22 where they have noticed a 30 percent increase in heart
23 attack mortality over the last two years. And are trying
24 to figure out exactly what the cause of that is.
25 Their measures on all of -- performance

1 measures are outstanding. So that's not the cause.
2 They're at 98 percent on all of them.
3 It's the linkage of the processes to the
4 outcomes to try to figure out what happened two years ago
5 that is essential to figuring out what to do about it
6 now.
7 So the remedy lies in accountable organizations
8 and a system-based model where we hold organizations
9 accountable for all categories of care that I outlined.
10 And traditional quality improvement tools will work here.
11 Preference-sensitive care is a different
12 problem. The choice about whether to have a hip
13 replacement or whether to have a local excision of a
14 breast cancer or a mastectomy depends -- is a consequence
15 of two underlying causes.
16 One: continued scientific uncertainty. For
17 prostate cancer, for instance, we don't know yet whether
18 screening for prostate cancer is a good idea -- amazing
19 to think about.
20 But the second element of that is that we have
21 physician-dominated decisions in most of our healthcare
22 systems currently. So the remedy lies in outcomes
23 research, making sure we understand better what works and
24 doesn't in medicine so that we know the outcomes and can
25 present balanced information to our patients and then

1 share decision-making, informed patient choice, making
2 sure that patients are well informed of the risks and
3 benefits of the treatment options they face and can make
4 a choice in a setting that's not dominated by the values
5 of the physician.
6 Supply-sensitive services, which is where most
7 of the money is in healthcare -- we believe that the
8 cause of unwarranted variations and poor quality is
9 variations in local supply, local supply available to the
10 hospital.
11 Most patients are loyal to the hospital where
12 they get their care, especially if they have chronic
13 disease. And hospitals differ in the numbers of patients
14 that they care for, the relative size of the population
15 that they provide services to.
16 So we have variations in supply across regions
17 and across hospitals. And those resources are delivered
18 to patients under the assumption that more is better --
19 largely.
20 What we need to do is manage capacity and
21 monitor performance.
22 So how do we put it all together?
23 Right now we have weak organizations incapable
24 of either improving overall quality or implementing
25 private healthcare planning to control the growth of

1 capacity and use of supply-sensitive services.
2 We need accountable care organizations that can
3 be held accountable for all three categories of services
4 that we've outlined: effective care, preference-sensitive
5 services, and supply-sensitive services.
6 These could be integrated delivery systems,
7 large groups, or medical staffs and the hospitals to
8 which they admit most of their patients.
9 We have inadequate information on the quality
10 and efficiency of current providers. And I think it's a
11 major failing to look only at underuse of care because
12 there's an obvious interaction in our data at least
13 across regions between overuse and outcomes.
14 We also need better information on the efficacy
15 and effectiveness of new and existing technologies and
16 treatment strategies. That's a simple challenge to
17 provide the information. We just give Carolyn twice as
18 much money as -- or 10 times as much money as she
19 currently has. But we need to be able to monitor and
20 report on all aspects of performance.
21 Finally, we have flawed incentives. And this
22 is the thing we all tend to ignore. But it is, I
23 believe, a mistake to focus only on incentives to assure
24 the delivery of effective care because it ignores the
25 problems of misuse of preference-sensitive procedures and

1 overuse of supply-sensitive procedures.
2 So what we want to do is reward improved
3 performance on all three dimensions of care.
4 Thank you. That's the summary of the argument,
5 and it was a treat being here.
6 (Applause.)
7 MS. IGNAGNI: Good afternoon. I'm Karen
8 Ignagni, with the American Association of Health Plans.
9 Can you hear me in the back? Yes? No? That's not a
10 good sign. Okay, I'll pull the mic closer. I'm Karen
11 Ignagni with the American Association of Health Plans.
12 I want to begin by commending the agencies for
13 having these hearings. Often when we talk about the
14 issue of antitrust, competition, and matters that relate
15 directly to the jurisdiction of the FTC and the DOJ, we
16 never really get down to what is inside the box. And so
17 I think for our competitive markets to work, information,
18 access is key. And quality is key from a consumer
19 perspective.
20 I'm going to also commend the agency for
21 reaching out very broadly. This is part of a series of
22 hearings. And David didn't ask me to say this, but we've
23 been quite impressed with the diligence with which the
24 agencies have reached out to try to get a range of
25 opinion on these questions.

1 My colleague Stephanie Kanwit, our general
2 counsel, has spoken here and been part of these hearings
3 several times. And we very much appreciate the
4 opportunity.
5 I'm going to be talking about three large areas
6 this afternoon:
7 First, the broad quality challenge, which my
8 colleagues have already put on the table. And it's a
9 treat to be here with all of the folks on the panel.
10 Second, what health plans are doing to respond to some of
11 the challenges which have been laid out this afternoon.
12 And third, what is the role of the regulatory agencies as
13 we talk about quality, as we talk about information, as
14 we talk about competitive markets.
15
16 There's been a great deal of discussion in past
17 hearings about the institutional side. I'd like to make
18 some comments this afternoon on the physician side as
19 they relate to this matter.
20 I wanted to begin with some context and I think
21 both Carolyn and Elliot did this very well as well. And
22 mine's a little different. From our perspective in the
23 delivery system you won't be surprised.
24 First, both of my colleagues have made the
25 obvious point that costs and access are at the top

1 concerns for American families. Just one statistic to
2 put this in context: the Kaiser Family Foundation two
3 weeks ago reported that awareness and concern about
4 healthcare is in fact the top matter on the minds of
5 families.
6 We've heard a great deal over the last month,
7 two months about families' concerns about 401K's and the
8 stock market. Healthcare has completely eclipsed by
9 double in terms of what people are thinking about and
10 what they're worried about.
11 Secondly, from the perspective of the GE
12 negotiations starting this summer, I think that what we
13 will see is that healthcare once again, now more than a
14 decade after it first became the major issue at the
15 collective bargaining table, will once again become the
16 collective issue -- or the central issue at the
17 collective bargaining table.
18 The third point is axiomatic in policy circles,
19 but we rarely talk about it in Washington, which is that
20 the regulatory system, which is supposedly to guide and
21 frame what is done in healthcare, is very transactional
22 and not at all performance based.
23 So while colleagues, very important academics,
24 are writing about the importance of performance-based
25 measurements and outcomes in the health research area and

1 quality area, we need to begin to think about translating
2 that to what we have as a regulatory structure, because
3 when we are ready and reach consensus about what to do
4 about the problems that have already been put on the
5 table, we will hardly have the regulatory structures to
6 deal with that.
7 Let me give you one example. Everyone is
8 familiar with HIPPA, the regulation that our community
9 strongly supported which protects individual consumers'
10 privacy. That is regulated at the federal level.
11 But 50 states are also promulgating regulations
12 on HIPPA -- inconsistent, conflicting. And we have
13 health plans that may be in full compliance with the
14 federal regulation and out of compliance with the state
15 regulation on similar issues.
16 So I think that we have a long way to go as we
17 think about the regulatory system.
18 The legal system provides counterproductive
19 incentives. This is an issue that is greatly debated in
20 this town and state capitals around the country, but it
21 is very clear that the legal system is driving defensive
22 medicine -- maybe in many of the communities that Elliot
23 talked about. That is something we really need to get
24 our hands around if we're going to begin to solve those
25 problems systematically.

1 Also the area of reporting of errors. It is
2 unreasonable to expect healthcare providers to report
3 errors and then have that be grist for suits by
4 plaintiffs' attorneys. And so we have to get our hands
5 around that kind of protection.
6 Both of my colleagues talked very persuasively
7 about the fact that healthcare is not evidence-based.
8 That's often talked about in Washington and in state
9 capitals around the country. It is chilling to see the
10 research on how little healthcare is in fact evidence-
11 based. And I'm going to come back to that.
12 And I suspect that Reggie Herzlinger is going
13 to be speaking about this quite a lot -- that consumers,
14 with the exception of health plans, which are disclosing
15 over 50 data points, as Carolyn said earlier, to NCQA on
16 HEDIS data -- there's very little data yet in the
17 healthcare system in the public domain. So consumers are
18 clearly in the dark.
19 The IOM report, the two reports -- Elliot
20 referred to the first on safety. The second I think is
21 even more important in terms -- and I'm not implying,
22 Elliot, that you didn't suggest this in any way. But the
23 second really does give us a roadmap to improving
24 quality.
25 And three matters that I'd like highlight

1 because they do relate to my testimony here today. The
2 Institute of Medicine made the very sensible
3 recommendations of collaboration and care coordination,
4 meaning case management, disease management.
5 I am proud to tell you that according to
6 surveys, virtually all of our health plans are running
7 disease management programs in diabetes, cardiac care,
8 and asthma now. 96 percent of them have disease
9 management programs in depression, high-risk pregnancies
10 -- another very, very high area for disease management.
11 So our health plans are going right down the
12 line and targeting the conditions that have led to a
13 broad range of variation in both practice patterns, a
14 lack of diffusion of evidence into practice and are
15 targeting their efforts directly to improve patient care.
16 My colleagues, Dr. Woody Myers from Well
17 Point, and Reed Tuckson from United Health Care, will be
18 here later in the week. And they are going to be giving
19 very specific suggestions about what they're doing and
20 very specific examples of what they're doing in these
21 areas.
22 In my testimony I've provided quite a lot, by
23 way of example, of health plans all around the country so
24 you can get a broad geographic look. We are also
25 appending to our testimony a very detailed book of case

1 studies of over 50 very specific examples with track
2 records, data, very concrete data, to share with you in
3 over 20 states around the country. So I'm very pleased
4 about that and proud of what we're been doing in that
5 area.
6 Public reporting -- the IOM has given again a
7 roadmap for the importance of public reporting. I'm
8 going to come back to this in a minute.
9 And clearly the alignment of payment incentives
10 with safe, effective, and high quality healthcare. And
11 I'm going to be talking about that in a moment.
12
13 Our community in collaboration with private
14 (and over the last probably 12 months now in some cases
15 public) purchasers were beginning to move in this
16 direction very systematically. And I'll talk about that.
17 The quality challenges. Carolyn, and this is
18 not a commercial for AHRQ, but -- did a very, very
19 wonderful job of stopping short telling you that -- I
20 think the one data point that everybody needs to know.
21 And she didn't put me up to this.
22 I went to look over the weekend as I was
23 preparing my testimony about the relationship between the
24 NIH budget and the AHRQ budget. I just want to say again
25 for the record, Dr. Clancy did not put me up to this.

1 The NIH budget is at $27 billion. The AHRQ
2 budget is at 250 million, more than a hundred times.
3 Now, I am not making the argument to reduce the
4 NIH budget. I want to be very clear about not making
5 that argument.
6 I am, however, making the argument that we need
7 to, if we're spending such dear and valuable resources on
8 the importance of plotting new ground in research and
9 being so successful at it as a country, we need to carry
10 through this R&D function to begin to think about getting
11 our arms around translating this wonderful research into
12 practice.
13 AHRQ has some resources relatively speaking.
14 You know, with such a small budget, they've done a very
15 good job of trying to start efforts in this area all
16 around the country.
17 But I think as a nation, as we think about the
18 challenge particularly that Elliot laid out, we need to
19 get our arms around how are we going to do this. And I
20 think it needs to be done objectively. It needs to be
21 done at arms' length from a great deal of the clinical
22 research that's going on.
23 We talked about the limited diffusion of
24 research into practice, so how do we make the translation
25 from what's being done in important academic institutions

1 around the country, cataloging that, organizing it, and
2 then beginning to diffuse it and ultimately diffusing it
3 entirely into practice?
4 We're very, very -- we're small baby steps on
5 the continuum of knowing how to do that and organizing
6 efforts to do that.
7 Huge geographic disparities -- I'm not going to
8 say anything more because I think Dr. Fisher made a very,
9 very compelling case about that and I have nothing that I
10 could do to add to his excellent presentation.
11 The challenge of medical errors I do think is
12 interrelated to the liability system and I think creates
13 an innate reluctance in healthcare to report bad
14 outcomes.
15 And I think if we're going to move in the
16 direction that researchers have pointed to and the IOM
17 has pointed us to, we really need to get our arms around
18 a process for disclosing -- and not for its own sake --
19 disclosing and learning and doing quality improvement.
20 It's got to be a cyclical loop here or we're
21 not going to actually take advantage of all the
22 potentials. And I think that therein lies the challenge
23 of looking at where we are right now on the spectrum of
24 where we need to go.
25 There are a few quality improvement mechanisms,

1 speaking of assessment loops and assessment processes now
2 broadly in the system. And I think that, again, that
3 follows from point number one.
4 So how do we get there? We first -- I think
5 just take a typical economic demand-supply side analysis
6 -- what do patients, consumers, and purchasers need? --
7 and then look at the supply side and talk about how we
8 get it.
9 And as you can see, I'm going to be construing
10 demand and supply very, very broadly here for the
11 purposes of this analysis.
12 All right, solutions. I'm going to propose
13 eight to you.
14 First, all stakeholders need to commit to
15 transparency, developing consensus on what to measure and
16 publicly reporting it.
17 In talking about the great problems in the
18 healthcare system of the day, when you get to this issue
19 of transparency, reporting uniform data set, that is a
20 little bit of Snoozeville when it comes to actually
21 talking about that very specifically. But therein lies
22 the roadmap to moving forward.
23 Something is wrong in the healthcare system
24 when only health plans have committed to over 50
25 variables and are disclosing that. Now, I know we're

1 beginning to make progress in other communities and other
2 stakeholder groups.
3 We need to have a national discussion about
4 where do we put the balance point between what we're
5 disclosing, what's starting. You know, there is broad --
6 over 50 measures. 10, 12, 13, somewhere in between is
7 probably where we need to go.
8 And we need to create a process where that is
9 organized, where it's vetted, and where important
10 academics, such as are on the panel today, can come and
11 give us public input on that.
12 And then we need to disclose it in a way that
13 consumers can understand it, that will be valuable to
14 them. So we clearly need to involve consumer groups. We
15 probably need to involve teachers and people in the
16 community who are used to translating complicated
17 information in very, very specific and direct ways.
18 We need to, as I said earlier, support a
19 national effort that consistently translates clinical
20 research into practice and disseminates these results so
21 that folks will have a compass on how to proceed and
22 where we're going and we can learn from what has been
23 developed and what is in the pipeline.
24 We need to convert to an evidence-based, not an
25 opinion-based, healthcare system. It may be very, very

1 important or interesting for all of you. It certainly
2 was for me to learn that of the 43 states that have moved
3 in the direction of past external review legislation, not
4 one conducts external review in an evidence-based way.
5 Not one.
6 So we are -- we've done a great deal of work
7 over the last five to six years in talking about
8 processes for dispute resolution, almost no attention to
9 what is the mechanisms for making these decisions. And
10 they are still opinion-based despite the discussion we've
11 had about so-called patient protection.
12 That's an excellent place to start. Small,
13 baby step, but it would do a lot.
14 We need to commit to care coordination through
15 chronic disease management. And I'll say a little bit
16 more about that in a moment.
17 We need to pay for quality and effectiveness,
18 not for overuse, misuse, and underuse. And I think
19 Elliot is absolutely right that you can't just look at
20 the underuse, which has been the focus of a great deal of
21 the attention when you look at the data about the numbers
22 of procedures that are done unnecessarily.
23 With healthcare consuming 13 percent of the
24 GNP, with employers suggesting that they are finding it
25 harder and harder to continue to provide healthcare, this

1 is a very good place for us to start to begin to get our
2 hands around the definition of overuse and misuse.
3 We need to disclose medical errors, as stated
4 earlier, and provide the important legal protections.
5 It's unreasonable to expect entities to disclose if they
6 are not protected.
7 Malpractice is a very important part of this
8 because we really have a culture of blame, not a culture
9 of performance.
10 So we have the worst of all possible worlds.
11 We have a regulatory system that is transaction, not
12 performance based. We have a legal system that does not
13 encourage or reward performance. It looks for blame.
14 And we have no transparency with the exception of what
15 I've talked about in terms our community and what's in
16 the public domain right now.
17 So I think that we have a challenge as we talk
18 about moving to a system where there's more consumerism
19 in healthcare in getting our hands around how to actually
20 do it and what is the critical path to reform.
21 And since this is an FTC-DOJ discussion, it's
22 going to be very, very important to maintain and enforce
23 current antitrust guidelines.
24 I know that there probably will be individuals
25 who follow this panel, making in the name of quality very

1 compelling cases for changes in current guidelines or
2 legislation to allow collective bargaining for physicians
3 or something of those sorts of things.
4 And I think looking at the actions the FTC and
5 the DOJ have taken in the market over the last several
6 years really should give individuals pause. And we hope
7 that there will be continued vigilance on looking at the
8 guidelines, enforcing the guidelines, and as the
9 chairman, Dr. Muris, made a very strong point of at the
10 end of the fall last year, the importance of look-backs
11 in the antitrust context. So where there have been
12 opportunities granted for consolidation, for
13 collaboration, we hope the FTC and DOJ will continue on
14 the path of looking back and examining.
15 In terms of our advancing the quality agenda,
16 what we have done can be put into four categories.
17 We spend a great deal of time communicating the
18 latest information to physicians in our networks, posting
19 information on our website, and indeed collaborating with
20 the AMA and AHRQ on the guideline clearing house, where
21 there are, I am told now, Carolyn, 10,000 hits per month,
22 which is I think very exciting that that information is
23 being used.
24 We also have developed a number of committees
25 with different specialty societies, where we are in

1 dialogue about practice guidelines bringing our community
2 together with various specialty societies to discuss
3 care, to discuss practice, to discuss the research, and
4 to try to disseminate this as effectively as possible
5 across the industry.
6 I talked earlier about report cards on
7 performance and have spent a great of time in our
8 testimony on that. I would say that I think it is
9 important again for there to be a national discussion on
10 what is the appropriate template for disclosure.
11 We're engaged in these kinds of discussions
12 with purchasers and providers in large communities across
13 the country as we move forward with pay-for-performance
14 initiatives. And I think that we would be very, very
15 willing and anxious to engage in a broader discussion
16 about what should be measured, what should we have
17 reported, and how should it be reported.
18 On disease management programs I've provided
19 some top-lying data to you this afternoon in terms of
20 numbers of plans and what kinds of programs that they are
21 providing and executing.
22 There's a great deal of information in our
23 testimony and we are sending more information so that the
24 agencies will get a broad view of what is going on
25 throughout our industry to encourage care coordination

1 and case management.

2 Remember, approximately 20 percent of

3 individuals in a benefit plan consume 80 percent of the

4 resources. So this is an important place to start as we

5 look at diabetes, as we look at asthma, as we look at

6 cardiac.

7 Our community has pioneered the results on

8 using beta blockers. We've pioneered early intervention

9 in diabetes. We're preventing people from losing limbs

10 and going blind. We're proud of that. And we would like

11 to have the opportunity to work on a broader scale to

12 move these kinds of strategies into the delivery system

13 broadly.

14 And finally, we're doing a number of things in

15 concert with purchasers to reward quality, putting out

16 very specific incentives, benchmarks based on performance

17 standards, HEDIS-based in many cases, at the same time

18 looking at the important patient satisfaction variable.

19 Oftentimes when we talk about quality we forget that

20 patient satisfaction is a very important bell-weather to

21 how they think they are being treated. And also in some

22 cases investment in infrastructure and in IT.

23 Well, I talked about this. I'm going to skip

24 over this in the interest of time. I've talked about the

25 numbers of planned reporting. I'm not going to skip over

1 the second bullet. The fact that quality is improving is
2 not my comment. It's the NCQA's comment now for the
3 third year in a row, so we have documented improvement.
4 Administrative systems are improving. Our
5 community has started an important effort, which many of
6 you are familiar with -- the counsel for affordable
7 healthcare. We are very, very focused on reducing the
8 hassle factor for providers and patients, collaborating
9 across health plans to do credentialing, to work with
10 physicians so that they have one form rather than seven
11 or eight.
12 We're doing a number of other initiatives in
13 that context. And we've put a very significant priority
14 on reducing that hassle factor as a way of not only
15 improving the customer experience from the standpoint of
16 the patient, the consumer, but our partner experience in
17 terms of the physician.
18 Our partnerships to disseminate research are
19 many. The AHRQ partnership and the AMA in terms of the
20 clearinghouse. We have been partnering. And those
21 efforts continue with a number of specialty societies and
22 a number of other external organizations.
23 Finally, in terms of the role of FTC and DOJ,
24 we think enforcement of antitrust is very important. We
25 appreciate the opportunity to have participated on past

1 panels, to have commented on monopsony and a whole range
2 of other issues. And we've put all of that testimony on
3 our website so it is available for people to see.
4 We do think that Dr. Muris and framing the
5 importance of look-backs was absolutely right. We
6 applaud the FTC and the DOJ for signaling that they are
7 going to be looking at not only what is the case here and
8 now, but what is the case based on a looking back of what
9 had been approved. And we think that's very important.
10 We hope the regulatory agencies would continue
11 their position in opposition to collective bargaining
12 legislation that has been proposed by some.
13 And we are continuing to look very closely at
14 the Med South decision and how it is being interpreted --
15 not here in the agencies -- and we applaud the agencies
16 for their balanced interpretation -- but out in the
17 delivery system. And so we continue to look at that and
18 applaud the agencies for doing that as well.
19 Thank you very much.
20 (Applause.)
21 MR. HYMAN: Okay, just so everyone knows the
22 plan. Marty is going to speak and then we'll take about
23 a 10-minute break. And then we'll continue with the two
24 last speakers and go directly into the roundtable from
25 then on.

1 MR. GAYNOR: Thanks, David. That's so you have
2 something to look forward to -- that is, the end of my
3 testimony. Thanks.
4 I'm going to -- my talk is a little bit
5 different than the preceding talk by the other
6 distinguished members of the panel. It's a little bit
7 broader in that I'm going to touch on, in some sense --
8 I'm going to touch on competition broadly.
9 But it's also a little bit narrower. And I'm
10 going to focus mainly on hospital markets. There are
11 some issues, of course, that recur again and again. They
12 are not isolated to hospital markets. But in particular,
13 when I talk about evidence, I'm going to confine myself
14 to talking about hospital markets.
15 And there's a reason for that. I think that
16 actually the most concrete evidence, research evidence,
17 for the most out there on competition is mostly in
18 hospital markets. So let me do that.
19 Let me give you a background. Yet, again, you
20 see the little symbols on the outline here are evidence
21 of market power in the software industry because they're
22 not the symbols that I put on my computer, but they're
23 the symbols that some drone up in Redmond, Washington,
24 somehow put on in this version. And, again, if Microsoft
25 didn't have market power, they have to make these

1 compatible instead of being so sloppy.

2 I'll from herein on in I'll confine my comments

3 to healthcare markets. So outline. Let me talk, give

4 you a little bit of background of some of my thoughts on

5 general issues on competition in healthcare markets, give

6 you a little bit of history. I'm not an historian, so it

7 shouldn't be taken history with a capital "h."

8 And let me cover some specific issues, with

9 regard to price competition and hospital markets, the

10 role of not-for-profits, quality competition information.

11 I am not going to cover the waterfront of

12 issues in hospital markets. In particular, I'm not going

13 to talk about market definition, which is a very

14 important issue, but I'm just not going to talk about it

15 today. I'm not going to talk about vertical relations.

16 I'm not going to talk about efficiencies. A lot of

17 things I'm not going to talk about, but I think there

18 will be plenty of ground to cover nonetheless.

19 So, first, is healthcare different? Let me say

20 healthcare is not like a perfectly competitive market

21 that you've seen in your textbook for Econ 1 or Econ 101.

22

23 So what? Almost nothing is, right? Pick

24 toothpaste, pick cement, pick pencils -- none of those

25 markets are exactly like a perfectly competitive textbook

1 market. All markets are different. The markets for
2 computer-operating systems and cement are very different.
3 It implies that we use different economic
4 analysis and different antitrust analysis and treatment
5 of these markets. There's nothing particularly profound
6 in that, although sometimes the comment is made, "Well,
7 healthcare markets don't work" or "healthcare is not a
8 lot like other markets."
9 At one level that's a non sequitor. The cement
10 market again isn't like the operating system market. We
11 don't think twice about that.
12 But let's get into that a little more. It's
13 certainly true, healthcare has some specific
14 characteristics that we must take account of in economics
15 and antitrust. At one level this is totally consistent
16 with a standard antitrust view of case-specific analysis.
17 Now, coming to quality, which is the topic of
18 this session, quality is of particular in healthcare. If
19 your pencil breaks, you generally don't die for the most
20 part. I suppose a freak accident is possible. But there
21 are rather dire consequences, much more likely, at least
22 for a variety of services in healthcare.
23 Now, can healthcare markets give us what we
24 want in healthcare? I think this is an important
25 question to consider in even talking about the role of

1 antitrust. At present, for better or for worse, the
2 United States relies on a market system for healthcare.
3 Not markets without any government role -- far from it --
4 but basically a market system for financing and delivery
5 of healthcare.
6 That's unlikely to change anytime soon. I'm
7 not a political pundit, but my guess is if we could
8 listen to drums beating along the Potomac, they would be
9 perhaps more market-oriented in policy flavor rather than
10 more command and control in flavor.
11 A presumption of antitrust is that unregulated
12 monopoly is bad. Is this true in healthcare markets?
13 Does this seem to be a reasonable presumption in
14 healthcare markets?
15 Well, it depends. Let's think about what the
16 alternatives might be.
17 One alternative is no regulation at all,
18 literally unchecked monopoly. They all contend unchecked
19 monopoly is clearly bad. That cannot be a good thing.
20 Then the firms, hospitals have the opportunity to do
21 whatever they might want, regardless of whether or not it
22 benefits consumers.
23 What about self-regulation? That is often
24 promoted as an alternative to antitrust and enforcing
25 other kinds of regulatory oversight in this market. We

1 have to ask the question how likely is self-regulation,
2 regulation by market participants, to give us what we
3 want.
4 Not too surprisingly it's very hard for market
5 participants to self-regulate in a way that promotes
6 social welfare. Some forms of self-regulation can occur
7 and are very, very beneficial. So technical standards
8 are usually best on by the market participants
9 themselves. But that doesn't mean that we leave them all
10 alone when it comes to price settings.
11 So if I go ahead -- you don't even have to go
12 to golf courses now to collude to set prices. You can do
13 that any place you want. At least make it occur out on
14 the golf course or some place a little more difficult
15 rather than that.
16 I think there's also a track record if we look
17 at the legal record, for the medical professionals or for
18 hospitals have a lot of violations in the past. So I
19 don't think that gives us a lot of confidence. At least
20 it doesn't give me a lot of confidence.
21 So briefly my conclusion is that antitrust
22 enforcement is a critical element of health policy. It
23 preserves the functioning of markets on which the system
24 is based.
25 That's not all there is to health policy by a

1 long shot. But it is an important set of policy levers
2 that underlie the functioning of a great deal of the
3 system.
4 And it's relevant not just for the private part
5 of the system, but it's relevant for public part as well.
6 It's relevant for Medicare. And it's relevant for
7 Medicaid as well.
8 Let me say a little bit of something about
9 history. There is a long history of antitrust
10 enforcement and violations in healthcare. It goes back
11 at least to the 1930s. I'm not a legal scholar. So
12 David can certainly correct me on this. But there is a
13 Supreme Court case, I believe in 1936, against the
14 American Medical Association, in which they were
15 convicted of antitrust violation beginning a long and
16 illustrious history of such violation.
17 Hospital mergers have been an important area of
18 antitrust activity. The enforcement agencies have not
19 done well in recent years, meaning that they haven't won
20 a case since 1991 or a case they won has been since
21 reversed on appeal.
22 Well, why? I can't say that I know, but
23 perhaps there may be some underlying discomfort with the
24 notion of treating hospitals like other industries --
25 like cement or like software or like pencils or

1 toothpaste, what have you.

2 And there may be a number of elements to this.

3 One is that most hospitals in the U.S. are not

4 for profit. They are often called community hospitals -

5 - the notion that they are for, operate for the benefit

6 of the community and are in some way controlled by the

7 community.

8 Quality, whether some kind of discomfort over

9 whether competition will enhance quality and thereby

10 benefit consumers.

11 And issues about information. Do consumers

12 have the information? Are they well informed? Can they

13 rationally make choices that would benefit themselves as

14 opposed to some other entity making those decisions for

15 them?

16 Let me say something about price competition

17 and hospital markets and what we know about it.

18 First, there's a question that first has to be

19 answered -- is whether it would benefit consumers.

20 Remember that most consumers are very heavily insured.

21 And since they're very heavily insured, that tends to

22 lead to more consumption than would be optimal.

23 So lower prices might actually encourage that

24 excess consumption. That will not be the case so long as

25 the insurance market is competitive. A competitive

1 insurance market -- some work that I've done with my
2 colleagues Debbie Haas-Wilson and Bill Vogt -- will
3 produce an insurance policy that will make everybody
4 better in the presence of lower hospital or lower medical
5 care prices generally.
6 Intuitively so long as the insurance market is
7 responsive to what's happening in the medical market,
8 that it should be the case the price competition will
9 benefit consumers even if the consumers are heavily
10 insured.
11 Now, coming back to evidence, is there price
12 competition in hospital markets? The evidence that we
13 have, which I'll actually say for prior to the 1990s are
14 on what happened prior to the 1990s. This isn't all that
15 wonderful.
16 But the evidence -- and just in institutional
17 facts -- what we know about how hospitals were paid by
18 insurers seemed to indicate, no, there wasn't a heck of a
19 lot of price competition prior to the 1990s. Hospitals
20 got cost plus roughly reimbursement for Medicare and up
21 till the prospective payment system in the early eighties
22 and a cost plus reimbursement. Not a lot of pressure on
23 price. Selective contracting wasn't allowed for a long
24 time. So not a lot of pressure on price, not a lot of
25 competition.

1 Now, it seems clear from the evidence, however,
2 there's change in the 1990s. There's very strong
3 evidence that prices were lower, less concentrated
4 markets from the early 1990s on. Now, this is most but
5 not all studies in this area. My read on the evidence
6 though is that this is quite clear.
7 There's also evidence that hospital mergers
8 lead to higher prices although this evidence is not as
9 strong as the studies that use concentration. Now, there
10 are just some methodological problems because mergers are
11 not as common events as changes in concentration so it's
12 just harder to ferret out the statistical relationship.
13 There's evidence that individual hospitals have
14 considerable power to mark up prices. A study that my
15 colleague Bill Vogt and I did showed an average hospital
16 can mark up prices about 20 percent. Hospitals have a
17 lot of market power locally, geographically -- locally,
18 due to their location relative to where consumers are.
19 That's one too. This is relevant in
20 considering market definition issues in hospital merger
21 cases. Again I'm not going to talk directly about that.
22 But that would indicate, for example, that a relevant
23 antitrust market might be smaller than some of the
24 antitrust markets we have seemed to find in some cases.
25 Mergers that lead to large increases in

1 concentration can lead to very large price increases. In
2 these studies the effects are stronger -- the
3 relationship between concentration and price is stronger
4 -- where managed care is more prevalent.
5 Now, one comment. Most of the evidence thus
6 far has been data from the state of California. Why?
7 It's sort of what Willie Sutton says: Why do
8 you rob banks? That's where all the money is. There are
9 data in California. They are readily available. There
10 are a lot of them. There are lots of hospitals. There
11 is variation in concentration across hospital markets.
12 So it's not as if there's an end to the
13 research to be done. An academic never says that, right?
14 There's lots of funding opportunities in this area as a
15 matter of fact. But just to be clear about that.
16 Because California is not necessarily representative of
17 the entire U.S. And we won't get into that here.
18 What about not-for-profits? Well, one big
19 issue in hospital merger cases has been the question of
20 whether not-for-profits will exercise market power.
21 So defense in some recent cases has been no,
22 they are not-for-profits. They are community hospitals.
23 They are organized for the benefit of the community. So
24 even if a merger would greatly increase concentration,
25 the merged entities would not do something naughty and

1 raise prices and hurt the community.
2 That is certainly possible. That's possible;
3 it can't be disproven based on some theory. It's just a
4 question of facts. Now, of course, in the merger case
5 you're looking prospectively at what might happen. It
6 makes hard to discern from the facts. But I'll contend
7 that it's relatively unlikely.
8 What does the evidence say? Well, there's not
9 uniformity, but most but not all of the studies show that
10 not-for-profits do charge lower prices than for-profits.
11 So they don't have exactly the same objectives as for-
12 profits, not too surprisingly. But they will increase
13 them if they have increased market power.
14 There are a lot of studies that show this.
15 Again, referring back to my own work -- not that it's the
16 only work out there, but I am pretty familiar with it --
17 the work with Bill Vogt, we stimulated a merger to near
18 monopoly in San Luis Obispol, California, which is a
19 relatively isolated geographic area where a merger
20 occurred that the FTC intervened in and required some
21 divestiture.
22 We simulated what would have happened had they
23 not required that divestiture. And we found price
24 increases of about 53 percent. Whether the hospitals
25 were for profit or not for profit made absolutely no

1 difference. Not a dime's worth of difference in this
2 simulation.
3 I do need to mention, however, there are
4 exceptions, studies by Bill Lynk and Lynnette Newman,
5 which do have different results. The bulk of the
6 evidence in my opinion, however, shows that not-for-
7 profits do exercise market power if given the
8 opportunity. They don't really behave in this regard in
9 a substantially different way than for-profit hospitals.
10 Let me come to quality and competition in
11 healthcare. Let me say I don't view that price and
12 quality competition as separate issues. Competition is
13 over a number of dimensions. These are two particularly
14 important dimensions.
15 And I also want to say that they shouldn't be
16 treated as if they are completely delinked although in
17 the case of Medicare, where Medicare pays hospitals fixed
18 price, of course we don't have price competition because
19 for a given patient the price is the same in all
20 hospitals.
21 Well, why is this important? I don't think I
22 need to elaborate on that for this audience. Again, my
23 distinguished colleagues on the panel have done an
24 excellent job talking about this.
25 There's a lot of variation. Again, we know

1 that from what people have talked about. The
2 consequences can matter a great deal.
3 Now, what about the evidence here? Well, the
4 evidence on quality competition in hospital markets I
5 think is less settled than the evidence on price
6 competition.
7 In my opinion the best evidence so far shows
8 that quality is higher in less concentrated markets,
9 lower in more concentrated markets. There's a landmark
10 study by Dan Kessler and Mark McClellan, a couple of
11 other studies that are consistent with that. The
12 Kessler-McClellan study looks at Medicare patients. So
13 that's for fixed prices. I think it shows pretty
14 convincingly that in less concentrated markets, that
15 quality of care where here is measured as mortality
16 outcomes for heart attack, Medicare patients with heart
17 attacks, is better in less concentrated markets.
18 There are some conflicting results across
19 studies. You can see a couple papers I've starred here.
20 A paper by Kevin Volpp and Joe Waldfogel looked at what
21 happened -- again, heart attack patients in the state of
22 New Jersey post-price deregulation -- and compared that
23 to what happened in New York and found that outcomes were
24 worse post-price deregulation in New Jersey in New York.
25 So there are some conflicting results. It's

1 not a completely settled literature at this point. But I
2 think the best evidence thus far is that quality is
3 higher where we would think markets would be more
4 competitive.
5 An important outstanding issue that relates to
6 this literature and relates to antitrust cases are volume
7 outcome relationships. So a defense, a merger defense,
8 very well could be the merged entities will have higher
9 volume. They'll concentrate it in the single facility
10 and get better outcomes. And Elliot talked about some of
11 those.
12 Now, there have been a lot of studies that go
13 out -- get at this. I think the intuition is very, very
14 strong. We'd expect a volume outcome relationship for
15 reasons I think are self-evident to most of us.
16 It's hard, however, to actually ferret out a
17 causal relationship from secondary data. And again I
18 think the reason is obvious. Does volume cause outcome?
19 Or does outcome cause volume?
20 So we have hospitals with higher volumes
21 getting better outcomes. One story is practice makes
22 perfect. Another story is, well, gee, where do people
23 go? They go to where outcomes are better. So outcomes
24 cause volume. And it's not that easy to ferret that out.
25 And why is that important? You want to get the

1 causal relationship straight, one. And you want to know
2 the magnitude of the relationship. In particular, if
3 you're looking at a potential merger you really want the
4 magnitude of this relationship nailed to the extent that
5 you can get it.
6 There's a lot of work going on in this area. I
7 think it's an area where there will be a lot of progress.
8 And I think it's something that will have to be taken
9 into account in considering hospital mergers.
10 This is a tricky area because, of course, there
11 can be volume outcome relationships in many different
12 areas. Trying to evaluate all of those, which would be
13 benefits, potential benefits, of a merger against
14 potential downsides, which would be price increases
15 associated with that, would be a complicated business.
16 But it's certainly an area that attention
17 should be devoted to. Not-for-profits -- so far as I
18 know there's not really any significant evidence on
19 behavior non-for-profits versus for-profits in the
20 quality competition area thus far. And I may be ignorant
21 of this because it's a rapidly growing area -- but not
22 that I have seen.
23 Let me talk briefly about information. Can
24 markets work without information? No. Again I think
25 that's self-evident. Does everybody have to be well

1 informed? Does everyone have to be perfectly informed?
2 No or not necessarily. If you have enough people -- and
3 don't ask me exactly what enough is in a quantitative
4 sense -- but if you have enough that are well informed
5 and sellers can't readily discriminate between well-
6 informed and less-well-informed individuals, the well-
7 informed individuals can help drive the market.
8 So well-informed purchasers can be a very
9 powerful force even if they don't constitute 100 percent
10 of the purchasers. They may not even have to constitute
11 a majority. Now, does that mean we can relax and say
12 information is not important? No, I don't mean that.
13 Is information a panacea? Well, no. And a
14 trivial example is, suppose you had perfectly informed
15 consumers facing a monopolist. Well, it would be nice to
16 be informed so you could feel real bad about the crummy
17 quality you were getting and the high prices you were
18 getting, but there wouldn't be too much you could do
19 about it. Information is certainly important in and of
20 itself. It's not the only thing that matters, but it's
21 an important element of making competitive markets work.
22 Will better information make healthcare markets
23 like other markets? Well, this of course is impossible
24 to know. I wouldn't expect to see healthcare markets
25 looking like markets for toothpaste any time real soon

1 although for certain kinds of healthcare that is
2 certainly possible. But again, ask the question about
3 whether chicken soup could help somebody who is ill. The
4 answer, of course, is it couldn't hurt. So information
5 is generally a good thing.
6 Let me summarize briefly. Competition and
7 antitrust are important for healthcare in the U.S. We
8 have a market-based system. We are relying on that for
9 the foreseeable future. We have to make it feasible for
10 the markets that we have to work as well as they possibly
11 can.
12 The evidence at this point supports the
13 presumption that competition benefits consumers. I won't
14 say that it's decisive. But I don't think there's any
15 significant scientific evidence to overturn that
16 presumption, which is a basic presumption of antitrust.
17 Information is critical for the functioning of
18 markets and will undoubtedly play a bigger role in the
19 future in healthcare. A number of the prior presenters
20 have mentioned information technology and the role that
21 information technology is playing and will play. I
22 expect that to expand in the future.
23 Let me -- actually let me conclude at that
24 point. Thank you.
25 (Applause.)

1 MR. HYMAN: Okay, we're going to take a 10-
2 minute break and then reconvene at 3:30 for our last two
3 speakers. Thank you.
4 (A brief recess was taken.)
5 MR. HYMAN: And we have two more speakers.
6 We're on a tight ship here. That's why we end on time.
7 First, Professor Regina Herzlinger and then Michael
8 Millenson. And then I expect we'll sort of go directly
9 into a roundtable and sort of discuss what we've heard so
10 far.
11 MS. HERZLINGER: David, I don't share your
12 confidence in technology.
13 MR. HYMAN: Well, it's only because I've been
14 to 10 of them and had the same experiences. It's not
15 because I have faith in technology. Here we go.
16 MS. HERZLINGER: All right, here we go.
17 Something is blipping there.
18 All right, why don't I tell you what I'm going
19 to talk about meanwhile. I'm just thrilled to be here.
20 And I wasn't exactly sure what the subject of this panel
21 was. I assumed it as information.
22 And I'm going to talk about good markets. I'm
23 going to talk -- we heard about the shifting market
24 whether we wanted to or not -- shortly. I'm going to
25 talk about other good markets and what the essential

1 ingredients are that make them good markets.

2 I'm going to talk about why healthcare is not a

3 good market. I'm going to talk about the role of

4 information in any good market. I'm tell you about some

5 scare stories that I've heard and that you're heard about

6 healthcare information. And then I'm going to talk about

7 the role of the government in insuring the provision of

8 good information.

9 Thank you so much, David. Thank you.

10 So before I start, since I'm an old teacher,

11 I'm going to ask you a question. What are some

12 industries where the average consumer is an idiot? Not

13 an idiot in general, but just an idiot about what they're

14 buying. Nevertheless, the product has better and cheaper

15 over time.

16 Car industry, right? I mean the car is just a

17 huge number of microcircuits. I used to understand how

18 cars operated, but I haven't a clue now. And when I go

19 to a showroom and I see somebody looking under the hood

20 of a car, I think what the heck are you looking at, you

21 know? Nobody knows what's going on.

22 Nevertheless, cars have gotten cheaper over

23 time. It used to cost a year of income to buy a car. It

24 now takes 30 weeks of income to buy a car. And they are

25 more reliable. They are more fuel efficient. They are

1 more stylish. They have many wonderful qualities even
2 though the average consumer has no idea what they are
3 buying.
4 What's another example? Technology --
5 computers. When I graduated from MIT I had to program a
6 PDP-11. None of you even know what that is. Only people
7 of my age know what that is. Well, it's a deck mini-
8 computer and it cost $150,000. I had to program it,
9 machine language where I developed my lifelong aversion
10 to further contact with a computer and it had less
11 computing capacity than my cell phone.
12 Now, most people have no idea how a computer
13 works. I wonder who does. Somebody must. Nevertheless,
14 computers have become better and cheaper. And these are
15 examples of good markets. Things become better and
16 cheaper over time in these markets.
17 Now, what are their characteristics.
18 Characteristics of the automobile market and the computer
19 -- these are, they used be 10 commandments. But I guess
20 for economists there are only 3. Consumers can freely
21 choose. Providers are free to innovate. And they have
22 good information on product quality and price.
23 Let me illustrate this in the automobile
24 market. In the automobile market there are 220 models of
25 automobiles. And the woman who typed this said, "This

1 can't be right. This citation is the economics of
2 pantyhose." But it is correct because the article was
3 from the Fed in Dallas and was about of plethora of
4 choice and how a plethora of choice drives better,
5 cheaper products. Manufacturers are free to innovate
6 subject to, in my view, very good environmental and
7 safety standards.
8 And there's excellent information. There's
9 government information about safety and environmental
10 data. There is information from businesses. J.D. Power
11 is a real person, Dave Power, who has a really bustling
12 business -- measures consumer satisfaction. And then
13 there are data from non-profit organizations like the
14 exemplary Consumer Reports.
15 So when I do to buy a car, I pick up the
16 Consumer Reports. I skip all the stuff about how the car
17 works. I couldn't care less. And I go to data. I'm
18 very interested in reliability. I don't want to spend my
19 life in the garage. Thank you very much. Very
20 interested in safety. I'm very interested in price. It
21 gives me a lot of information, so even if I don't know a
22 piston from a valve I can still be an intelligent
23 consumer.
24 So what's happened in the automobile markets?
25 It's very interesting. The average quality has risen.

1 These are data from J. D. Power, where the total industry
2 is in the white and the yellow. And then the green thing
3 is Mercedes Benz. So with time the average quality of
4 cars has approached that of Mercedes Benz and probably
5 nowadays a Toyota is better overall than a Mercedes Benz.
6 So in good markets what happens is quality
7 rises. All boats rise in a rising sea. And quality
8 differentials narrow. There are differences, but they're
9 not as profound as they were back when we started in this
10 in 1987.
11 Healthcare sectors. So this is -- I'm done
12 with it. This is my three-second snapshot of good
13 industries. What makes them good? Not that the
14 automobile industry is my exemplar of terrific industrial
15 competition, but the cars have gotten better and cheaper
16 without demanding that the average consumer be an
17 automotive genius.
18 In the healthcare sector we have higher prices
19 and unknown but variable quality. I have searched high
20 and low for healthcare productivity data, which DRI used
21 to publish.
22 According to their data -- they have some data
23 now -- productivity has gone down, but it's something
24 that people would like to stay away from because it's so
25 difficult to measure improvements in quality. And

1 certainly improvements in technological quality in the
2 power of our drugs and devices are enormous. But these
3 are true statements. Higher prices and unknown but
4 variable quality. Why is this so in healthcare? It is
5 because none of the three commandments hold in
6 healthcare.
7 Consumers have very limited choice and they
8 have very limited choice when it comes to insurance
9 policies. They have insurance policies that give them
10 access to greater freedom to access providers for a
11 greater price, lesser freedom for a lower price.
12 But if you look at Switzerland, which has a
13 consumer-driven healthcare system, you look at the
14 variety of insurance policies in Switzerland. In
15 Switzerland you have to buy insurance, but you buy it.
16 So you would expect in a consumer-driven market there
17 would be a lot of variation in supply.
18 And there is considerable variation: variation
19 in benefits, variation in coverage, variation in term.
20 Term is a financial concept; it means how long the
21 insurance policy is for so you can get a five-year
22 insurance policy, which arguably creates a greater
23 incentive on the part of the insurer to make sure that
24 you're okay in five years or -- not okay, but anyway,
25 changes the incentive function of the insurer. There are

1 policies in Switzerland where if you smoke you pay 20
2 percent more than if you don't smoke. Huge variation.
3 We don't have that here.
4 Producers cannot freely innovate nor price.
5 Ralph Snyderman at Duke innovated an integrated program
6 for the treatment of congestive heart failure.
7 Everybody's talking about integration. He did it.
8 It was marvelous. In one year he saved $86,000
9 per person and not by reducing the pay of the providers.
10 He saved that money by making people healthier. And they
11 were so healthier that hospital admissions and re-
12 admissions were greatly reduced.
13 What reward did Snyderman get? Snyderman had
14 to eat the entire savings because he gets paid for
15 running a hospital. He doesn't get paid for making
16 people healthy under integrated management of their
17 diseases.
18 So, ironically, the healthier he made them, the
19 more money he lost. And it's very difficult although the
20 health plans are now moving in this direction. In the
21 past it used to be very difficult for providers to
22 distinguish themselves and establish some sort of product
23 identity on the basis of their prices.
24 And the third is there's virtually no price or
25 quality information. You ever try to find out what the

1 price is for a certain procedure? I mean you'd think,
2 huh, probably easier to get some information out the FBI.
3 So what is going on? There are two theories of
4 health care. One is a top-down micromanagement kind of
5 theory. You limit choice. The reason you limit choice
6 is big is beautiful. Big is beautiful means costs go
7 down because there's such high volume.
8 You limit provider freedom to price and
9 innovate. Same kind of theory. It's kind of an old
10 economy theory. You have these massive establishments.
11 They have a lot of volume. They drive down the price.
12 Information just confuses consumers. They
13 can't process it. And it should be done through
14 voluntarism. That's one way of looking at it. But
15 enough.
16 Consumer-provider interaction is a
17 fundamentally different choice. The idea of about
18 healthcare -- one is you give consumers considerable
19 choice. You give providers tremendous freedom to
20 innovate and to price. And you give a lot of
21 information. And the information comes from a free
22 market.
23 Now, there are a lot of scare stories about
24 information. And I should tell you that in addition
25 teaching healthcare at the Harvard Business School I have

1 a course on innovating healthcare. I also teach
2 accounting. I should say I try to teach accounting.
3 So I have many views of information. Some
4 people say, well, it's just going to bewilder the
5 consumer. And the indifference, the famous indifference
6 to NCQA and HEDIS is always trotted out as an example of
7 how data will confuse the consumer.
8 The question that is hardly ever asked is
9 whether these are data that the consumer wants to look
10 at. And it may be that they are so famously indifferent
11 to these data because consumers don't find them
12 compelling.
13 Second is that healthcare information will
14 punish the providers. This is one of my favorites.
15 There was an article in JAMA and the article said that 90
16 percent of physicians had fewer than 60 diabetic
17 patients, so if you measured their performance you
18 couldn't do it because they don't have enough diabetics
19 to get statistically reliable data.
20 This seems to me to confuse the purpose of
21 healthcare. Is the purpose of healthcare to protect
22 providers or is to provide excellent care? And if you
23 swallow the argument and say it's to provide excellent
24 care, then people who don't see enough diabetics to
25 register statistically significant information, perhaps

1 they should not be treating those diabetics.
2 You know, and perhaps that would be a very good
3 thing to happen -- to have a fallout and a
4 differentiation of providers by their skill set.
5 The third argument is nobody is going to treat
6 the sick. You start measuring the stuff. Well, if you
7 don't pay them more for treating the sick, they may well
8 have aversions to treating the sick. But if you have a
9 more consumer-driven system where people are rewarded for
10 taking the risk of treating the sick with financial
11 rewards, I don't think that mechanism would be as
12 powerful.
13 The fourth one is measures are impossible,
14 especially risk adjustment. And this was a famous
15 argument when portfolio theory first came out and the
16 idea that consumers would invest in stocks, and when
17 mutual funds first came out. And people said, as they do
18 in healthcare, "The average consumer's an idiot." Not
19 you, but the great of them -- out there.
20 And one thing that they could not do is adjust
21 for risk appropriately so that what they do is buy very
22 high risk mutual funds, which in the short-term would
23 bring great rewards. And you just couldn't measure for
24 risk.
25 And there was a guy at the University of

1 Chicago who believed that he could. And he wrote a
2 doctoral thesis for Milton Friedman about how to adjust
3 for risk. That measure is now called beta.
4 And Friedman thought it was the dumbest thing
5 he'd ever seen since liberal economists, but the author
6 of that, Harry Markowitz, won the Nobel Prize. And there
7 have been repeated Nobel Prizes given to people who have
8 refined risk measures in finance.
9 In other words, this is not impossible. It's
10 hard. But it's not impossible to measure risk correctly
11 or to get appropriate definitions of outcomes.
12 Now, this picks up on Marty's excellent -- all
13 these presentations were so fabulous, so I'm just going
14 to go quickly.
15 Why is it that consumers don't get confused by
16 information? Now, here is your hoary Economics 101
17 demand curve, right? So who invited her? And this has
18 the fabulous insight that when price is high, very few
19 people buy, and when price is low a lot of people buy.
20 Hello, right?
21 The question is, how did the price get low?
22 And the answer is that in most markets it takes a small
23 group of people who are assertive, knowledgeable,
24 demanding, obnoxious about that particular good or
25 service and they drive down the price. And all the rest

1 of us are free riders on those people.
2 So I have a friend Dave, who goes home with --
3 he's an engineer. He goes home. He has 18 pens in his
4 pocket. He reads computer engineering news for fun.
5 He's in that group. You know that's why they talk about
6 the marginal consumer rather than the average consumer.
7 And he reads electronic engineering news,
8 computer advances, you know. So I call Dave and I say I
9 want a PDA. What do you advise, Dave? And an hour later
10 I finally get what I want. So I'm a free rider on Dave,
11 who makes markets. Dave makes the computer market.
12 Somebody else makes the automobile market.
13 Now, are there people like this in healthcare
14 who are obnoxious, assertive, demanding, and
15 knowledgeable? If you look at the -- it's usually 16
16 percent, Marty, in my reading of the literature, 16
17 percent of consumers who are required to shift markets.
18 In other words, 84 percent can be idiots like me about
19 cars. And consumers in the 16 percent will make the
20 market for me.
21 If you look on the Web there are 80 million
22 people on the Web for healthcare. And the health policy
23 community says, oh, it's who's on that Web. Well, it's
24 people who read Dr. Clancy's material or Karen Ignagni's
25 or Dr. Fisher's. It's terrible, but if you take my -- in

1 other words, they are well educated, they are assertive,
2 they are wealthy. They are self-seeking, narcissistic,
3 effective people, eh? They are all of us in our
4 particular areas.
5 And if you say health policy, oh, is terrible.
6 It's not terrible at all because these are the people who
7 make those markets.
8 And even in Medicaid, even in lower income
9 populations, in people who have Medicaid or Medicare,
10 you'll find this same kind of assertive group that
11 transforms the market.
12 But what you also need is excellent
13 information, which is missing in action in healthcare.
14 Here's some examples of the impact of
15 healthcare information. New York state CABG: It improved
16 results through the impact on providers. New York state,
17 when it started the reporting for risk-adjusted CABG
18 results, had mediocre CABG results at the end of the
19 period, had the lowest mortality rate in the country.
20 People said, well, providers stopped treating the
21 sick. But in fact that average age of the people who got
22 CABGs in New York state increased so I find that
23 assertion hard to believe. This is an experiment that
24 needs more analysis.
25 BHCAG. BHCAG is the Buyers' Health-Care Action

1 Group. It is a consumer driven kind of innovation. They
2 publish information about the quality of different care
3 teams, quality as perceived by consumers, not clinical
4 dimensions of quality. And there are different prices.
5 And what happened when this information came
6 out is consumers migrated to lower cost, higher quality
7 care teams. You know they did what you'd expect them to
8 do when you gave them information -- said this is the
9 quality and this is the price, they're going to optimize
10 and they will get the best quality-price combination for
11 themselves.
12 Direct to consumer advertising, the bane of
13 many people's existence. I think what's interesting is
14 how effective it is -- whether you like it or don't like
15 it. And I personally can't believe in a society where we
16 ban information no matter how distasteful we might
17 personally find it. But regardless of our personal views
18 about it, it's how effective this information is. So
19 it's an example of the impact of healthcare information.
20 People are really interested.
21 Here is another unreadable chart that my friend
22 at General Electric gave me. And these are GE data to
23 show that high quality does not equal high cost. We know
24 that from the rest of the economy. The higher the
25 quality, the lower the cost.

1 And the reason is: The higher the quality, the
2 fewer the mistakes. The fewer the mistakes, the fewer
3 the retreads. The fewer the retreads, the lower the
4 cost.
5 That's true in healthcare too. So this chart,
6 for example, quality ranking number one is in
7 Pennsylvania for CABGs. There are two such institutions.
8 And you can find in New York for quality ranking number
9 3, for worse quality, three institutions that charge a
10 heck of a lot more.
11 So in this chart for both angioplasty and CABG
12 there is the beginnings of the verification of the fact
13 that holds true in other industries, and that is higher
14 quality is usually lower cost, not higher cost.
15 Another example is Denton Cooley, who has --
16 this eminent surgeon, who has dedicated his life to
17 lowering the cost and improving the quality of CABG. And
18 in my new book I have a chapter by Cooley. If you think
19 I'm shamelessly flogging this book, you're right. But
20 the royalties, net royalties, all go to the Harvard
21 Business School.
22 So Cooley charges 13,800. The general
23 providers charge 26,000. Cooley is fabulous at doing
24 what he's doing because he's done 90,000 open hearts, you
25 know, so when he opens your chest he knows what side the

1 heart is on. This guy is not practicing on you. And he
2 has a team that does nothing but CABGs.
3 In fact, even though his price is roughly
4 percent of the average, everything for everybody, I
5 believe Cooley makes a huge profit at this price.
6 And I called him and I said, "Dr. Cooley, would
7 you permit me to look at your books and see how much
8 profit you make at 13,800?" And smart as he is, he said,
9 "Huh, are you kidding?"
10 So it's a very interesting economic. If he
11 weren't such a zealot, he could price above the market
12 because he's Denton Cooley. And he's the tradename
13 you're talking about. But because he's trying to prove
14 his point that higher quality is lower cost, he brings
15 the price way down.
16 So what are the healthcare information
17 characteristics? People want information about doctors
18 and hospitals. They have information about health plans.
19 The information about health plans is very important. I
20 don't mean to denigrate this. But if I'm getting a
21 mastectomy, I really want to know a lot about my doctor
22 and my hospital. And the health plan information is not
23 as critical for me.
24 They want to know information about outcomes,
25 not process. They are not as willing to swallow the

1 supposition that process equals outcome. And the reason
2 they're not is that medicine is such a young science.
3 If it were physics, there is very strong cause
4 and effect causality. In medicine there are a lot of
5 questions. And ordinary people understand that a certain
6 process does not necessarily imply a certain outcome.
7 They want price information. They want
8 comparative information. They want a lot of data from
9 their peers. How do other people in my situation, who
10 underwent a mastectomy or prostate surgery, how did they
11 feel?
12 How not to obtain healthcare information.
13 Voluntary disclosure in my opinion, having reviewed this,
14 is a flop. And the reason it flops is low scoring
15 participants can opt out. And arguably those are the
16 ones you want to know about, the ones who got really bad
17 scores -- say I'm out of here. But perhaps I certainly
18 would want to know who they are.
19 Process-based measures are not what people
20 want. The data are unaudited. I cannot extol the
21 virtues of auditing after Enron, et cetera, but it is
22 better than not having audited data. And there are very
23 few standards of measurement.
24 How do you make it happen? How do you get good
25 healthcare information? One model is the model of the

1 SEC and the Financial Accounting Standards Board.
2 Now, I want to tell you two things. I am not a
3 person whose mind normally jumps to government as a
4 solution for a problem. Quite the contrary. So this is
5 from my habits of mind, this is an unusual solution.
6 And secondly, people now pooh-pooh the SEC and
7 the FASB. But it would be instructive to look back at
8 what things were like before the SEC and the FASB were
9 put into place. The SEC, of course, the government
10 agency that requires information, and the Financial
11 Accounting Standards Board is a group of private experts
12 who derive the standards of measurement through a
13 prolonged lobotomizing process, item by item, broad base,
14 with lots of disclosure.
15 And people say, oh, the SEC is a mess. But
16 before the SEC acts came along, 1933, 1934, publicly
17 traded corporations disclosed virtually no data, no
18 information. So if you invested in a company, you had no
19 idea what it is you were investing in.
20 George Westinghouse, the head of Westinghouse,
21 who was a brilliant engineer, held 10 annual meetings and
22 he never disclosed any information. He said why do you
23 need it? Here I am. I'm fabulous.
24 And when Roosevelt was elected in the heart of
25 the depression, he was urged to regulate these

1 organizations and to do a lot of things. And Roosevelt
2 is psychologically to me of never ending interest because
3 he was a man with no private sector experience, who was
4 raised by his mother, who moved in with Eleanor and him.
5 Is this the key to a happy marriage?
6 So despite all of this he was in many ways an
7 incredibly brilliant president. And he came up with the
8 idea of the SEC. Not he came up, but he agreed to the
9 idea of the SEC. And he said rather than regulate, I'm
10 going to tell people the truth. He called it the truth
11 agency.
12 The SEC has the power to establish standards of
13 measurement, but it never has taken that power and
14 instead delegated it to private sector organizations that
15 develop the standards of measurement.
16 So this model, the government requires audited
17 regular disclosure, punishes miscreants more or less
18 diligently in cycles as things are always very cyclical.
19 The private sector develops measurement standards and
20 audits the data.
21 It is interesting, it is generally interesting
22 to me -- of course, I teach accounting, so I have a huge
23 appetite for boredom. But generally accepted accounting
24 principles did not exist until the SEC acts came along.
25 But accounting was discovered in the middle of

1 the 15th century. So absent a government requirement
2 that you measure, not only measure, you disclose and you
3 audit. GAAP or standards of measurement did not come
4 into being until the government required them.
5 So memo to the FTC and Department of Justice:
6 Provide information and it will lead to your good health.
7 That is a glass of sparkling water.
8 (Applause.)
9 MR. HYMAN: Finally, Mr. Millenson.
10 MR. MILLENSON: Good afternoon. I want to
11 thank David for the invitation here. As the last speaker
12 you have a lot to draw upon. Since Reggie gave you the
13 three commandments, I think that I can have my own faith-
14 based initiative.
15 And having heard all these comments of the
16 distinguished panelists who have gone before me, I would
17 like to say from your mouths to God's ear. If some of
18 what you've heard was all put into place, I think we'd be
19 better off.
20 What I'd like to do is take a different
21 approach. Knowing the panelists who have preceded me and
22 the wonderful fact-based presentations they would make,
23 I'm going to try to go in a little different direction
24 and raise some questions from the point of view of a
25 consumer, perhaps a medical historian, some economic

1 history, and put it all into some sort of a context here.
2 And I'm going to do something very daring and
3 not use power points or the Apple equivalent, which we
4 had earlier, and just talk a little bit. And I will make
5 the entire text available for the Internet site.
6 In 1913, a year before the passage of the
7 Federal Trade Commission Act, the American Medical
8 Establishment voluntarily took an action that would seem
9 to make this series of hearings irrelevant. By unanimous
10 vote the regions to the American College of Surgeons
11 accepted the need for improving efficiency in hospitals -
12 - their word -- by measuring patient outcomes and making
13 the results public.
14 The initiative was deemed so important that the
15 surgeon sent a detailed copy of the recommendations to
16 the American and Canadian medical associations and to
17 every hospital in North America. One the United States'
18 most prestigious hospitals, the Harvard affiliated
19 Massachusetts General, had already put the system of
20 outcomes measurement into place.
21 The goal was to insure that the quality of care
22 given patients was as high as medical knowledge allowed,
23 what we would call evidence-based medicine. Results at
24 each hospital would be made public, what we would call
25 transparency, with patient outcomes followed for up to

1 one year after discharge, what we would call an episode
2 of illness, and those outcomes explicitly linked to
3 actions taken by the hospitals' clinicians.
4 As a result of this accountability for results
5 doctors and hospitals would voluntarily provide only that
6 care at which they excelled, an early focused -- and
7 patients would be cured more quickly and reliably, saving
8 money for everyone and making the economists happy.
9 In addition, patients would comfortably choose
10 their providers based on outcomes information, a true
11 consumer-driven healthcare. No need for government
12 oversight. No need for managed care. No need for
13 Institute of Medicine reports or health services
14 research. In other words, everyone in this room can go
15 home.
16 All of this exactly 90 years ago. All of these
17 projected achievements were supposed to result from
18 implementing the end result idea of Boston surgeon Ernest
19 Amory Codman. And, of course, none of them ever came to
20 fruition.
21 Codman's influence had reached his apex with
22 the theoretical agreement to put his ideas into action.
23 But in the years that followed, even Mass. General lost
24 interest in actual implementation. And in fact, when I
25 looked at the Mass. General annual reports, the year that

1 he had his end result idea they called it one of the most
2 important things that ever happened. Fifty years later
3 when they did a review of what had happened in their
4 history, they ignored him completely.
5 He went into obscurity as of the end result
6 idea. Codman failed for a number of reasons. But the
7 central problem that he faced is one that I believe
8 remains a critical barrier to change -- and one that I
9 believe the Commission would do well to ponder.
10 After looking at this issue for over 10 years
11 now and spending a lot of time with communities, I like
12 very much what Codman said about why we have not made
13 more progress. For whose interest is it to have the
14 hospital efficient, by which he means higher quality,
15 lower price.
16 Strangely enough, the answer is no one. There
17 is a difference between interest and duty. You do your
18 duty if the work comes to you. But you do not go out of
19 your way to get the work unless it is for your interest.
20 Interest versus duty. Every physician, nurse,
21 hospital administrator, and health insurer certainly has
22 the duty to insure that patients get the highest quality
23 care. On the other hand very few have the slightest
24 interest in the public being given information that might
25 reveal their failures to do so.

1 In our time, as in Codman's, making available
2 quality of care information that is credible and easy to
3 use by consumers poses a potential threat to the economic
4 livelihood and the reputation of many people in the
5 healthcare industry who do quite well -- thank you -- in
6 the absence of that information.
7 Among those threatened are many doctors and
8 hospitals whose reputation and their own feelings about
9 how good they are may not be reflected in the data. And
10 those who assemble networks of doctors and hospitals,
11 since many health plans and many employers pay very
12 little attention to clinical indicators in making network
13 selections.
14 It is also possible that the drug makers may be
15 less than totally enthusiastic about competition based on
16 objective data, although of course all those
17 advertisements are fine.
18 Here's a little known fact. The Institute of
19 Medicine first called for disclosure of risk-adjusted
20 outcome data in 1974. That proposal had such little
21 impact on the actual practice of medicine that, 30 years
22 later, the Institute of Medicine itself has no
23 institutional memory of its own recommendation.
24 This is the challenge that you confront. Make
25 no mistake. Empowering patients with quality information

1 is as destabilizing to the medical establishment as the
2 Protestant reformation was to the Catholic church.
3 It involves taking information that for
4 centuries was available only to a select elite and giving
5 it to the masses. Yes, the Catholic church survived and
6 adapted after the Reformation. Nonetheless, as Thomas
7 Kuhn wrote in his landmark, The Structure of Scientific
8 Revolutions, altering any long-standing paradigm is
9 disruptive and traumatic.
10 Sharing reliable quality of care information
11 with patients is a true paradigm shift, a radical change
12 in the basic assumptions upon which our healthcare system
13 has always been based since Hippocrates made the first
14 house call.
15 But this kind of paradigm shift occurs only
16 when the defenders of the old ways can, as Kuhn put it,
17 no longer evade anomalies that subvert the existing
18 tradition. So what can the Federal Trade
19 Commission and Department of Justice do to subvert the
20 existing traditions of medicine, the ones that swallowed
21 up the efforts of Ernest Amory Codman and so many others
22 who followed.
23 How can the FTC create a situation where it is
24 the interest of those who now control quality of care
25 data to make that data available and to compete with each

1 other based on results? Finally, what specific type of
2 information should the FTC concentrate on having
3 released?
4 To address those questions let's start by
5 looking briefly backward once again. In 1919 the result
6 of the first large-scale inspection of hospitals were
7 given to the regions to the American College of Surgeons.
8 Of 692 hospitals surveyed, only 89 passed. And those
9 that failed included some of the nation's most
10 prestigious institutions.
11 Afraid that this list would fall into the hands
12 of the press, a problem even then, the surgeons took the
13 pages down to the furnace in the basement of their hotel
14 and burned them.
15 Since 1919 there's been steady progress in the
16 dissemination of these results. First, the bad news was
17 burned. Then for many decades it was kept totally
18 secret. Today, however, the bad news is merely
19 suppressed until it's almost irrelevant to decision
20 making.
21 Let me explain.
22 A summary of the results of surveys by the
23 Joint Commission on Accreditation of Health Care
24 Organizations has been available to the public on line
25 since 1996.

1 However, there are two caveats. First, the
2 report is posted only after the problems have been
3 corrected. Secondly, there is no detail given about the
4 problems, only a general description of what type of
5 standard was involved.
6 Here's an example that everyone in this room
7 can appreciate. The Washington Hospital Center at 110
8 Irving Street, N.W., is the nearest hospital to this
9 hearing room in case any of you are having, planning are
10 having an urgent problem that one of the M.D. panelists
11 cannot fix.
12 If you examine this hospital's latest survey,
13 you will see that the hospital was told on September 28,
14 2002, that it had to meet various "requirements for
15 improvement," which by the way the Web site of the joint
16 commission helpfully defines as having to do with type 1
17 recommendations.
18 In order to receive full accreditation I'm not
19 sure what they were, but the hospital did receive a "2"
20 on medication usage, putting it roughly in the lower half
21 of all hospitals. Forty-nine percent got a "1."
22 Since details are confidential, we don't know
23 whether the difficulty represented an actual patient care
24 problem or only a minor infraction of some rule that
25 those terrible bureaucrats make hospitals follow.

1 In any event, by the time the hospital made the
2 needed improvements, was resurveyed, and a new report was
3 posted it was April 24, 2003, seven months later. Until
4 then only a summary report from 1999 on the hospital was
5 available.
6 Here's another difficulty with the joint
7 commission disclosure and some of the other disclosures
8 that are available on line. There's a hospital about a
9 mile from my house that my kids have, alas, used on
10 several occasions. My children were born at another
11 hospital, about a half an hour south. And there's a
12 third hospital about a half hour drive southwest, where
13 my mother in law recently had surgery.
14 All three hospitals are owned by the same
15 parent corporation. There is just one Joint Commission
16 report on the whole corporation. The same problem
17 cropped up when I tried to go on line to get clinical
18 outcomes from some of the other firms from some of the
19 other firms that analyze Medicare claims data. Should
20 three operating hospitals be aggregated into one report?
21 The same corporation, by the way, boasts on its
22 Web site that its been rated "among the top 100
23 nationally" without, by the way, ever saying who gave
24 them the rating. Or when you go and find about the
25 rating -- could take full-page ads in The Tribune that

1 way too -- top 100. Very impressive. Not even in the
2 small print.
3 But nowadays they do talk about the small
4 print. And it's a combined financial-clinical score.
5 You all know who I'm talking about. Is that acceptable
6 for advertising?
7 I found another hospital on line, which just
8 posts its own quality data.
9 These are the kinds of questions I believe the
10 FTC needs to raise.
11 A quick addendum. To be fair, the Joint
12 Commission does undertake many activities to improve
13 hospital safety and quality. They are not seen by the
14 public. But none of them enable the consumer or large
15 purchasers to make choices.
16 Meanwhile the Joint Commission has announced
17 that it will be making more timely information available
18 soon although I forget the year. Maybe next year, maybe
19 the year after.
20 The key point, however, is that the Joint
21 Commission accredits fourth-fifths of American hospitals.
22 Is that accreditation truly facilitating competition
23 based on quality?
24 Again, I don't know the answer. But I do
25 believe the FTC should be asking the question. And it

1 should ask the question of the state health departments
2 to do accreditation as well.
3 The Joint Commission is controlled by
4 representatives of the American Hospital Association and
5 the American Medical Association. Are they interested in
6 quality-based competition?
7 Well, in 1993, before everybody decided to hate
8 HMO's instead of doctors, a public opinion poll found
9 that 54 percent of respondents thought doctors try to
10 hide each other's mistakes. Of nurses interviewed 73
11 percent believed doctors try to hide each other's
12 mistakes. And that, ladies and gentlemen, was in a poll
13 taken by the AMA.
14 There are reasons for that perception. In 1994
15 a woman named Karen Burton sued University Hospital in
16 Iowa City, asking to see the hospital's infection rate
17 before undergoing surgery. Her rationale was that the
18 hospital as a taxpayer supported institution should have
19 to disclose the information under the Freedom of
20 Information Act.
21 Burton won at a lower court level, but lost in
22 an Iowa supreme court decision in 1997. The hospital,
23 backed by the local medical society and the state
24 hospital association, argued persuasively that releasing
25 infection data would cause doctors to stop reporting it.

1 You may not have heard of this case because it
2 involves someone in Iowa, not someone in Washington,
3 D.C., New York, Los Angeles, or some place the rest of us
4 care about. It tells you, however, what has happened to
5 the public disclosure of data.
6 This type of provider attitude reminds me of
7 remarks made several years ago by Dr. Donald Berwick,
8 founder of the Institute for Healthcare Improvement. Dr.
9 Burwick noted: "There's continuing lack of conviction by
10 doctors that improvement is needed. The conviction is
11 we're darned good. Why don't people pay us what we
12 want?"
13 There is a middle ground on information
14 disclosure. Rather than reporting unaudited data on
15 infections, which might not be comparable among
16 institutions, we could post a separate safety rating in
17 the lobby of each hospital.
18 That rating would incorporate indicators such
19 as the infection rate and the medication error rate, all
20 audited, based on standards that the experts agreed were
21 appropriate. It's just that the experts' judgment would
22 be made public in an actionable form.
23 I see it being posted on the way to the
24 elevator in big type so you can't miss it: Safety -- high
25 pass, pass, fail. Just like the ratings on cleanliness

1 that you see in restaurants.
2 Do you think that would be a motivator for
3 action? Do you think that would get us the 16 percent of
4 consumers caring about safety and making some decisions
5 based on the data?
6 Remember how Codman put it? You do your duty
7 if the work comes to you. But you do not go out of your
8 way to get the work unless it is for your interest.
9 Might that precipitate some interest?
10 In his classic work, Diffusions of Innovations,
11 Everett Rogers demonstrated that an innovations
12 acceptance depends on much more than its objective
13 merits, like safety.
14 Five characteristics hold the key: relative
15 advantage over what currently exists; compatibility with
16 existing values and behaviors; lack of complexity; the
17 ability to be subjected to experiment (trialability); and
18 producing results everyone can see (observability).
19 The first of Rogers's rules, that an innovation
20 produces relative advantage, means the innovation must
21 not only be real, it must be perceived as real and
22 producing real advantage. The perception must be there.
23 This is a formidable barrier in healthcare, given the
24 lack of information on outcomes. And it is an area where
25 the light and heat generated by public disclosure can

1 make a real difference. And we may discuss in the
2 roundtable whether public data disclosure is always good,
3 but certainly it is a 2'x 4' in getting folks attention.
4 Let me give you a few examples. Consider:
5 general surgeons and pediatricians knew for years that
6 tonsillectomies on children were far too common, leading
7 to completely avoidable deaths and complications, not to
8 mention the financial cost.
9 A 1962 California study, for example, found
10 that the percentage of appropriate tonsillectomies at
11 community hospitals was an almost unbelievable two
12 percent.
13 How did the profession react to the medical
14 literature? Well, a decade later, after Congress held
15 hearings on the problem they started to correct
16 themselves. Another triumph of self-regulation.
17 Similarly, anesthesiologists knew for years
18 that the injury and death rate for anesthesia was too
19 high. But the profession did not promulgate guidelines
20 and take tough steps to enforce them until the
21 combination of soaring malpractice rates and a network TV
22 exposé made it very much in their interest to do so.
23 However, if you've heard anything about the
24 Harvard guidelines in anesthesia, you've heard the
25 doctors talk about it as a triumph of self-regulation,

1 the memory of what caused them to self-regulate having
2 vanished down the memory hole.
3 Orthopedic surgeons were urged by a consumer
4 advocacy group back in 1985 to take action to reduce
5 wrong-side surgery. Only after a major scandal shook the
6 profession and drew national headlines in 1995, cutting
7 off the wrong foot of a diabetic in Florida, did the
8 orthopedic surgeons finally see it as very much in their
9 interest to spearhead precisely such a campaign.
10 A raft of important studies from the 1970s to
11 the early 1990s sounded the alarm about the tens of
12 thousands of deaths annually in hospitals from
13 preventable medical mistakes.
14 And by the way, a real type A person takes
15 Lucien Leaps, analogy about 747's. And a physician I
16 know said it's wrong because he does not have the average
17 load factor of a 747 correct and has recalculated the
18 numbers.
19 Hospitals and doctors, however, did not accept
20 their duty to act forcefully to reduce errors and tens of
21 thousands of patient deaths until, and only until, a
22 highly publicized Institute of Medicine report in 1999,
23 followed by the way by Congressional hearings, finally
24 made it very much in their interest to do so.
25 The Institute of Medicine's national cancer

1 policy board concluded in 1999 that a substantial number
2 of individuals with all types of cancer do not receive
3 care known to be effective for their condition. In every
4 state in America there is a cancer registry that contains
5 information on the outcomes of cancer treatment. That
6 information, however, is not public.
7 Those registries also contain data on the
8 volume of surgery by individual hospitals. I had the
9 idea of posting it on a Web site, so I called. It turns
10 out that data is only semi-public, collected by the
11 American Cancer Society, but available only on request if
12 you happen to know to request it.
13 The FTC, I believe, should ask questions about
14 cancer registries. And if you want to focus on one
15 medical condition for empowering consumers, one that will
16 get you public gratitude, media attention, and is needed,
17 I could suggest cancer is the place to start.
18 Now, consumers will act on information that is
19 specific, actionable, and clinically relevant. The
20 United Kingdom, for example, has been publishing five-
21 year survival rates for breast and cervical cancer for
22 specific English hospitals since 1999.
23 Do we in this country believe that it is
24 acceptable to hold a government run healthcare system
25 accountable but not the private sector? Well, in a sense

1 we do, by the way, because it's always easier to bash
2 government than it is to take on entrenched economically
3 powerful, politically powerful private interests.
4 So about the same time the Institute of
5 Medicine was saying our cancer care here was not very
6 good and getting about a paragraph story, I believe, in
7 the newspapers, the British managed to bash the
8 government for cancer care, calling it a "pig's
9 breakfast." Ahh, for the British.
10 The medical literature tells us the experience
11 of the individual surgeon makes a difference in outcomes.
12 In New York state a woman who has breast cancer can find
13 out the number of lumpectomies and mastectomies performed
14 by individual surgeons. Why should New York state be the
15 only state in which this type of information is readily
16 available to consumers?
17 A New York woman I know, who is an attorney and
18 breast cancer survivor, has made it her personal mission
19 to call state governments, badger them for quality of
20 care information that is in theory public, and then post
21 that information on the Web site that she pays for
22 herself. And you can visit that site at
23 www.healthcarechoices.org.
24 Unfortunately in many states she leaves empty-
25 handed. Outcomes information on hospitals that collected

1 under a government mandate is analyzed by the state
2 hospital association and then is sold to that state
3 hospital association's members.
4 The information is not public. Should this be
5 of concern to the FTC? And on my way over here I stopped
6 and made a phone call to an old high school friend and
7 found out that his wife had breast cancer and spent days
8 looking for information.
9 Allow me to make one more point and then I'll
10 conclude. When I was writing demanding medical
11 excellence, I learned the hard way to listen very
12 carefully for statements couched in the present tense
13 that really belong in the future, hopeful tense, as in
14 "Employers today are demanding quality data."
15 Translation: About 10 big employers are demanding.
16 Another bunch would like it. And we hope to get the
17 other 80 percent any day now.
18 Or "The era of accountability in medicine has
19 arrived." Translation: In two procedures on a pilot
20 basis with more to come if all goes well. Mostly these
21 are not deliberate fibs, they are more like over
22 enthusiasm.
23 In the days to come you may well hear testimony
24 that sounds like an argument for the FTC doing nothing at
25 all because the marketplace is working just fine and

1 without you.
2 The nations' hospitals, as you've heard, are
3 working hand in glove with the Medicare program on a
4 pilot data disclosure project and many individual
5 hospitals are working with their local communities in the
6 same vein.
7 Physicians' specialty societies regularly beat
8 the drum on behalf of evidence-based medicine, safety,
9 and accountability. A slowly growing number of states is
10 disclosing detailed quality data on doctors and
11 hospitals.
12
13 Meanwhile a number of the nation's largest
14 health plans, as well as so-called consumer-driven plans,
15 are making available to their members much the same kind
16 of detailed ratings that are put out by various
17 commercial data analysis services.
18 And, of course, private employers are demanding
19 measurable performance improvement from those who care
20 for their employees and families.
21 The news media is starting to pay attention on
22 its own. There's a regular informed patient column in
23 the influential Wallstreet Journal, while the National
24 Association of Healthcare Journalists has put out a
25 detailed guide to reporting on quality issues. You can

1 see news stories today not just in the biggest newspapers
2 but in places like the Palm Beach Post and the Fort Worth
3 Star Telegram.
4 So is your intervention needed? Is the
5 marketplace taking care of things all on its own as the
6 invisible hand of Adam Smith hovers above us all?
7 The economist Kenneth Arrow in his seminal
8 essay, Uncertainty in the Welfare Economics of Medical
9 Care, explained in 1963: "Medical knowledge is so
10 complicated the information possessed by the physician as
11 to the consequences and possibilities of treatment is
12 necessarily very much greater than that of the patient --
13 or at least so it is believed by both parties."
14 In other words, the medical marketplace cannot
15 operate like other markets. Has Arrow become obsolete
16 while the FTC was busy elsewhere? Have we as a society
17 moved to a place where the consumer is instead harkening
18 to the advice of quality guru W. Edwards Demming: In God
19 we trust; all others bring data?
20 The answer, I believe, is no. The irreversible
21 paradigm shift is not yet upon us. Yes, I believe that
22 economics, technology, and the spirit of our times, the
23 Zeitgeist, make that change inevitable.
24 But there is a big time gap in inevitable. Do
25 you mean two years? Five years? Ten years? And twenty

1 years? A big gap that makes a lot of difference when it
2 is your loved one who was sick and scared and in need of
3 the best possible care.
4 The Federal Trade Commission has the power to
5 regulate and to advocate, to make law, and to make news.
6 Using your bully pulpit you can help push the U.S.
7 healthcare system into the information age. You can help
8 empower consumers because you are consumers.
9 The FTC, God bless you, is not a healthcare
10 organization. And you can push for changes that are
11 comprehensible and irreversible because market forces
12 make them so. The transformation of medicine in a new
13 partnership between clinicians and patients has begun.
14 But the time of its completion remains to be determined.
15 If you will not act to bring that date closer, then who
16 will do so? And if you will not act now, then when?
17 Thank you very much.
18 (Applause.)
19 MR. HYMAN: Thank you, Michael. Well, everyone
20 has scrupulously respected the property boundaries on our
21 time and so we actually have about a half an hour for a
22 moderated roundtable.
23 I have a whole series of questions. But my
24 tendency is to ask the early speakers whether they wish
25 to comment on, amplify, or respond to subsequent speakers

1 since they suffered the disadvantage of going first.
2 So I'll just start with Dr. Clancy and come
3 down and if you have additional remarks you'd like to
4 make at this point, feel free.
5 DR. CLANCY: I'll pass. I'm actually just
6 listening to others.
7 MR. HYMAN: Waiver is a perfectly acceptable
8 strategy here.
9 DR. FISHER: Well, I'd like to comment that I
10 think it's remarkable to the degree to which we agreed on
11 the need for better information in healthcare.
12 And I think that the challenge we face is on
13 trying to make sure that the provision is to the best,
14 the best we can achieve is evidence based. I am fearful
15 that some of the data that can get out there could
16 actually cause more harm than good.
17 And although my inclination is to feel that --
18 especially I'm quite comfortable about being critical of
19 my fellow providers. And I agree that right now it is
20 not in our interest to have any information out there.
21 But I think we should be careful about what
22 kind of information we put out and how we do it so that
23 we get good information, because a lot of the information
24 that's out there right now is awful.
25 And I think that is, that is -- we all know

1 it's easy to present either reputational information or
2 biased information. And the challenge is to present
3 balanced information that will be useful to patients.
4 MR. HYMAN: Karen?
5 MS. IGNAGNI: I completely agree. And I, too,
6 would like to pass because I suspect people in the
7 audience have questions so I'll yield my time.
8 MR. HYMAN: Marty, Reggie? Actually we don't
9 do questions from the audience. We instead beat up on
10 one another. Or as Marty put it, "Let's you and him
11 fight."
12 Well, let me just start by throwing out a
13 question and see whether anybody wants to take a whack at
14 it and me. I mean, there's been an extensive discussion
15 about both information and incentives and let me just
16 reverse the order.
17 There seems to be broad-based consensus that
18 the incentives are deeply problematic, certainly at the
19 provider level and potentially at other steps as well --
20 and also consensus that there isn't enough information or
21 good information.
22 And the question that that raises is how does
23 the information interact with the incentives? And does
24 the analysis differ on the supply side versus the demand
25 side?

1 And how does Dr. Fisher's data on supply-
2 sensitive versus preference-sensitive care complicate the
3 ways in which you think about using information to drive
4 the incentives in a more systematic way to enhance
5 quality of care?
6 So is it just -- is it simply posted near the
7 elevator and let it work? Or do you need to figure out
8 what the measures are in advance and what measures and
9 who's going to audit them?
10 I mean, there are a whole series of operational
11 questions, but I think that's a nice way of looking at
12 both the 10,000 foot question and also down in the
13 trenches question.
14 So does anybody want to take a whack at that?
15 Or do I just get to ask it and then there's an
16 uncomfortable silence.
17 MR. GAYNOR: Yeah, I think this is a
18 complicated issue, but I think it's also one where you
19 have to be careful for the excellent not to be the enemy
20 of the good.
21
22 I'm not disagreeing with Elliot's prior
23 statement to be careful about what to put out there and
24 make it be as good as possible. At some point, however,
25 a leap has to be made and with the recognition that it's

1 not going to be perfect. There will be some adverse
2 consequences that flow, but you just have to get started
3 somewhere.
4 Obviously incentives can't exist without
5 information. If information is really, really good, then
6 in some sense the market will just take care of
7 everything and you won't need to worry about exactly how
8 it happens.
9 If information is less complete, then you may
10 need to have some other kinds of mechanisms in place and
11 worry about that and that sort of thing. But I'll leave
12 it that for the time being.
13 MS. IGNAGNI: I think a tangible example of
14 what you're inviting us to talk about is tiering.
15 There's been a transformation shift in reimbursement.
16 And it really -- it's surprising.
17 It hasn't been very well chronicled in the
18 academic literature. In terms of incenting, take
19 pharmaceuticals. Patients, giving them information, and
20 incenting them to make prudent purchases.
21 So to the extent that they use generics when
22 their physician indicates they are properly and
23 appropriately available, then they spend a minimal amount
24 of money to the extent that they use more high-priced
25 drugs because that's what they are comfortable with (or

1 their physicians). They spend a little more. That is a
2 very simple example, I think, of putting information into
3 individuals' hands, encouraging them to make appropriate
4 choices.
5 And I think on that framework what people will
6 see is that health plans building to move from
7 pharmaceuticals, where we've encouraged generics, we've
8 taken advantage of bulk purchasing techniques, and we've
9 done disease management very effectively.
10 I think we'll be transporting that into
11 hospital care, physician services, provided that the
12 information is available, which is why I think the
13 partnerships, absent what Reggie talked about, which is
14 the government moving in and requiring a template or a
15 FASB-like structure --
16 I think it's been very, very important for --
17 as health plans have worked with employers, there have
18 been some very helpful contributions and get a sense of
19 what employers are looking for, what data they and the
20 employees believe is important, and then you can
21 structure incentives.
22 So I think we'll see much more of that. These
23 are early generation products. And then you can see them
24 transitioning to much more complicated and effective
25 products.

1 MR. HYMAN: Carolyn.
2 DR. CLANCY: Well, there's an irony here. We
3 are funding a couple of studies on this phenomenon. And
4 the irony is that the studies are being conducted in
5 provinces of Canada. And the reason they are is because
6 the Canadian government, for reasons that aren't entirely
7 clear to me, has not gotten into the negotiation with
8 pharmaceutical companies' -- that goes on here.
9 So to some extent there's a challenge and
10 building on that example, Karen, although I like it,
11 because what you can't see are all the rebates that are
12 hidden in terms of how the pricing structure is
13 determined.
14
15 So all of this makes me reflect on an editorial
16 problem we have at the agency. You'll hear from Irene
17 Frasier about the fact that we're going to be issuing a
18 national report on the quality of healthcare, as
19 imperfect as our measures are now, in the fall. And
20 we're very excited about that.
21 But the editorial problem we have is always,
22 are we talking about quality information? Or information
23 on quality? And the editors keep sending this back. You
24 know, which is it that you want?
25 And I think the reality is that we want both.

1 Now, this makes it verbally awkward. But the essential
2 question I think for the FTC that you're going to need to
3 think about as you get into this issue is: To have real
4 transparency that's meaningful do you need consistency in
5 the type of information that's required?
6 And I would argue there's a boat load of
7 information out there and an awful lot of it is useless.
8 And the reason I know this is because when I do see
9 patients one night a week, you know, what I use is the
10 same Internet-searching engines that all of you use when
11 you are looking for information on various health
12 problems.
13 And I have probably precisely the same
14 experience. Sometimes I know exactly what I need and I
15 get exactly what I need. And other times, twenty minutes
16 later I say to the patient, "You know, it's actually
17 going to be a little more efficient for you to just come
18 back and I'll be able to speak with someone who has more
19 expertise in this in the meantime," which is not exactly
20 where we want to be, so --
21 MR. HYMAN: Reggie?
22 MS. HERZLINGER: I'm not sure this is
23 responsive to your question, David, but I'm trying.
24 MR. HYMAN: You're a professor. You're not
25 supposed to be responsive.

1 MS. HERZLINGER: Oh, no. I teach in a School
2 of Business, David. It's a very different kind of
3 environment, where my teaching is rated and published and
4 compared to all my peers, by the way. So that's an
5 incentive system like you won't believe.
6 So I'd like to go back to the finance industry,
7 where there is the SEC that requires generally accepted
8 accounting principles and financial statements, balance
9 sheets, income statements, cash-flow statements, notes.
10 There's the FASB that comes up with the rules. And
11 that's a very independent, political process of lots of
12 knowledgeable people.
13 And then there is an army of interpreters. And
14 an interpreter is MorningStar. An interpreter is
15 Bloomberg. An interpreter in the guy with no hair on
16 MSNBC or that gorgeous woman. Or, you know, there's just
17 tons of interpreters of these data and then the market
18 speaks.
19 So MorningStar is a clear winner.
20 MorningStar's presentation -- it competed in the market
21 and has those cute little stars. Very robust I judge
22 them.
23 I consider myself rightly or wrongly capable of
24 judging caliber of this information. I judge them
25 excellent. And they have a simplistic format. They have

1 a multi-star format for rating mutual funds by categories
2 of risk and categories of types of investment.
3 So there's a whole other market layer that
4 comes about if the information they use is reliable, if
5 they feel confident that these are good data. They then
6 mine that data and present it in multiple ways. And the
7 market process winnows out the winners from the losers.
8 MR. MILLENSON: I think that Elliot's
9 definition of the kind of treatments that we had where we
10 talked about things where there was a clear consensus of
11 what should be done -- that is, where there was a patient
12 preference -- supply driven -- is very good and also
13 tells us different areas where empowering patients will
14 and will not work.
15 On something like safety -- you know, pass,
16 high pass, fail, pretty good -- consumers understand
17 safety and having that information posted is enough of an
18 incentive. If it's right there in the elevator lobby,
19 you really don't need to worry about tiering the
20 hospital.
21 On the other hand, whether no patient is really
22 competent to judge whether or not I should have been sent
23 to the ICU or whether that was done because of a capacity
24 issue. Or did I need to come back and see my doctor in
25 10 days or 2 weeks or 3 weeks?

1 And that's where you have to have some sort of
2 external review organization and where I -- or recently
3 David Lansky, for the notion of accountability, talking
4 about this, and I agree.
5 There are some things where individual consumers can
6 make the marketplace work. And there are other areas
7 where it's so complicated and you need large numbers of
8 people to make it significant where you need another
9 reviewer, such as the health plan, such as the Medicare
10 QIO, such as an employer.
11 The second area where I think incentives may
12 take us on tiering is a number of years ago Dr. George
13 Diamond in Los Angeles came up with something that he
14 called "fee for benefit," which I always thought it was
15 where it eventually will go, but it's a long ways off.
16 And so, for instance, if you have coronary
17 artery disease and the evidence base says that drugs
18 should be able to fix what you have pretty well, you
19 know, no problems. It's minor. Pharmaceutical therapy
20 is best for you. It costs $5,000.
21 But your neighbor down the way had bypass
22 surgery with Dr. Cooley. Didn't cost that much more.
23 Boasts at cocktail parties, "I had bypass surgery with
24 Denton Cooley. Certainly worth it. Felt much better.
25 You'd like bypass surgery." That's fine. We'll pay 100

1 percent for the first $5,000 and after that you pay
2 something different.
3 For consumers to accept that, of course, would
4 take quite a revolution in what we have now, including
5 for physicians to accept the fact that evidence can be
6 more important than what their own personal judgment says
7 is right. And we're a long way from there.
8 MS. IGNAGNI: Can I make another observation?
9 Because in an effort to be somewhat provocative and
10 thinking about from the vantage point of the FTC and the
11 DOJ what might become relevant as a consequence of your
12 question, David.
13 It strikes me that it's worth remembering that
14 12, 13 years ago at the end of the eighties Bob Brook and
15 company at RAND talked about all the unnecessary
16 procedures. We had bypasses, hysterectomies -- everybody
17 is familiar with the data.
18 Health plans went out to do that job and to get
19 unnecessary procedures out of the equation and out of the
20 delivery system. And we could argue about whether or not
21 it went as seamlessly as we would have liked -- all of
22 us.
23 And we're now putting a great deal of emphasis
24 into the customer service and the relationships between
25 us and our business partners on the physician and

1 hospital side.
2 Leaving that aside, however, I would like to
3 just talk about the anatomy of what happens in a
4 professional community when entities -- nongovernmental
5 entities and governmental entities -- try to solve
6 problems.
7 And so I think we should remember that quite a
8 lot of the so-called patient protection was protection of
9 suppliers and markets and strategies to do exactly that.
10 We can't -- Reggie and I were talking the other
11 day on the phone. We are prevented from doing the kinds
12 of things that she talked about in Switzerland because we
13 have a whole range of state mandates that prohibit us
14 from doing that.
15 We are prevented from using now some baseline
16 techniques that we invented to deal with the
17 accountability question because we are prohibited by
18 regulation and law from doing that.
19 So one could anticipate that as we all move to
20 try and get more information to consumers, as we try to
21 re-orient the paradigm from one that pays for procedures
22 to one that pays for performance, that we could see a new
23 generation.
24 So I hope that the FTC will look at this very
25 carefully and so much -- and I'm again going back and

1 quoting Dr. Muris, his talk that he gave out in Chicago
2 in November, where I think he said quite accurately that
3 quite a lot of the -- or a great deal of the concern
4 that's been raised from suppliers and markets has been in
5 the name of quality and it has not found to be
6 substantiated.
7 And I hope that the Federal Trade Commission
8 and the DOJ would look very carefully at backlashes and
9 efforts to shut down the efforts to incent performance
10 because I think we'll see those. And I think that's
11 going to be very important.
12 DR. FISHER: Yeah, I think there's a
13 distinction that it's worth trying to be really clear
14 about. And it may be -- it may not be -- there's
15 certainly some areas of overlap.
16 But I think the decision about what information
17 do consumers need to make clear and wise choices about
18 specific treatment alternatives -- which is an issue of
19 what is the efficacy of this treatment, what are the
20 risks, what are the harms? -- should be at least
21 understood as a different challenge than the challenge of
22 choosing providers.
23 That is, who is a safe provider? Which one of
24 my physicians is like -- which one of the physicians in
25 this community is likely to do a good or bad job caring

1 for diabetes?
2 And the information required for the former is
3 good scientific information synthesized and presented in
4 a balanced way about the treatment alternatives. That
5 will help us a lot with the problem of inappropriate care
6 and overuse of -- if we can get good information to
7 consumers and ensure that the incentives are right there
8 so that physicians don't get around them.
9 That is, a surgeon who is talking to a patient
10 about the particular procedure doesn't have a strong
11 incentive right now to provide balanced information to
12 that patient.
13 When you move to evaluating providers in health
14 plans, you can, however, ask about what is safety, what
15 is quality, and how good are they in providing balanced
16 information?
17 There are a number of measures now of the
18 effectiveness of informed patient choice. Those sets of
19 measures should be measures that should be put in place
20 at health plans to say how good a job is this health plan
21 or this provider doing at providing balanced information
22 about this specific treatment alternative.
23 Say, screening for prostate cancer -- widely
24 promoted. But that should be an evidence-based choice
25 that the patients themselves are making. And there are

1 instruments that can be used in a survey that say, does
2 the patient understand what was at stake in the tradeoff?
3 If so, they are likely to have had informed patient
4 choice.
5 So keeping those two areas of information
6 separate will help us get the information better
7 presented to patients.
8 MS. HERZLINGER: I think it's important to note
9 that information transformed the automobile industry and
10 other industries. So when you measure things that are
11 important to consumers, the suppliers reconfigure
12 themselves to provide what it is that the consumers
13 wanted.
14 And the American automobile industry -- and
15 somebody at JCAHO told me to stop talking about
16 automobiles, just found it terribly distressing to be
17 compared with the automobile industry. And the point is,
18 if the automobile industry does it and it's arguably so
19 unimportant, why shouldn't the healthcare industry do it?
20 But at any rate, the automobile manufacturers
21 dramatically reconfigured their manufacturing process in
22 response to information that showed that they were losers
23 relative to the Japanese and the German manufacturers.
24 MR. HYMAN: Marty.
25 MR. GAYNOR: Just one comment. I think that

1 all this is important.
2 One thing to bear in mind. There's a principle
3 in incentives: you get what you pay for. And if some
4 things can be metered easily, you tend to pay for those
5 things you meter. And what you don't get as much of is
6 the stuff you can't meter because you don't pay for it.
7 It also applies for information. And I don't
8 want this to be taken as a negative at all against, you
9 know, against working hard towards providing better
10 information.
11 But we do have to have to be careful. And we
12 have to understand the ways that patients make choices
13 and what matters to them because we don't want to do
14 something like provide information about one part of care
15 that's important and neglect another part of care and
16 find out that we're actually worse off than we were
17 previously or worse off than we had intended.
18 And I don't -- again I don't want this to be
19 construed as argument against more information. Far from
20 it, but that we do need to take the possibility of
21 unintended consequences into account.
22 DR. CLANCY: I wanted to speak to a couple of
23 points. One is to amplify a point that Elliot has made I
24 think pretty eloquently and that is the issue of
25 preference-sensitive care.

1 The proportion of healthcare -- and I don't
2 know if it's 10 percent or higher -- where there's
3 clearly one right answer is clearly a minority of what's
4 provided in healthcare. Flu shots, being vaccinated
5 against pneumonia, things like that, aspirin if you've
6 had a heart attack, and so forth. Unambiguous should
7 happen -- a really small proportion of the action.
8 And frankly, if anything that proportion, I
9 think, is going to decrease because of our investments in
10 biomedical research, which will give us more and more
11 options.
12 As we think forward into the future I would
13 suggest that, particularly since this is a quasi-academic
14 set of hearings that you're having, that you and your
15 colleagues might be thinking about how do we get ready
16 for the point in time when more and more healthcare
17 systems do have good clinical information systems.
18 What's a public good here in terms of making the
19 information available? Or are we depending on
20 willingness to pay?
21 In theory if I am facing a choice between a
22 lumpectomy and a mastectomy, I'd love to get on line and
23 find out about the experience of women like me who had
24 those choices and what their outcomes were and so forth.
25 If you can find that now it is a -- it's, you know, 1

1 percent of the 16 percent who made that happen. And it's
2 somebody like Michael's friend, who made that happen.
3 In terms of your other question about
4 disincentives, one of the other challenges here is that
5 to some extent you're going to be dependent on providers
6 to give you the data that you need to set up your audit
7 trail and so forth.
8 And that's where I think incentives for
9 reporting become very, very important. If you punish
10 people now or sue them or sanction them because of making
11 errors, there's a really easy way to fix that problem.
12 And I think most of the medical profession is highly
13 familiar with it, and that is, don't report it.
14 So you can have a sign in the elevator, but it
15 will be based on extremely incomplete information. So I
16 think that that needs to be part of this equation as
17 well.
18 MR. HYMAN: Okay, I have another question. And
19 this relates to how we come up with the measures. I
20 mean, Dr. Clancy has observed that there is a legitimacy
21 problem with some of the measures, that the process
22 measures are easy to measure -- at least certainly
23 significantly easier than outcome measures -- but the
24 nexus between them and the outcomes is not always so
25 clear.

1 And if you sort of flip it over to the later
2 part of the discussion I think there was a considerable
3 amount of criticism of the utility of any and all of the
4 measures because they don't synchronize with what
5 consumers actually care about.
6 So although they might be the things that the
7 professionals care about, they are a matter of complete
8 indifference from the perspective of the consumers.
9 So a couple of, I think, related questions.
10 One is, do we solve that in a top-down or a
11 bottom-up fashion? If we try and solve it all, how do we
12 -- given that collecting the information is often
13 expensive -- balance the burdens that are imposed on the
14 providers and also the health plan if they are collecting
15 and disseminating the information?
16 How do we deal with the legitimacy problems
17 that are associated with it? Is it "let 1,000 flowers
18 bloom"? Or is it the command goes out from Washington?
19 And the sort of last, related point: Given that
20 the government is a major purchaser of healthcare
21 services, how does the government mind its own
22 expenditures, recognizing that everything it does has
23 spillover effects on the private market?
24 So I think a range of questions people can sort
25 of take a whack at if they like. Anyone?

1 MS. HERZLINGER: I can start. In the financial
2 area there are a myriad of questions. They always change
3 as the economy changes, as the investment bankers come up
4 with new clever schemes to avoid disclosure one way of
5 the other.
6 So the issues change. And there are private
7 sector task forces composed of professionals --
8 accountants. I don't think there is an equivalent
9 profession in healthcare. Perhaps epidemiologists might
10 be that profession. I don't know.
11 MR. HYMAN: Health services researchers,
12 although --
13 MS. HERZLINGER: Perhaps, but --
14 MR. HYMAN: Uwe Reinhardt pointed out no one
15 ever, you know, in a playground says, when I grow up I
16 want to be a health services researcher.
17 DR. CLANCY: We're changing that.
18 MS. HERZLINGER: I don't think they are exactly
19 analogous. The accountants are business people. And
20 they are also professionals. And they constantly have to
21 balance -- and they did it very poorly -- the demands of
22 their profession against the demands of their business as
23 opposed to researchers that have a different set of
24 incentives from them.
25 So I can't find the analogy. Perhaps it

1 exists. I just don't know what it is.
2 But I think the process works very well.
3 Important issues are brought to the forefront and they
4 are debated over and over from many different
5 perspectives so nobody owns the issue and the government
6 is not going to say aye or nay.
7 Perhaps and sometimes the Congress has stepped
8 in on accounting issues where the discussion has been so
9 disgusting that the Congress finally said, "Okay, we've
10 had it. We require you to do this."
11 But by and large, the discussion is very open,
12 broad-based. The relevant issues are brought up by
13 professionals and experts in the industry like the people
14 at this table, that represent various interest groups. I
15 think that's a great process. It ensures a democracy of
16 ideas.
17 MS. CLANCY: I guess the analogy I would use
18 would be the National Committee on Quality Assurance.
19 About 10 years ago there was an article written
20 that compared performance measurement to the Wright
21 brothers' airplane, that it was wondrous in two respects.
22 You know, one, that it got off the ground at all. And
23 the other was how primitive --
24 And to some extent it would be hard to argue
25 that we've advanced a whole lot more than that given the

1 state of data, how we collect it and so forth.
2 But nonetheless the process I think is quite
3 exemplary. What it does not have behind it is the power
4 of auditing and the power to make people play. And that,
5 I think, is a limitation in terms of thinking about how
6 Regina laid out what she would like to have a market
7 functioning.
8 So the people who do report are punished in
9 some way. And in some areas we simply don't know how
10 verifiable the information reported it.
11 Again, thinking forward to a time when it's
12 going to be cheaper to get that information, I do think
13 that there's a very nice model there of having the
14 purchasers, interested parties, experts, and so forth at
15 the table.
16 MS. HERZLINGER: I didn't mean to interrupt,
17 Carolyn, but just to get back to your point of who bears
18 the cost. One of the things about requiring data is
19 everybody bears the cost, so it's not differential. It
20 may raise overall costs only if you believe that the cost
21 of collecting information is less than the benefit that's
22 derived from it. I don't believe that.
23 DR. CLANCY: I think you're making a very
24 important point about the concept of uniformity which
25 underlies transparency. And until we start talking about

1 these goals of transparency and uniformity, there's
2 plenty of opportunity for payers and suppliers to compete
3 once we have some disclosure uniformity. But absent
4 that, I think what you're likely to see over the
5 foreseeable future are these pods of activities.
6 Everything is being done in silos.
7 And as meritorious as NCQA process is -- and
8 we're certainly very proud of our compliance and how many
9 people are covered by over 50 data points -- I think
10 increasingly what we're hearing from employers is whether
11 or not, you know, that might be too many. Let's try to
12 shrink the number. Let's get to the performance, move
13 away from the transactional and really give consumers the
14 kinds of things they want. I think that needs to be an
15 objective process. We're involved, as Reggie says.
16 However you do, whether you call it FASB or
17 some quasi-public, private thing or a private panel, you
18 have to have a number of, I think, folks from different
19 walks of life coming together to help inform this
20 process. And then we could have a great deal of
21 competition.
22 But absent that I think we won't have the kind
23 of transparency that I think everybody is talking about,
24 which is absolutely key to assuring competitive markets.
25 So plenty of opportunity to compete, but often

1 competition is used as a way to distract from this goal
2 of transparency and uniformity. And I would hope that
3 the Commission continues to push down this area. It's
4 very important.
5 MR. MILLENSON: One of the areas that I have
6 not seen transparency, what is actually uniformity pushed
7 and the auditing is, is some of the ratings of providers
8 that are now available on line or from commercial
9 services.
10 And I'm not talking about simply, you know,
11 fly-by-night Web sites. I think there's sometimes a
12 disconnect between what government sees and how fast the
13 marketplace is moving in terms of what purchasers and
14 others are buying.
15 So, for instance, there are several highly
16 reputable firms that sell hospital-specific, procedure-
17 specific ratings based -- that are supposed to be risk
18 adjusted. HealthGrades, Siegrist, HealthShare
19 Technology. All highly respected firms.
20 I have seen nothing in the academic literature
21 comparing them. Only HealthGrades was early on line for
22 free. And there was some comparison.
23 I have no idea whether or not they compare, but
24 millions of people are using them -- people like Blue
25 Shield of California subscribes. Well Point. Others.

1 Millions.

2 And yet because they're not based here and
3 they're not on the radar screen -- this is moving the
4 marketplace. At least you should look at it.

5 A second area is in rating physicians. Again,
6 I'm not talking about fly by night. I'm talking about
7 people like Health Pages, which has millions of customers
8 and is a directory of providers that is used by a number
9 of organizations to give you PPO and then rate your
10 doctor or the foundation for accountability.

11 It reminds one of what happened to the all star
12 team when it went from being picked by the managers to
13 being picked by the fans. And you could vote early and
14 often. You could vote based on service, reputation, or
15 how you felt without any sort of other objective kind of
16 thing.

17 And we have a real, real propensity here to
18 have a market distortion, or to turn off doctors finding
19 themselves being rating poorly by three people or the
20 like.

21 One of these services that we've looked at says
22 we won't put up any ratings unless there's three. So I
23 look up a doctor and it says two. Right. Three is a
24 very significant number. Moe, Curly, and -- the other
25 one.

1 So I think that if government is not to allow a
2 Gresham's law to sort of take place here, you need to be
3 much more proactive in looking at what's out there and
4 marketed by entrepreneurs.
5 MS. HERZLINGER: It's actually the other way
6 around. HealthShare Technology was started by one of my
7 students, Rick Siegrist, who's a wonderful, wonderful
8 guy.
9 But CMS just shut down access to the data. The
10 data are available only to non-profit researchers.
11 Now, what's the problem with that? Non-profit
12 researchers are wonderful. Well, one of the things,
13 Siegrist did -- has to be approved also. Disclosure has
14 to be approved by the government.
15 One of the things Siegrist did is he cut his
16 price by five-sixths. And people in the industry -- this
17 fledgling -- you know, fragile industry were tearing
18 their hair out. But he behaved as you would expect
19 market participants to behave. He cut the price, you
20 know, and he got a hell of a lot of business. And now
21 governmental action has made it impossible for what I
22 think are excellent examples of what I'm talking about to
23 proceed.
24 MR. MILLENSON: As you have in the States, you
25 can't get it because the hospital associations provide

1 it. The providers can buy the data from other firms for
2 themselves. The hospitals buy it all the time to compare
3 themselves to their competition. So the only people who
4 aren't in on the game are the patients.
5 DR. FISHER: I want to follow up on a couple of
6 points that have been made.
7 First, I think it's true there are a lot of
8 lousy measures out there and that we may not want people
9 responding to a lot of lousy measures.
10 And what we have is we have a model in the
11 securities industry and I think a fledgling model in
12 healthcare to move toward getting good measures and then
13 making sure those measures are widely available and are
14 audited and balanced and will provide the level playing
15 field across which providers can be judged.
16 NCQA and the people, you know, that Carolyn's
17 agency has put together can choose good measures on all
18 of the dimensions of care that we have identified, you
19 know, whether it's overuse of care of some services to
20 underuse of effective services.
21 But the measures need to be developed. And
22 then they need to be put in place in a way that's
23 auditable and reliable so that consumers can judge them
24 and have access to good information.
25 Right now consumers are subjected to a barrage

1 of information, most of which is biased toward the
2 assumption that more medical care means better medical
3 care. And I think we should be questioning that
4 assumption and try to get good information on the table
5 for consumers.
6 MR. HYMAN: I'm afraid our time has sort of run
7 out. And we're very sensitive not to overstay people's
8 patience.
9 I'll close with two observations.
10 The first is that the University of Maryland,
11 our course evaluations, are not public. So the students
12 felt compelled to start their own independent course
13 evaluations that they have access to. So markets are not
14 -- do find a way of working themselves out.
15 The second is we'll reconvene on the 29th at
16 9:15 where we'll spend the day focusing on hospitals and
17 quality and consumer information.
18 And could you join me in a round of applause
19 for our wonderful panel.
20 (Whereupon, at 5:04 p.m., the hearing was
21 adjourned.)
22 * * * * *
23
24
25

1 **C E R T I F I C A T I O N O F R E P O R T E R**

2

3 DOCKET/FILE NUMBER: P022106

4 CASE TITLE: HEALTH CARE AND COMPETITION LAW AND POLICY

5 DATE: MAY 27, 2003

6

7

8 I HEREBY CERTIFY that the transcript contained

9 herein is a full and accurate transcript of the tapes

10 transcribed by me on the above cause before the FEDERAL

11 TRADE COMMISSION to the best of my knowledge and belief.

12

13 DATED: JUNE 11, 2003

14

15 ______________________________

16 LISA SIRARD

17

18 **C E R T I F I C A T I O N O F P R O O F R E A D E R**

19

20 I HEREBY CERTIFY that I proofread the transcript for

21 accuracy in spelling, hyphenation, punctuation and

22 format.

23

24 ______________________________

25 SARA J. VANCE