Health Care 2000:
Do Health Care Markets Require a New Model?

Proceedings of a Conference Held
May 4–5, 2000 at Stanford University

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Agenda

Day One: The Evolution of the Health Care Market in the United States
Keynote Address
Alain C. Enthoven, Professor, Graduate School of Business, Stanford University

Reflecting on the Last Ten Years of the Health Care Market
Moderator: Alain C. Enthoven, Professor, Graduate School of Business, Stanford University

Panelists:
Michael E. Abel, Director and Senior Advisor, Brown & Toland Medical Group
William J. Cox, President and CEO, Alliance of Catholic Health Care
Bill Gradison, Former President, Health Insurance Association of America
Mary R. Grealy, President, Healthcare Leadership Council
Richard R. Pettingill, President and CEO, Kaiser Permanente, California Division

Day Two: The Effects of Market Forces Overseas
Six International Case Studies
Morning Moderator: Paul F. Basch, Professor Emeritus, Department of Health Research and Policy, School of Medicine, Stanford University

Afternoon Moderator: Alan Garber, Director, Center for Health Policy, Stanford University

Panelists:
ENGLAND
Alain C. Enthoven, Professor, Graduate School of Business, Stanford University
JAPAN
Koichi Kawabuchi, Chief Senior Researcher, Japan Medical Association Research Institute
THE NETHERLANDS
Hans Maarse, Dean, Faculty of Health Sciences, University of Maastricht
NEW ZEALAND
Roger Bowie, CEO, Southern Cross Healthcare
SCOTLAND
Harry Burns, Director of Public Health, Greater Glasgow Health Board
SINGAPORE
Choon-Yong Loo, CEO, Raffles Medical Group

Closing Remarks
Daniel I. Okimoto, Professor, Department of Political Science, Stanford University
Health Care 2000: Do Health Care Markets Require a New Model?

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Introduction

On May 4 and 5, 2000, health care leaders, professionals, and academics convened at the Bechtel Conference Center at Stanford University for the Health Care Conference 2000. Sponsored by the Comparative Health Care Policy Research Project at the Asia/Pacific Research Center (A/PARC), in cooperation with the Center for Health Policy (CHP), the conference was held for the purpose of discussing health care policies and issues facing nations today. With the pressures of rising costs, aging populations in industrialized countries, and rapid technological advancements, the need for an accessible, affordable, and effective health care system is urgent and greater than ever.

The first conference of its kind at A/PARC, the Health Care Conference 2000 established a forum for candid discussion about the past, present, and future of health care. Over sixty participants attended the conference. The panel consisted of speakers from governmental institutions, for-profit and nonprofit organizations, universities, and research institutes. The first day of the conference featured a discussion on the evolution of the health care market in the United States, while the second day focused on the effects of market forces overseas, specifically in England, Japan, the Netherlands, New Zealand, Scotland, and Singapore. The 1990s marked an era of major health care reform. For many nations with socialized health care systems, it was a decade to explore alternative systems and to move toward privatization. The implications of such changes were discussed in detail at the conference.

The Health Care Conference 2000 was a successful and informative meeting, which opened the doors for future discussions on issues concerning health care around the world. These proceedings present, in edited form, the remarks of all primary conference speakers. Please contact A/PARC if you have any questions about the conference, or about the Center’s work in general.
Day One: The Evolution of the Health Care Market in the United States

*Keynote Address*
Alain C. Enthoven, Professor, Graduate School of Business, Stanford University

*Afternoon Session—Reflecting on the Last Ten Years of the Health Care Market*
*Moderator:*
Alain C. Enthoven, Professor, Graduate School of Business, Stanford University

*Panelists:*
Michael E. Abel, Director and Senior Advisor, Brown & Toland Medical Group
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Keynote Address
Alain C. Enthoven, Professor, Graduate School of Business, Stanford University

It’s a real pleasure to be here, and an honor to be chosen for this role. I spent the latter third of the twentieth century very interested in health care. I observed that while socialism was failing everywhere it had been tried, the preponderant thinking in the United States about public policy and health care favored implementation of more government controls on prices, capacity, and modes of operation. This thinking eventually culminated in the Clinton administration’s 1993 proposal to nationalize the whole health care industry. Since that model wasn’t working anywhere else, I began thinking about how we could make market forces work in health services, and I formulated some ideas, back in the twentieth century.

Now, I have a new career in the twenty-first century, which is explaining why market forces didn’t work very well. I think the exercise did a lot of good—maybe more good than its critics would realize or admit—but I believe that some people thought they could buy pieces of the model without buying the whole thing. The British, for example, thought they could have a market model in an information-free zone. We usually associate markets with incentives to improve quality and cost. But you can’t expect markets to provide such incentives if nobody has information on cost or quality. The British did not have such information, and they failed to put into place many other institutions needed for a market model to produce good results. My general view is that the model could have worked much better and could be made to work better still, if all the pieces were put together. It’s trickier than most people think. Today I’ll talk about the American experience, and tomorrow I’ll discuss the British.

Our story goes back to the traditional model of health insurance after World War II: the fee-for-service payment to providers system typical through the 1950s and 1960s. As a provider under this system, the more you did, the more money you got. As a patient, you had indemnity insurance, which meant you took your bills to an insurance company, who reimbursed them. Based on this model, providers were not responsible for costs or outcomes of care. Insured consumers were completely unconscious of the costs of the things they were ordering or having done on their behalf (at least when they became costly enough to be covered by insurance). As the model evolved, it made consumers even more unconscious of
the cost. There was no contract between the provider of services and the payer for those services. The payer could not lay down contractual conditions about what the price would be, or how utilization would be managed. Care processes became fragmented—sometimes referred to as “silos of care.” There was the doctor’s office, the hospital outpatient, hospital inpatient, and the home, with little integration among care processes in each of them. Hospitals were also competing for doctors. Of this scenario, my friend Paul Elwood would say that hospitals don’t have patients. Hospitals have doctors and doctors have patients. Hospitals compete by offering doctors access to the latest and best equipment—hence “the medical arms race.”

Organized medicine insisted on a set of principles. The best articulation of these principles, that I have read, was stated by the French Medical Association back in the 1920s. (Notably, these principles were also in force in Korea, where I learned that the group practice of medicine had been outlawed.) The traditional medical model was that everybody would have complete free choice of doctor at all times. The entity that was going to pay for the services had no right to influence, shape, or direct your choice, and therefore had no bargaining power over the doctor. There was free choice of prescription, which meant that there was neither quality management nor utilization review. There were wide variations in the way physicians practiced medicine. There was no market force to bring about standardization of practices. The fee-for-service payment system meant that nobody else could control the doctor’s income. The physician could make more money by doing more procedures, and especially by doing procedures that paid more per unit of time. The issue of doctor/patient negotiations over fees still hangs over our system. Now, there’s a contest over managed care. The medical profession is fighting back, to try to restore this golden era from their point of view, not the patient’s point of view. I think that doctor/patient negotiation for fees is a particularly reprehensible notion because it is an unequal contest. When my injured child is lying on the operating table is not the time when I want to pull out my pocket financial calculator and start negotiating with the doctor about how many sutures he’s going to use or what I’m going to pay for the procedure. I would prefer to negotiate that with the doctor ahead of time, when I have some choices. Solo practice meant that there was an absence of the checks and balances that exist in a group practice mode.

This model of medical organization and finance turned out to be extremely inflationary, and it was reinforced by all kinds of other public and private purchaser policies that made it even more inflationary.

Employers got into the habit of paying the full premium of the health insurance scheme that their employees chose, if they had a choice. The Internal Revenue Code made employer contributions to health benefits tax-free to the employee without limit. It was a powerful incentive for employers to have comprehensive group insurance for their employees—an incentive that now costs the federal budget about $120 billion dollars a year in tax subsidy to employer-paid health insurance. Sometimes people would say it was the second largest federal health insurance program, yet no one knew it was a health insurance program when it was enacted.

Moreover, many small employers cannot act as effective purchasers. Medicare and Medicaid, the big public programs enacted in the mid-1960s for the elderly and the poor also adopted this fee-for-service, indemnity, inflationary model. With all due respect and apologies to Bill Gradison [former president of the Health Insurance Association of America], insurance carriers played all kinds of games to segment the market, select risks, and generally make it hard for the market to work.
The economic consequences of this model were that national health expenditures grew rapidly as a share of the gross domestic product (GDP) from around 5 percent in 1960 to 13.6 percent in 1993. For example, in Northern California our premiums doubled between 1987 and 1992. I was chairman of the benefits committee here at Stanford at the time. The family premium went from $2,500 to $5,000 per family per year. One of the consequences of this was that it priced health insurance out of the market, beyond the reach of many families of moderate means. As a result, the percentage of nonelderly uninsured increased from 15.2 percent in 1988 to 17.4 percent in 1995.

For our foreign guests, I think I ought to say something about the 44 million without health insurance. They don’t just die in the street without medical care. In fact, a speaker who came to my class on Monday said he counted 189 federal government programs that are enacted to compensate for the fact that many people are uninsured. There are programs such as the federal disproportionate share payments (for hospitals serving a disproportionate share of poor people), and the Children’s Health Insurance Program, as well as many different kinds of grants. It’s the American way to do it—messy and complicated. There are also county hospitals. Every county in California has a hospital and/or a health care system. It’s an imperfect system with a lot of problems, but it’s not quite as brutal as it might sound. If you visit our county hospitals, you’ll see that they are actually fairly reasonable in the standard of care that they provide.

At any rate, that was the traditional model and it wasn’t working. So, we converted to the idea of managed care. Managed care is a generic term, which might mean “anything but the traditional model,” or “any significant departure from the traditional model.” Managed care in general was based on the re-engineering of some of the traditional model principles. First, providers were selected for quality and cooperation with the insurer’s utilization and quality management processes. Insurers select providers, which means that the insured person does not have complete freedom of choice when it comes to the provider. They either have strong incentives to go to the participating providers, or forfeit their insurance if they did not, which gives the insurer increased bargaining power.

Utilization management involves the creation or adoption of professional practice guidelines from specialty societies. How do you treat this, that, or the other? How do you approach various cases to deal with wide variations? Prior authorization and concurrent review infuriated a lot of doctors because they had to get permission before doing a procedure. A couple of years ago I chaired a commission in California that was studying managed health care. The medical director of one of our local HMOs spoke about what is being done to improve the quality of care. He said that all surgeons are now required to answer a series of questions before an operation is approved. For example, last year, one of the questionnaires for hysterectomy asked whether the patients had had the procedure clearly explained, and they understood that by it they would be unable to have babies anymore. In two cases the box wasn’t checked. The medical director went back and investigated. It turned out that the patients had not understood the questionnaire. When the doctor explained the situation to them, they no longer wanted the operation.

When negotiated fees became legal around here, Blue Cross of California signed up a million people. Then they went to doctors and said that all these people would have strong financial incentives to go to doctors whose names were on the Blue Cross list. Blue Cross would then want to have a conversation about how to get your name on the list. It depends on quality management, or at least the measurement of outcomes and satisfaction. This was a significant departure. One of its main manifestations was a minimal adaptation from the
traditional system, called preferred-provider organization or insurance, or PPOs. Blue Cross of California started negotiating fees for doctors. Take, for example, hip replacements in 1994. That year, they paid $4,602 to the orthopedic surgeon. By 1998, they'd driven the payment down to $2,380, a 48 percent reduction. Spinal fusion surgery experienced a 44 percent reduction. The fee for setting a bone was reduced 32 percent. Rotator cuff surgery was reduced by 31 percent. Lumbar spinal surgery was reduced by 20 percent. Physicians took a hard hit on fees.

However, these reductions didn’t get at actually organizing care, which brought us to the idea of the health maintenance organization (HMO), which had already been around for many years. In its present incarnation, one of the main HMOs is the Kaiser Permanente Medical Care program, which was started by Henry J. Kaiser back in the 1930s and opened to the general public after World War II.

The HMO was not only an insurance scheme but also an attempt to organize or arrange health care services. They are responsible for providing care, not just paying for it. HMOs are at risk for the cost of care, so they prosper by keeping people healthy and out of the hospital. The HMO shares risk with the providers. There are many different models, but mainly they work on the health maintenance philosophy rather than the casualty insurance philosophy. If you think you might be sick, come in early and we’ll test you while we might be able to intervene and prevent a more serious condition. The full realization of this idea is in the comprehensive care system, as at Kaiser Permanente, where delivery, financial responsibility, providers, and populations are all linked and integrated. The comprehensive services are integrated and doctors and hospitals work in partnership.

All of these events brought us to the idea of managed competition. A framework was required, within which there would be competition and strong incentives to improve quality and service, while decreasing costs. This in turn became the idea of managed competition. For managed competition to work, there must be price competition or value-for-money competition. This means that you must have price elastic demand. It was a remarkable thing to start looking at all our institutions. How many institutions have been created to prevent price elastic demand? I became acquainted with this back in the 1970s when I was consulting for Kaiser Permanente. Kaiser not only provided better quality care, but also had lower costs. People would ask, if this is such a good idea, why hasn’t it taken over the world? I started cataloging reasons that it hadn’t. First, employers were paying for the whole premium, so they couldn’t market their superior cost-effectiveness. Second, most employers weren’t offering any choices. If choices weren’t offered to the customers, then the government’s open-ended tax breaks subsidized people who chose more costly health insurance. If you wanted to use price competition, you needed to reverse this scenario and begin to use phrases like “coordinated open enrollment.” According to this model, everybody had a range of choices laid out side-by-side, so they could make comparisons. Switching costs are therefore reduced to a reasonable amount—an important element of insurance that people seldom think about.

A few years ago I decided to shop for my auto insurance. I asked for quotes from several different providers of auto insurance and I laid them out. I could see the policies were different and I’d have to go to work figuring them out. Finally, I realized the difference in price from the low to the high was about $200 and it would take me a couple of days to figure this out precisely. Even at the low pay of Stanford professors, it just wasn’t worth my time to do all this work to save $200. If you want the market to work, you have to find some way to save people all that effort—like standardizing the coverage contract.
On the topic of subscriber responsibility for premium differences, the employer cannot pay for the whole plan. Most employers still pay substantially more if an employee chooses a more costly health care plan. One big problem in creating competition in any health care model is that the first, best way to prosper is to attract healthy individuals who don’t need medical care, and to repel the sick who do need it. A competition model has to include a design to avoid or compensate for adverse risk selection. The idea in practice in some places is an independent clearinghouse or exchange for enrollment, so you don’t have to go to the insurance company hat-in-hand and say, would you please insure me? For example, you go to the benefits office at Stanford, which is such an obvious place, you may wonder why I even mention it. In fact, one reason to bother mentioning it is because the federal government’s Medicare program for the aged and disabled doesn’t allow that option. The system incurs enormous costs because individual consumers have to deal individually with the different health plans. They don’t do what the federal employees’ health benefits program, or Stanford, or other rational purchasers do, which is to bring everything together in one market, with one clearinghouse. Standardize the coverage contract to eliminate risk selection and the tricky exclusions that don’t cover things that people with chronic diseases need.

Risk-adjusted premiums are determined based on the diagnostic history of the people enrolled in a plan, using a medical econometric model. Convert that into the expected costs, and then have payments transferred from the health plans with the healthy people to the ones with the sick people, to remove selection of risks from the competition. Managed competition also includes the idea of equitable rules, consumer protections and information, and purchasers trying to measure and reward quality.

What happened with this great idea? It was working pretty well, for example, for federal employees, the state of California, other public employees, and for Stanford employees. It was working pretty well in the 1970s and the early 1980s, until health care costs took off in the late 1980s, and premiums doubled in five years. Many employers panicked and wanted to move quickly to managed care. They thought, we’ve got to get out of the old system into the new one and bypass this important notion of offering employees responsible choices. The managed competition model would say give employees, say, $150 per person per month, or whatever the fixed dollar amount happens to be, and provide a fairly wide range of choices. If employees want the more expensive plan, let them pay the difference themselves. Again, it seems obvious, but in fact a recent survey indicated that less than 20 percent of American employed insured people have a defined contribution and a responsible choice of plans. Employers imposed managed care on employees, offering little or no choice. And they continued to pay for the whole premium, so employees were unaware of any cost savings being created by managed care, and therefore had no reason to accept a less expensive scheme.

If you’d done it right as an employer, and said, “We will pay this defined contribution,” then employees could respond, “I’ll pick the most efficient HMO for my $150,” or “I’ll pick the most expensive fee-for-service for $300. I’m willing to accept this, and the other limitations in order to save money.” If this were the scenario, people would be in a different frame of mind, and would have a reason to accept and voluntarily enroll in a plan with restrictions on where and how they received care.

The HMO had started out as the consumer’s choice, which had in turn originated in an environment in which employees were going to their employer and asking to be placed in an HMO so they would get better coverage. In fact, back in the 1970s, Kaiser Permanente in Southern California shut down their marketing department because groups were coming to them all the time, wanting to join. They were growing about 10 percent per year—about as
fast as they could recruit and train the doctors they wanted, and build the hospitals. In those
days, this was the consumer’s choice, and it existed because of popular demand. Tragically,
though, the HMO became the tool of the employer, who took away something that people
valued. Employers, not employees, became the customers. Moreover, managed care was
originally a doctor-created vehicle. Kaiser Permanente was a large partnership of doctors.
Competing with them were other doctor-created vehicles, which marketed their services in a
competitive environment. Again, somehow the system got out of their control. Employers
used it as a tool to impose restrictions on doctors, and that resulted in the backlash we read
about and see in the movies.

Eventually, the issue became employer choice versus consumer choice. The employer
wanted to deal with an HMO to take care of its employees and ideally wanted to pick just
one, so they could minimize administrative costs. Consequently, they would tell the HMO,
for us to contract with you we want you to sign up every doctor in the state, so our
employees can go to the doctor they’ve always gone to. The HMO can’t drive a hard bargain
if it has to sign up every doctor and every hospital. The effectiveness of these organizations
was greatly diminished by that lack of bargaining power.

Employees were disempowered over an important aspect of their lives. They were
frequently forced to change doctors and price inelastic demand resulted. If an employment
group is entirely with one HMO—let’s say HealthNet—and then they want to consider
switching to another one—let’s say PacificCare—it’s a costly process. It involves a lot of
work to make sure everybody can still get to the doctor of his or her choice. Employers are
therefore afraid or reluctant to move for small price differences, whereas individual employ-
ees might have been perfectly happy doing so.

Managed care started as a doctor-created vehicle to market services to cost-conscious
consumers, but it became imposed on doctors. Doctors became very angry over their loss of
autonomy and income. (Actually, it turned out that doctors’ incomes continued to grow.) It
was a great contest between managed care and doctors for the mind and hearts of the
American people. There was a lot of research that showed a great deal of inappropriate
surgery; surgery that people would have been better off without. For example, a famous
study on carotid endarterectomies showed one-third inappropriate, one-third equivocal, and
only one-third clearly necessary. Much of this research was pioneered at the Rand Corpora-
tion. A Rand study showed one-quarter of hospitalizations as inappropriate, and hospitals
as dangerous places. Patients would have been better off not being in the hospital. The study
showed another 17 percent of hospitalization to be avoidable through outpatient surgery.
Nevertheless, patients had doctors, and the doctors said they needed a given operation, in the
hospital. The patients felt that there must be something terribly wrong if some insurance
company bureaucrat—even one who was an M.D.—declared the operation to be inappropriate.

In a proper consumer choice model, or a well-designed market model, doctor participa-
tion in managed care would be entirely voluntary. But the changes to the system all
happened very quickly. In 1988, 71 percent of employed insured people were in the
traditional fee-for-service indemnity model. By 1997, it was down to 18 percent. The
American health care system might have problems, but the inability to change is not one of
them. This is amazing change, both in terms of its speed and its extent. I suppose you could
say that underneath all that apparent change, there remains significant resistance to it.
HMOs doubled in a ten-year period. Preferred-provider insurance roughly tripled. So now
HMOs and preferred-provider insurance now cover about 80 million people each. POS
refers to point-of-service plans—a classic HMO with a preferred-provider insurance scheme
tacked onto the back end. If you belong to one, as I happen to, you get all your covered services for free or for a $10 co-payment, provided you go to the doctors in your medical group. If you want to go elsewhere you’re free to do so, but you have to pay a substantial deductible and a substantial fraction of the bill (perhaps 20 percent), as you would with a more traditional insurance plan.

All of these changes—though imperfectly realized in my view—had important effects. One was that premiums in California, which had doubled in the previous five years up to 1992, were flat between 1992 and 1998. There was a remarkable period during which premiums just didn’t change. Some of them even came down. One year, the Kaiser Permanente premium for our group dropped 13 percent. The percentage of GDP spent on national health expenditures stabilized from 1993 and thereafter. It even declined. That was a big change. Critics might express disappointment with some aspects of this development, but it certainly did have an effect on greatly reducing cost growth.

HMO membership was growing at about 12 percent per year, and reached 80 million members in 1998. Hospital systems were cutting overhead and capacity. In California the surplus of specialists was exposed, and many left the state. I remember when this information appeared in the newspapers. Reporters would ask, what can we do about this situation? I would say that the dispersal of specialists around the country was a positive development—people in Idaho, Wyoming, Nevada, and elsewhere are now receiving the specialist care they had often lacked in the past. Now, rather than having a concentration of specialist skills in one area—which is arguably bad for patients’ health as well as their pocketbooks—market forces have driven these physicians to the places they are needed.

HMOs have had a tough time recently, caught between consumer expectations and employer demands. Employers want and demand stability of premiums. Consumers want the freedom of the good old days. In the last couple of years, HMO profits have fallen to near zero, or even worse. At one stage, Kaiser Permanente was losing about $250 million a year. Many medical groups and independent practice associations of doctors in California are losing money. More than half the hospitals in California are losing money. Former fee-for-service providers are struggling to learn to manage care. These problems arose through changes in the financing system. The changes in the actual care processes and the culture down on the ground have been even slower. Not surprisingly, one of the lessons I observed in Britain, is that for a market model to work, you need providers who are capable of responding to market forces. I think ours did quite a bit, but they’re being pushed to the limit now, and a little more. We’ve had a lot of changes in health care delivery under managed care. We’ve certainly improved customer service. For HMO patients, same-day appointments have become the standard. You may not be able to see your own doctor today, but we’ll guarantee that you get to see a doctor today. We’re also seeing more outcomes studies and evidence-based practice guidelines. Evidence-based medicine has become a big buzzword both in Britain and the United States. It was interesting when I first started hearing this. I thought, “You mean medical practice was not based on evidence before?” But it opens up a complex set of issues. Studies comparing outcomes in HMOs and in fee-for-service so far have found that they are similar. You can’t make the case that one is better or worse. It is clear that HMOs do more screening and early detection of chronic disease, and they’re way in front on things like cancer screening. We’ve seen shorter hospital stays and fewer hospital admissions. The percentage of operations performed in outpatient surgery increased dramatically. There has also been continuous quality improvement adopted in many capitated groups, although I think that has been fairly slow in coming.
Medical entities need help from industries that are way ahead of them in quality improvement. Auto companies, for instance, have taken many steps to reduce the injuries on the job. We need to send people into hospitals and teach them how to do that the same.

Process improvement is also well under way. Not long ago, the length of stay in the hospital for a total hip replacement was eighteen or nineteen days. A couple of years ago, Sara Singer [of the Center for Health Policy at Stanford University] and I visited a hospital in San Diego, where they had the length of stay down to three-and-a-half days. We asked them how they did it. They told us that the old process was as follows: doctor and patient agreed that the patient should have the operation; the patient came into the hospital and had the operation. When the patient felt well enough, he or she began rehabilitation. When that was completed, a nurse checked out the home site—made sure there were no slippery rugs, or big dogs to knock the patients down—and then the patient went home. Now, all that has been turned around. The process begins with going to the home site and getting that straightened out. Then the patient comes in for “prehabilitation” instead of rehabilitation and learns what they must and must not do. They learn how to walk with a walker so they’re all set for the operation. Then they have the operation. The doctor comes in the same day or the next day and says, “you’re not sick; you had a hip that was sick. We took it out and put in a new one, so get up and walk.” The patient’s expectations are different.

There has also been quite a bit of provider profiling and selection. Care coordinated by primary care physicians is something we learned from the British, and many good things have happened as a result.

I mentioned earlier that I chaired a commission in California, and that the politicians were very upset about all the complaints about managed care. I think a big reason for the complaints was the problem of involuntary conversions to HMOs. The commission hired a survey research group to investigate the issue, and surveyed about 1,300 Californians. Questions asked included, have you had any problems with your health insurance in the past year? The sample was divided into two groups. First were the so-called network HMOs, which are largely former fee-for-service providers who’ve been roped into contracts they don’t like, and whose patients wish they were in fee-for-service, yet neither the patients nor the employers are willing to pay for it. Second was Kaiser Permanente, a classic HMO in which everybody is there by choice or preferred-provider insurance, which is the last remaining vestige of fee-for-service. There was no traditional fee-for-service indemnity because there weren’t enough people in California to fill that cell in the sample.

The survey found that 47 percent of the people in the network HMOs had had a problem in the past year with their health insurance. It also turned out that most of those people also said they were satisfied, so their problems couldn’t have been too bad. Fourteen percent of them said they had problems getting a referral. Sixteen percent said they had trouble with covered benefits. Some had difficulties with bills, insensitive people, and changing doctors. Kaiser Permanente, on the other hand, had far fewer people with problems. Everybody was there by choice. There were no problems getting a referral because there are no artificial restrictions within the group. There were no problems with covered benefits because they have early comprehensive coverage. They did have one problem: insensitive people. They were having labor difficulties about that time, so I suspect that disgruntled employees may have contributed to that complaint.

Our survey asked people if they were satisfied with their health plan. Seventy-five percent of people in the network said they were satisfied. Eighty-three percent in Kaiser Permanente said they were satisfied. Seventy-four percent in the preferred-provider insur-
ance column said they were satisfied. Interestingly, the doctors on our commission kept speaking of the golden era before the arrival of managed care, when everybody was happy. If preferred-provider insurance is really traditional fee-for-service with an upgrade—that is, with a list of doctors who will accept the insurers’ fee as payment in full—then HMOs couldn’t be all bad. They rated higher than fee-for-service.

Then people said, “Well, it’s because everybody’s healthy that everybody’s satisfied. If you just talk to the sick people, you’d find that they would hate this HMO/managed care business.” The commission took another sample, which included a large number of people with costly chronic conditions. We found that they were even more satisfied. Ninety percent of the Kaiser patients in this category said they were satisfied and would recommend the plan to their friends.

We asked another question, which I think reveals a great deal about the political process. Our question was: If you had a problem, what did you do to resolve it? Thirty-seven percent said they contacted their doctor. Another 37 percent said they contacted their health plan. Three percent that said they contacted an elected official. If you multiply that 3 percent by all the people in managed care, you have 202,000 Californians contacting an elected official. I think that tells you a lot about why HMOs got politicians energized. What’s ironic, though, is that many other surveys indicated even higher percentages of people satisfied with their HMOs. The Los Angeles Times published an article generally condemning and attacking HMOs. Yet amazingly, their survey indicated that 90 percent of the people said they were satisfied with their HMO.

Where, then, is managed care? For one thing, it is all bogged down public policy. We have in Congress a legislation called the Patient’s Bill of Rights. I don’t think it’s going to do much good, because it doesn’t get at the basic problem—the lack of responsible choice. Some of the ideas are pretty good, but others are grounded in the stories that get going about HMOs. We would hear that a dreadful thing had happened, yet when we tried to track it down it wouldn’t be there. One doctor wrote to me urging that “nuclear capitation” be outlawed. I asked, what’s nuclear capitation? Well, it’s when an individual primary doctor takes the risk for all of the costs of his patients. I called him up and said yes, this sounds bad—it’s too much risk for an individual doctor to bear. I asked for an example of when this happens, because I wanted to investigate it. There was a long silence and no example. It was just a rumor he had heard. But one thing that probably did happen goes like this. An older man falls down. He has a big pain in his chest. The family is very scared. They call 911. The man is taken to the hospital. He is wired up and spends the night in the hospital with blood pressure monitors and all the rest of it. In the morning, the doctor comes in and says, we’re happy to tell you that you didn’t have a heart attack. Then the insurance company comes along and says we, too, are happy that you didn’t have a heart attack because that means it wasn’t an emergency, and we’re not going to pay.

In any market system, you have to have contracts, and to have contracts you need established definitions of the terms in the contract. In this case, there were contracts that said the insurance would pay for emergency care, but because there was no established definition of an emergency, a disagreement arose. HMOs should have negotiated these definitions with employers, but they didn’t. Legislatures actually had to step in and provide the definition of an emergency for coverage purposes. You don’t have to have insurance that includes that coverage if you don’t want it, but an emergency ought to be what’s called “the reasonable person’s standard.”
Another contentious issue concerned provisions about continuity of care. Someone belongs to one HMO and is forced by their employer to switch to another one. But she would like to finish her pregnancy with the same doctor, for example, or another particular episode of care with the original doctor, if the new HMO doesn’t offer the same doctor. Legislation is being prepared to facilitate this continuity. Protecting doctor/patient communications was yet another problem. There was a Time magazine picture of a doctor with a mask over his mouth—a “gag”—who wasn’t allowed to talk honestly with his patients. There was a big flurry. Then the General Accounting Office, the investigative arm of the Congress, was put to work to look into this situation. They reviewed five hundred managed care contracts, but could not find a gag clause preventing doctors from talking to patients about their needs for care.

Another element of the Patient’s Bill of Rights concerns processes for grievances and appeals. I think this is a good thing, yet there are some bad ideas that go along with it. One of them is what I call the obstetrician/gynecologist (OB/GYN) bypass. You go to your primary care physician, who refers you to a specialist, so you don’t waste a lot of money shopping around among different specialists at the insurer’s expense. If you want to do that with your money, that’s fine, and you ought to be able to do so. Obstetrician/gynecologists noted that women were frustrated with this system—they wanted to go directly to their OB/GYN. Pediatricians soon demanded the same treatment. You can picture a great big pork barrel being created here, as every specialty comes into Washington with bags of money, makes campaign contributions, and gets itself included in the Patient’s Bill of Rights. There are laws that legislate the length of stay. There was a big flap back in the mid-1990s, for instance, over some women delivering babies with no problems who were asked to go home in twenty-four hours. That became a women’s issue. Legislation now requires coverage for forty-eight hours, which adds a lot of cost without adding much value. Women could stay longer, but how much would the insurance pay? This happened to an English cousin of mine in London. She had a baby in a National Health Service hospital and went home in six hours. To be sure, this might be a commentary on the hospital but in any case many other British women choose to deliver at home.

The final issue I’d like to cover is expanding tort liability. I think it will be a tragedy if Congress falls for this. There are proposals for tort liability to reach through to employers, which might cause employers to drop health insurance altogether, to avoid punitive damages without limits. One of the big ironies is that a few years back, the HealthNet HMO was sued. There was a $100 million judgment against them, because they refused to pay for a bone marrow transplant and high dose chemotherapy for a metastasized breast cancer case. The studies are just being published now. HealthNet said they wouldn’t pay because the procedure was experimental. In fact, it wasn’t even experimental. It hadn’t been tested in a controlled trial. Now, studies are coming out that show this procedure to confer no value at all.

Our commission was discussing what to about tort liability. Some of the moderates suggested expanding the liability, but also putting reasonable limits on how much can be paid in damages. The trial attorney on the commission and his allies in the legislature said that they would rather have no recommendation at all, than have one with limits. Trial lawyers, in fact, are driving this train of thought.

The argument is based on wanting “to make HMOs pay.” The problem is that you can’t make HMOs pay. They’ll buy insurance, and fold it into their premiums, which we will pay for in higher health insurance. I don’t see the present legislative approach doing much good with respect to solving the problems of managed care.
In the end, I believe that we need to create institutions that allow everyone a wide range of choice, but also assign them the responsibility for their choice. What are necessary conditions to solve this problem? First, we need people to take on more financial responsibility. Employers or the government need to help people with their health insurance by making defined contributions. If you want a more expensive program, you pay the rest. Second, we need cost-conscious consumers at the point-of-service (POS). One of our witnesses in our task force is a doctor who said that he didn’t like the HMO business because it creates an adversarial relationship between physicians and patients. He remarked that he had a pregnant woman come in who wanted an ultrasound. He told her that he saw no medical indication for an ultrasound at that time and refused to order it. She went away angry. My first reaction was to say, “Thank you, doctor.” We need doctors not to order unnecessary tests. My second reaction was that if she had to pay half of the cost of an ultrasound she, too, would say, “Thank you, doctor.” People need a wide range of choices, whether they are in traditional fee-for-service plans or organized HMOs. Let consumers choose for themselves the amount and type of cost-containment they desire. In American political culture, that’s the way we’ll have to go. Thank you.
Reflecting on the Last Ten Years of the Health Care Market

Michael E. Abel, Director and Senior Advisor, Brown & Toland Medical Group

It was interesting to put this talk together. I took three binders and flipped through them, because to cover ten years in twenty minutes is impossible. I hope to create a story to highlight what went right and what went wrong in health care. I’ll be speaking from the perspective of a physician, who has been involved in managed care since the early 1990s, and who truly believes that managing the care of patients is the most logical, sensible thing that physicians can do. Therefore, I’m an advocate of managed care. Perhaps not exactly the way we’ve been practicing it, but I certainly support the principles. During the last ten years, there have been too many hospital beds, and too many physicians. The uncertainty of physician and institutional income has really influenced the market. The formations of employer coalitions, which look primarily at cost-containment, have, I think, been disguised under the umbrella of quality expectations. Lately, though, there has been some movement toward real quality—a hard look at the performance reporting of both health plans and providers is under way. Health plans, first and foremost, are interested in profit margin. They’re merging to maintain their profit and their market share. But what went wrong with each of these health care components?

The mistake we all made—health plans, employer coalitions, employers, and providers—is that we have failed to communicate to our customers, consumers, and patients what we are going to do and why it makes sense. Why is managed care good for public health in this country? Why is it better for the individual patient to prevent an illness rather than treat an illness when it happens acutely? We blew it by not appropriately communicating with the various constituencies.

I don’t believe that fee-for-service will disappear. There will be a high end, Harley Street-type practice in every large city in the United States. Nor will managed care go away. We may use different letters of the alphabet to describe it, but this is an avalanche that is unstoppable. Whether we call it PPO, POS, or HMO, managed care will stay with us. I think it’s good, because with the right components, physician organizations, such as the rise of independent practice associations (IPAs)—can indeed improve the quality of care in this country. As HMO enrollment increased, IPAs took a greater share of the market in providing care. The vast majority of them concentrated in large cities, yet beyond this, there has been little growth in the network and group side of the delivery system.

Why do physicians merge? Why do physicians want to consolidate (1) their practices, and (2) their different specialty practices into an IPA or a group? I think it is for income stabilization. Physicians want to protect their income, and their economic position in the world. Whether IPAs and medical groups will survive depends on their ability to contract-negotiate as a unit—a collective bargaining unit that deals with insurance companies, hospitals, and other vendors. I think this is the most significant incentive for physician groups to merge.

Fear is another reason. Physicians were scared about their future, changes in their practice, and limitations on their decision-making responsibilities. Insecurity also pushed them into larger organizations. Here, as a case study, is our story. In 1992, four independent practice associations—692 physicians—merged to form the California–Pacific Medical Group. A few years later, we tried to do something similar in a regional basis in San Mateo, Alameda, and Marin Counties. We created the organization, but essentially, it failed. In
1996, then, we merged the community-based physician organization with the University of California’s faculty practice to create Brown & Toland. We began our attempt to gain control of the revenue flow, and to function as a mini-HMO of our own.

The following year, we attempted to acquire control of the infrastructure by buying out the hospital’s interest in the managed care company that was responsible for all the operations. In 1998, we integrated and expanded down to the Peninsula following the merger between the University of California, San Francisco (UCSF) and Stanford. Within one calendar year we engaged and then disengaged from the relationship. We officially started on January 1, 1999 and ended December 31, 1999. It didn’t work, and that’s a separate discussion in and of itself. It’s interesting to note, though, that everything that we did locally in San Francisco pretty much worked. When we tried to take it beyond our borders to the East Bay, North Bay, or South Bay, it didn’t work. There is a loud and clear message here that, as far as health care delivery goes, physicians probably ought to stay on their own turf, because they have a much higher chance of succeeding than if they try to become regional, or larger.

Over the last ten years, we have talked a lot about physician–hospital organizations and integration. It didn’t work. There was insufficient money in the system and we constantly fought over the revenue split. The question of who got how much became paramount. We’re not able to look at the medical management component—the profiling, the benchmarking, and so forth—which we could and should have worked on. Before we revisit this once-failed integration, therefore, I think the whole system needs to disintegrate. I also believe that marginal physician organizations and physicians should close shop. Institutions that fail to deliver quality care at a reasonable, competitive cost should close. There must be some sensible organization or regionalization of these high-end centers. For this reason, I was excited about the UCSF–Stanford merger, because I thought it would set the stage for an institution to treat a tremendous volume of unusual, rare, or exceptionally expensive cases with much greater efficiency. It is so unfortunate to see it disintegrate.

For Brown & Toland, access for our patients was important. Obviously we have to stabilize revenue and increase market share. We have done well, despite some of our financial struggles in 1998. We have about 360 primary care physicians, and nearly 1,300 specialists. Many people say that there is no way we can run an efficient organization with this many doctors and specialists, I disagree and I’ll show you why. Ninety-three percent of the patients are seen by half of the specialists. Two-thirds of the patients are seen by one quarter of the specialists. How does this happen? To answer this question, we started to benchmark performance, profile the physicians, and to spread this information throughout the organization. These were the right physicians, and they are doing pretty well economically. They have not seen increases in their income, but neither have they seen dramatic decreases, despite the peak of managed care, when well over 50 percent of the population in the City and County of San Francisco was enrolled in some sort of managed care program. This success is what I wish we could promote. Likewise, it would be wonderful to be able to pay these physicians more money as a reward or an incentive.

Employer coalitions also began to look at health plans critically. They started scrutinizing provider groups, and asking for individual physical performance reports in an effort to make individual physicians accountable for their results. This is a positive result of managed care. Managed care companies feel that further cost containment is possible. I agree because I believe that we have designed an inefficient system that doesn’t make sense economically. With respect to administrative costs, they exist at each and every level. If you look at the
HMO and a physician organization—including our own—approximately one quarter to one third of the health care dollar goes to administrative paper shuffle. This is stupid. There’s no other way to put it. Basically, the HMO squeezed the dollars on the physician side and on the hospital side because it was the easiest thing to do. However, I believe they could have maintained a compensation close to existing levels if they had taken this redundancy, this 30-odd percent administrative cost, and reduced it by one-third or one-half. There’s absolutely no doubt in my mind that it is possible. We’re doing it within our own organization already, and I think it can be accomplished on a much greater scale. Quite frankly, if we are successful in reducing administrative costs and by being more efficient in managing care, I think there is ample money to provide care for the forty million uninsured people in this country.

Physician compensation is the Achilles heel of this whole system. The last ten years have been an experiment for us in looking for the right way to pay doctors. We found that the combination of a capitation and fee-for-service hybrid model was not bad. For primary care, we pay in capitation and have fee-for-service carve-outs to “incentivize” the physician for what we consider to be the right behavior. However, the specialist side has been tough. We haven’t yet figured out the best solution. Some level of capitation makes sense in a physician compensation scheme. There’s no doubt that costs are lower in a capitated system and quality is equal, if not better, than in a fee-for-service system. I happen to believe that the quality is better.

As for quality, we have a poor track record if you look at the health care delivery system performance. Why aren’t we, the clinicians, more responsible and accountable for quality care and outcome? I haven’t been able to figure out and answer to this frustrating question, except to say that I think physicians believe they are very good at what they do. I think physicians are extremely concerned by facts and data that may reflect poorly on them and disapprove of profiling and benchmarking.

Before concluding, I would like to talk a bit about encouraging providers to report their performance. To ensure quality care, we need to have all the players participate in order to determine and identify the guidelines for quality care. We have to streamline administrative functions and come up with a way to best use information technology (IT). There is no question that IT will be the most important strategic asset of this century. What are the critical needs in a delivery system? Automation, for one. Automation reduces cost. It’s crucially important. For another, the sharing of information, which must include those who actually purchase or pay for health insurance. I think it is important for the individual patient and customer to contribute, because the system will be more effective in creating an intelligent consumer if they have to put in some real money. I think this will be an incentive to improve the system. It has to be flexible, scalable, and low-cost.

I believe that the Internet will change the entire delivery system. In the future, I’d love to see an accountable system practicing evidence-based medicine. Will it happen? Maybe. Why am I pessimistic? I don’t think that either physicians or patients want evidence-based medicine. I think we have a steep hill to climb to sell the idea that we’re going to practice medicine and deliver care based on evidence. There are some major political, social, and moral issues that we will have to confront. I’d love to see objective standards established and an efficient system put in place. Forget about hospital admissions and utilizations per thousand—just reduce variation. If we reduce variation and look at the best practices, we will discover a great deal of efficiency. We also need to be effective in the use of technology and the distribution of data. The delivery system has to be financially stable. If the insurance
industry continues to squeeze the providers, the most desirable providers are going to say the hell with it, we quit. This would be a disaster, because I think there is enough money in the system for these providers to get paid better for their services. It would also be unfortunate to take out the best and most skilled individuals and restrict patient access to them. Financial stability will be important. Delivering comprehensive services as an organization will also be vital in the future. The consumer must be satisfied with both access and service. Thank you very much.

William J. Cox, President and CEO, Alliance of Catholic Health Care:

It’s a real pleasure to be here. I have found it an instructive exercise to think about what has occurred in health care over the past decade. Where were we in 1990? Where are we today? What kinds of challenges do we face, particularly in my area of expertise, health care and public policy? Since 1990, the distance we have come down both of these roads has been extraordinary. In 1990, health care costs were rising rapidly and having an adverse effect on a wide range of activities. They were affecting corporate profits as well as personal income. As personal incomes rose, an ever-larger portion of one’s income had to be applied to rising health insurance premiums. The number of uninsured continued to grow as small employers found it impossible to provide health insurance coverage. Federal and state deficits were also increasing. Health care began to consume an even larger portion of our gross national product. Furthermore, while we were spending 30 to 40 percent more per person on health care in this country, many of us felt that we were receiving little additional benefit from all that additional spending. In fact, health care costs were growing at such a rapid rate back in the early 1990s that there was a joke going around Washington, DC. If this trend continued, so the joke went, and you wanted to go out for a movie and dinner with your wife, you’d have to check into a hospital. This gives you some sense of how people then viewed the health care system. Risk selection in private health insurance markets was making it difficult for people with pre-existing conditions to get health care, and the system seemed out of control.

It was so out of control that Bill Clinton was able to run for president, and be elected, on a commitment to fundamental national health care reform. When he was elected, it seemed to many of us both right and left that there was a powerful political commitment on the part of the American people to reform the system, and that Clinton would probably be successful. He indicated that he would propose a system to control costs effectively, to reform private health insurance markets, and to provide universal coverage. In 1994, two years after he was elected, he did propose a system for fundamental change. His wife, Hillary, put the proposal together with a team, and I recall very well when she went to Capitol Hill to present before various Senate and House committees. It was considered a tour de force in Washington, yet I recall only one member of the House of Representatives taking her seriously, and even he seemed surly in doing so. He was Dick Armey, then a little-known member of Congress from West Texas. About eighteen months later, the Clinton proposal was dead, politically finished. Subsequently, absolutely nothing was done in Washington to control costs, to address the problems in private health insurance markets, or to expand the number of people who would be able to get health insurance coverage. Not only was the proposal dead in Congress but the Clinton initiative also seriously damaged the Democratic
Party. So much so that after fifty years of controlling the House of Representatives, the Republicans found themselves in control of Congress as well, running largely that Clinton went too far, too quickly.

Other things happened at about the same time. The state of Washington had fundamentally changed its health care system, and set up a commission to anticipate the changes that would occur as a result of the Clinton initiative. In the year that the Republicans took control of the Congress, they also took control of the Washington state legislature and repealed every one of the changes put in place in anticipation of national health care reform. It was an extraordinary time. It was particularly extraordinary if we look back from this moment to find the president of the United States at a press conference in 1995 or 1997 saying that he was still relevant to the processes of government. He was that politically low and that weak.

Many Washingtonians like to say that we don’t have a health care system in the United States, and that as a country we need to find a way to rationalize our existing hodge-podge of programs and financing mechanisms. However, as one wag recently noted, if you don’t think we have a health care system in the United States, just try to change it. That is a good lesson for all of us; it is a good antidote for analytical hubris. After the Clinton administration failed to reform health care, private markets became the engines of change to reform the system, and to some degree, they succeeded much more than did President Clinton. Since the 1980s, the managed care plans have been developing experience in controlling health care spending. When the Clinton initiative failed, most employers were tired of coping with rapidly rising health care costs. They also lacked confidence in the government’s capacity to control them, and worried that the government would try to manage its portion of Medicare and Medicaid costs by shifting its responsibility to private employers through cost-shifting, or higher health insurance premiums. Employers turned to the managed care companies and asked them to use their skills to get the situation on track. We will support you, they said, and the rest is history. Alain has already talked a great deal about what went right when this happened. We got price stabilization in health care. We saw lower lengths of hospital stay. During this period, fundamental change was also occurring in the way hospitals behaved, and we saw—and will continue to see I think—a significant consolidation of hospitals. That process will continue especially, I believe, here in California.

So what went wrong? Alain identified one of the problems earlier: corporate health care. We got a good dose of “corporate-run health care,” not “government-run health care.” Corporations essentially imposed on their employees the concept of managed care without offering any choices. This sea-change from a fee-for-service system to a managed care system (over a mere ten years) was not accompanied by choice, which prompted immense anger among health care professionals, among the population in general, and among political and media élites, an important group that, I think, is often underestimated. As a result, whether on network television or at the movies, it’s hard to identify a time when there was even one positive story on the benefits of managed care. If you talk privately with people, especially smart staffers on Capitol Hill, they’ll tell you they don’t like managed care. “We’re very suspicious of it,” they say. “It might be good for Medicaid beneficiaries. It might be good for other parts of society, but the dirty little secret on Capitol Hill is that we’re suspicious of it.”

The combination of professional and popular dissatisfaction, accelerated by the media and political élites, has created not only anger about managed care practices, but has also seriously damaged the very idea of managed care in this country. State and federal legislatures are now passing bills to force it into what they perceive to be socially responsible behavior. So this is one area that went awry.
We have a very paternalistic health care system in this country. If my employer called me in and said, “Gee, Bill, we have two vacation choices for you this year. You can go to Disney World in Florida, or for a 20 percent co-pay, we'll send you to Paris,” I'd be flabbergasted. I think most of us in this room would be angry about our choice being compromised on something important to us. We do that in health care all the time. With a few exceptions, Stanford among them, our employers call us in and say, here are your two possible health insurance choices. Or maybe it’s just one plan, and you just have to live with it. A friend of mine, who is a highly paid executive at a major Silicon Valley firm, was forced to do exactly that. He got one plan, and the list of doctors, and didn’t recognize one of the physicians on the list. In this country, we have failed to find a way to introduce more choices and to make those choices sensitive to price. I think this is unfortunate, for both employees and employers. We have also done very little about risk selection. It is still a significant problem in health insurance markets, and specifically in private health insurance markets. We have not significantly expanded coverage during the past decade; in fact, the number of uninsured people has grown. And while we stabilized costs for a while, I fear that they are on the rise again.

I represent hospitals, but I think that during the past decade they have primarily been involved in countervailing competition. The smart hospitals have developed a strategy in various markets to ensure that the insurance companies can’t leave them out, which means becoming larger through consolidation. Many are also beginning to get clever about negotiating with insurers over premiums. In the early years, most hospital executives didn’t know what portion of the premium payment they deserved. Many were intimidated by the emergence of intense price competition in local markets and accepted contracts that were totally inadequate with respect to their hospitals’ actual financial needs. They justified the low paying of contracts by believing the hospital would make it up in volume. But, in many instances, it turned out that the hospital was paid less than the cost of providing care for most of its patients. Fortunately, however, this situation is changing. As hospitals become stronger in various markets and more adept at dealing with insurers, the insurers will have a harder time controlling premium costs. Many other cost pressures exist within health care that will also drive prices up again.

Where do we go from here? The past decade has been a chastening experience for anyone involved in health care. Personally, I believe that we have to return to the promise of managed care. I don’t know how else we will ever arrive at a system that is both efficient and effective, without managed care being an integral part of it. We may not call it managed care going forward, but we will have to harness its original promise and make it an important part of health care. We should be working on structural changes to the system. The Clinton administration, unfortunately, attempted to do everything at once. Much of what they recommended in their health care plan was valid, and much of it should be done, but it couldn’t, and can’t, all be done all at once. I wish that we had spent the past decade putting some structural changes in place, such as creating tax incentives to encourage small employers to develop health insurance purchasing cooperatives, which would help them move to a defined contribution plan and provide their employees with greater choice. We should also have been seriously addressing the problem of risk selection and private health insurance markets, by developing risk adjusters that would ensure fairer competition between plans. We should, I think, oppose legislation that prohibits the use of appropriate and rational economic incentives. In this current environment, it’s difficult to oppose that sort of legislation, primarily because of the way that managed care has been demonized. However,
as Michael indicated, appropriate economic incentives are crucial to bringing about a more effective delivery system in the future. Thank you.

Bill Gradison, Former President, Health Insurance Association of America

I’m delighted to be on this panel, and especially glad to follow Bill Cox, since the Health Insurance Association of America has the pleasure of representing the Alliance of Catholic Health Care in Washington.

While that kind introduction focused on the political side of what I’ve done over many decades, the reflections that I want to share with you have to do almost entirely with what’s happened in the last ten years in health care markets. I have been struck by two overriding impressions. The first is that so many forecasts made ten years ago have proved to be wrong, or at least wrong so far. The second is that markets do matter, and are highly unpredictable. When the economist Joseph A. Schumpeter described capitalism as creative destruction, he could have been thinking about health care in the United States during the 1990s. I sometimes think that the best training for people going into this field today is a heavy dose of chaos theory, because the future is truly so uncertain.

What are some of these failed forecasts? One has already been mentioned. Health care was expected to rise as a percentage of GDP in a linear way. It hasn’t done so, however, because of moderation of health care inflation and the strong growth of the economy itself. HMOs, especially not-for-profit groups and staff models, were thought by many to be the wave of the future. The industry is now perhaps two-thirds profit to one-third not-for-profit, and maybe more. Furthermore, the HMO market share is actually declining. PPOs were considered a transitional product, a temporary stop on the road to more restrictive, more highly managed plans. They were intended to help the public get used to the idea of restrictions on choice. At the moment, PPOs are gaining market share at the expense of HMOs, which may be a fluke related to the current strength of the economy and of markets. Time will tell.

Many people thought that national plans would dominate the market. Certainly the withdrawal of some of the largest plans, selectively, from both the private and public markets—Medicare plus choice, as well as a resurgence of many Blue Cross/Blue Shield plans, which were losing market share for many decades—suggests that regional players still have an important role to play. Traditional health insurance was expected to go the way of the buggy whip. In a way, that has happened, but some health insurance companies have morphed into successes, making the full transition into the HMO form. Indeed, as I see it, fee-for-service seems to be making a comeback but in the new forms, POS and PPO. As Alain showed in his figures, roughly two-thirds of the market is made up of entities which, to me, look an awful lot like a traditional fee-for-service system. This is after many, many years, in which HMOs have not only been encouraged by employers, but were also given the green light by the national government stretching back to the Nixon administration.

Many believed that managed care would succeed by improving outcomes and lowering costs. This is sensitive ground, but numerous studies suggest that managed care is as good as fee-for-service. In my view, if its promise had been fulfilled, managed care would be consistently superior. Judging by the work of Hal Luft at UCSF, and others, that does not appear to be the case. In other words, just being good enough is not necessarily adequate, considering the potential. That may change. I don’t think it has happened yet. Regrettably,
our capacity to manage care currently far exceeds our actual management of care; that is also true among some of the HMOs. Some believed that the underwriting cycle in the insurance business was dead; that modern data processing would enable plans and insurers to monitor costs on a more current basis and to move quickly in making appropriate adjustments in premiums. But as in the past, the cycle has continued, as many managements seeking a larger market share have consciously underpriced their products and ended up in a sea of red ink. Last year almost half of the HMOs in the United States operated at a loss. And now plans are striving to increase profit margins and give less attention to market share.

On the provider side, many felt that integrated health systems were the wave of the future. The indication that that belief was going to shift came when Humana Hospitals tried to run both hospitals and a health plan. Not surprisingly, they discovered that people who were involved in health plans other than their own were not anxious to send patients to the Humana Hospitals, so they split that up. I think we’re going to see many more breakups of integrated health systems in the relatively immediate future. As for for-profit hospitals, many felt that they would replace not-for-profit hospitals. Remember the fear when it looked like Columbia might come into your town and that not-for-profit hospitals would fail or be taken over by for-profit chains? We don’t hear much about that anymore. Many experts felt that physician practice management firms would become dominant players. There was also going to be a boom in primary care at the expense of medical specialties. One of my many daughters—I have seven of them—runs the Family Practice Residency at Duke University Medical School. She was not able to fill all of her slots through the match this year.

How many careers, then, and how many fortunes, have been hard hit by the failure of these well-intentioned forecasts? It’s easy to say what went wrong. But let me share with you my thinking about what we can learn from the experience of the last ten years. Obviously, there’s plenty of room for modesty in making predictions, because so many of us have been wrong so often. I was one of the people who felt in 1993 that national health insurance was inevitable and it was just a question of how it was done. The reality is that people in the health care field have to make projections. They have to develop strategic plans. They have to enter into contracts and build buildings and make commitments. But the time horizon is getting shorter. That is to say, long-term planning for a lot of folks in various parts of the health care field is now two to three years. Maybe it’s shorter among the dot-coms and some of the computer firms, but that is a very short horizon when you’re making long-term commitments in personnel and financing. I also sense from talking to people in the industry that, just from a sound business point of view, financial planning requires review, and possibly revision of budget assumptions on a quarterly basis. That’s not usually the way health care businesses operate. The resulting turmoil and uncertainty has of course led to a rapid turnover of CEOs, both in hospitals (whose CEOs have traditionally averaged two-and-a-half to three years), and in insurance companies and health plans large and small.

In my contacts with MBA students in the health sector management program at Duke, where I spend some time, I have been struck that virtually none of them are entering the provider or health plan side. Most of them are signing on with consulting firms and pharmaceutical companies. They may be right and they may be wrong, but this is what is happening. Duke itself has some interesting decisions to make. They bought a lot of physician practices with five-year clauses. What will they do with these contracts and what will happen to the physicians who have noncompete clauses after the five years are over? Duke just accepted resignations from the heads of their two major hospitals, Durham Regional and the Duke Hospital. Duke now owns 100 percent of an HMO. New York Life
formerly owned the other 50 percent. What will they do with it? What decisions will be
made? In other words universities and medical schools—not just those bad guys out there in
the HMO industry—have some tough decisions to make.

Many years ago when I was a student at the Harvard Business School, we were told that
there are no answers to business problems. The most you could hope to come up with are
currently useful generalizations. So, with many caveats and cautions, let me offer a few.
First, I think the number of uninsured people will continue to rise. It’s remarkable and
distressing that it’s gone up in a period of such high-level economic activity, but it has. I
believe that consensus will develop about incremental steps to assist low-income workers,
perhaps through some combination of the children’s program, Medicaid (or here in Califor-
nia, MediCal), and refundable tax credits. While you don’t hear much talk about it, the
approach taken will likely be a federal–state approach rather than a federal-only approach.
Little attention has been given to the fact that two presidents, of different parties, a year
apart, said that we could totally reform the health care system and have universal coverage
without putting any more money in the system. That’s what George Bush said in February of
1992. Bill Clinton, with a different approach, said something similar just a year later. I don’t
know any serious decision-maker or policymaker in Washington who believes that today. So
the problem is not only what to do, but how to pay for it, in a world where there is
competition not only for the current budget dollar but also for the anticipated surplus from
such popular causes as Medicare prescription drugs, and Social Security. I’m also afraid that
the disruption of the physician–patient relationships will continue. Health plans that can
figure out how to overcome this obstacle have a bright future. I don’t believe the industry as
a whole has come up with a solution. There will be fewer insurers, fewer managed care
organizations, and fewer hospitals. We’re going to see a lot of mergers and attrition. Some
communities are actually seeing their hospitals close including, of course, Mount Zion in
San Francisco. A couple of hospitals in Cleveland are going through bankruptcy proceed-
ings at the moment.

The market share of for-profit health plans will continue to grow. I think this is mainly
due to the difficulty that not-for-profit plans have in accessing capital when they hit a
financial bump in the road. This will continue to happen unless the underwriting cycle is
totally tame. When Oxford HealthCare, in the metropolitan New York area, ran into
financial problems, they were able to obtain $700 million from private investors in order to
stay afloat. By contrast, when HIP in New Jersey and Harvard Pilgrim in Rhode Island got
into trouble, they were history. Even with so much of it around today, I see no signs that
private philanthropy is willing to replenish the depleted capital of not-for-profit health
plans. One of the ironies of this situation is the enormous contribution that the not-for-profit
sector has made. Many of the successful for-profit enterprises have grown by taking market
advantage of the innovations which have come out of the not-for-profit sector—HMOs, and
hospice, for example. I was involved with Leon Panetta in getting the hospice benefit written
into Medicare. It never occurred to me that there would be a for-profit hospice sector; it
never crossed my mind that this sector would develop as an industry. The same point can be
made about borrowing ideas from the success of for-profit entities in another part of the
health care field: clinical trials. Medical schools used to dominate clinical trials. Now they
are primarily done by for-profit entities. Why? The for-profit entities are doing it quicker,
cheaper, and more accurately than the medical schools. There is competition out there, and
not just within a given part of the health care sector. As the market evolves, some managed
care companies may look increasingly like indemnity companies. Certainly some of the
traditional indemnity skills are valued and needed. Health plans that haven’t had these skills—underwriting, financing, marketing, and actuarial—have landed in big trouble. I remember a time when the head of one big HMO claimed not to be in the insurance business. We’re not hearing that anymore.

Employers will increasingly move toward defined contribution plans to the extent that competition in the labor markets makes this possible. Right now, it isn’t possible. The future of the employer-based system is not at all clear. Some well-intended efforts—such as creating a market in which people are given money to go out and buy their own insurance—could actually lead to an increase in the number of uninsured. With all its faults, the employer-based system is what we have, right now. I would not take that first step toward changing it without knowing where the second, third, and fourth steps would lead. Should employers find themselves exposed to liability in connection with their self-insured plans? Many employers are saying explicitly, “Why should I be exposed to lawsuits for a benefit which I am giving voluntarily?” That’s how they see it. If you think of it that way, you can see the risks involved when employers provide health benefits for employees.

In the short run, I believe that commodification of health care markets, with an emphasis on price, will continue. And it will continue until we see more progress than we’ve seen so far in measuring and comparing quality and outcomes. Such comparisons won’t come quickly or easily. I’m a great believer in the concept of value-based purchasing—sometimes called value-based partnering. This concept is much discussed, but not a lot of it is actually happening. Risk adjustment is easier to talk about than to achieve. For better or worse, health plans don’t provide health care—doctors and nurses do. The performance of any health plan reflects the average, and not the experience an individual patient will have with an individual physician in that very important relationship. This is one reason, I believe, to be somewhat skeptical that people will necessarily follow what the averages indicate. In other words, medicine will continue to be both an art and a science, even as we move toward a little more science and a little less art. In addition, I think that cross-subsidies will be increasingly difficult to come by. Explicit subsidies will be needed to replace cost shifting, so that hospitals may finance uncompensated care, for example, and academic health centers can pay for their education and research missions, which traditionally they’ve covered with the profits from their clinical enterprises.

It’s hard to see the future. If the predictions I’ve made pan out, you heard it here. If they don’t, I don’t remember having been with you this afternoon. [Laughter] But I truly do believe that markets matter, even though they’re not going to finance either public goods or services for the uninsured. Prices make a difference. There is an advantage to having a nonsystem, which is what we currently have. With a nonsystem, it’s easier to learn from small experiments and small mistakes.

Having focused so much on markets, let me say one final thing about politics. In this country, if people don’t like what comes of the market, they turn to the government to bring about change. For example, farmers look to the government to help establish minimum prices. Steel manufacturers ask the government to try to hold down the flow of imports. Having spent years in the government sector, I assure you there are many segments of the health care system—in the past, today, and in the future—that will look to the government to slow, or even stop changes in the private sector that are perceived to be disadvantageous. Thank you.
Mary R. Grealy, President, Healthcare Leadership Council

It’s a pleasure to join you. It has been fun reliving the Clinton wars with some of my colleagues here. Those were wild times, and this is a timely conference. It’s great to be hearing some of the comparisons that have been made today.

My organization, the Healthcare Leadership Council (HLC), is a group comprised of the chief executive officers of companies from all sectors of health care. The HLC provides an interesting perspective on the issues we’re discussing here. We deal not only with health insurance plans and hospitals but also with pharmaceutical companies, medical device manufacturers, and physician groups. It amazes me that we have been able to coalesce around a common vision of a consumer-oriented, patient-centered health care system. An informed consumer, or patient, can help to drive the marketplace, and I think we are beginning to see how the marketplace is changing and responding to patients’ demands. Such change, I believe, will dramatically increase over time. The Healthcare Leadership Council strongly believes in the private sector and does not support excessive government regulation. We all agree that there is an appropriate role for the government, and we seek to find a balance between the private sector and government regulation. Where do we place the fulcrum as we try to achieve that balance?

At this point, we’re at a crossroads. You heard about the Clinton health reform wars. We’ve debated about which path to take, and how that balance will be achieved between government regulations and the marketplace. What is the private sector’s role? Today, Congress is looking at a Patient’s Bill of Rights, and the debate it has inspired is similar to the one we had about the Clinton Health Reform Plan. We’re looking at a lot of the same issues. Let’s look back a little. Earlier, Richard and I were commiserating about what is left to say after everything we’ve just heard from the wonderful panelists who have spoken so far. However, let me just touch on a few things and perhaps reinforce a couple of others we’ve already heard. Reflecting on the last ten years, I think pharmaceutical companies have worked well, even though many of the same arguments about price regulation, now as then, are being used against them. Ten years ago, employers wanted to reduce health care costs. Health insurance premiums were rising at a rapid pace, as Bill Cox explained so well. The market responded to the demands of those employers. I think we all have to agree that managed care—the marketplace—did achieve that goal of cost containment. Interestingly enough, I think that this change was occurring long before the Clinton administration introduced legislation to address health care costs. Yet this was one of the reasons that the health plan was ultimately defeated. The plan failed because it was way too massive. But it also failed because the marketplace had already started to address the problem, so there was less of a need for the government to intervene. Managed care has encouraged best practices, and my sincere hope is that we can continue to build on that. Furthermore, I hope that Congress does not take steps that will interfere with the development of those best practices.

I like to use anecdotes and personal experiences when discussing health care. My father-in-law, whose nickname is Boss, suffered from not being part of a managed care plan. He had a family physician, who had treated him for many years. This family physician was not part of a group medical practice. He was not being supervised or reviewed by anyone. Boss had congestive heart failure, and did not receive the treatment he should have, because he dealt only with that single physician. He eventually did see the right physician, but it took too long. He could have had a better quality of life for the last several years of his life had he received that treatment sooner.
There are good stories about managed care and these are the ones we need to tell. I think that what has been happening within managed care has also spilled over into those fee-for-service plans that we see slowly dwindling away. I don’t believe that physicians dramatically change the way they practice medicine based on who is paying for the services for a particular patient. They’re dealing with too many health insurance plans to know when a patient walks in the door that they should be practicing fee-for-service medicine with this patient, or managed care medicine with that one.

HMOs have focused on preventive health care. I have received more communication from my health plan in the last year than I ever did before I was in this type of health care plan. They are constantly badgering me to make sure I’ve had preventive screening tests, and to make sure that I’m going in for regular exams. I appreciate that information, and having that contact. We need to make sure that people are aware of managed care’s strengths in this area. Managed care itself needs to do a better job of telling its story, and breaking through the media drumbeat. It is constant, relentless, and difficult to get to the real story. We have surveys, which you’ve heard about today, that say that people are pleased with the care that they’re receiving as part of their managed care health plan. How do we ensure that this message gets to Congress, as opposed to the message of the 3 percent who have perhaps been dissatisfied?

I have another personal story—another good one—about my husband’s first experience with managed care. He had tremendous fluid build-up in his knee, from twenty years of neglect and probably not the right type of exercise. He needed to see a specialist but his HMO required that he go to the gatekeeper first. He thought this was ridiculous. He knew what needed to be done, so he went to see his gatekeeper physician and said that all he wanted was his ticket to see the orthopedic surgeon to get the job done. His gatekeeper, his managed care physician, prescribed a medication, and told him to come back in two weeks to see if the inflammation had gone down. My husband came home saying, “The physician didn’t spend five minutes with me. He doesn’t know who I am. This is ridiculous.” But then he went on the Internet and guess what he found out? The medication was exactly the treatment that was indicated. This discovery gave him a slightly different view. He went back two weeks later, and the inflammation hadn’t gone down quite enough. The gatekeeper physician said, “Now we’ll refer you to that specialist. We wanted to try this noninvasive approach first to see if it worked.” My husband wound up with the best orthopedic practice in the city and a great outcome. But right before he had the operation, his gatekeeper physician ordered an electrocardiogram (EKG), and didn’t like the way the test came out. My husband was annoyed at the hassle. He had to have another test done. But the physician said, you’re doing it for me and I’m doing it for you. So he went to have the more extensive test. It took a little longer, but he eventually got the treatment. And you know what? All of this was better care, and it was part of a managed care system.

My point here is that there may be some bad stories, but the marketplace is beginning to respond. We’re seeing it in the greater number of choices being offered to patients, either by their employers or through the health plans themselves. No doubt more changes will follow in the coming years. I hope they can take place outside the political arena. We don’t want Congress to micromanage the way our health care should be financed and delivered. It may be an appropriate role for government but I think that having the government determine my length of stay in a hospital is a horrifying prospect. I’m not qualified to make those decisions, and elected officials aren’t qualified to make them either. We must make sure to balance these issues appropriately.
What went wrong with managed care? One problem, as I said before, was the media drumbeat. Another problem was the existence of those who don’t believe in marketplace medicine, or marketplace health care, and never will. Frankly, they are using the so-called failure of managed care as a way to drive home their point that markets can never work in health care, so they call for a single-payer, government-dominated solution. I think we should turn our attention to what has actually happened with managed care. I think it is working. We should also look at the pharmaceutical industry, and at what we enjoy as a result of the private investment, research, and development that pour into that industry. We need to look at what the American public wants and to respond to those demands and desires. There have been tremendous breakthroughs in drug development, and improvements in the quality and length of life. I think that has been a result of the marketplace—of private health care and pharmaceutical companies funding research and then carrying it out.

How have the pharmaceutical companies failed? I think they have been too successful. We are now seeing pharmaceutical drug treatments that are treatments. They are shortening, and in many instances eliminating the hospital stays. We’ve seen a great increase in the quality and length of life because of pharmaceutical breakthroughs. The success of pharmaceutical companies has led to their products being much more highly utilized. Higher utilization brings with it higher costs, and we are now hearing from individual beneficiaries under the Medicare program who do not have a drug benefit. Some of them are having difficulty accessing the pharmaceuticals, or paying for them.

Accordingly, the attention of Congress has been directed to this issue. Congress wants to develop a Medicare drug benefit; its members are concerned about how much this will cost the program. Many hospitals are also saying they are under tight price controls from the Medicare and Medicaid programs. Frankly, because these hospitals failed to negotiate the best contracts with managed care, they’re suffering in the private marketplace as well. When we look at where our costs are rising, we see that there is much higher pharmaceutical utilization, which is increasing our costs. Here, then, we also hear the drumbeat. Just as managed care has been in the spotlight, so too are the drug companies. The bottom line is that this is a hot political issue, in a very political year. When you have close races—when Democrats in the House of Representatives know they have a chance to be in charge, and presidential candidates realize this is the hot button issue—it’s clear that the pharmaceutical companies present a big target.

What will we see in the future? My concern about managed care is that certain legislation may not improve the quality of managed care that is delivered, but will increase the price of that care. That price will not be paid by the health insurance plans; it will be passed on to employers. We have heard a lot today about the uninsured, and their growing numbers. They are getting care. They’re probably not getting care as efficiently as they could if they had private health insurance coverage. But, as we increase the price of health insurance, we will increase the size of those uninsured rolls. At a time when we should be making sure that more people have coverage, our Congress seeks to increase the price for those who already have coverage. Congress is also hindering employers who are trying to provide insurance for their employees.

The Commonwealth Fund recently released a survey which contained a startling statistic. Those currently without insurance were given a choice. Would you prefer to get insurance coverage through a government program, or would you like to have health insurance provided through your employer? A significant number said they would like to have employer-provided health insurance coverage. We should be working to find ways to
do that. It dismays me that we spend so much time worrying about populations with good health insurance coverage. We’re micromanaging that from Washington, rather than addressing the critical problem of how to provide coverage for the uninsured. It’s the right thing to do, and I hope that we will see it happen in the future. I am encouraged that Senator Bill Bradley was willing to step out in the presidential campaigns and make health insurance coverage an important issue. It forced other candidates to put it on their agendas. Having so many uninsured patients is the Achilles heel of a market-based health care system. If we can’t address this critical problem, it will continue to increase the cost of health insurance premiums and to drive advocates who favor a government-dominated, government-controlled health care system. We faced it when the Clinton administration came into office, and we may face it again if we don’t address it soon. Thank you.

Richard R. Pettingill, President and CEO, Kaiser Permanente, California Division

I’m glad to be here this afternoon. Thank you very much. When I was first asked to participate in this session and told that I had twenty minutes to present some thoughts, I asked how I could possibly present this complex story in so short a time. And now that I have heard one of the world’s renowned health economists talk for an hour, and industry leaders speak for another hour-and-a-half, I’m trying to figure out what’s left to say about the challenges that our industry currently faces.

I started my career back in 1971 at Stanford University Medical Center. I enjoyed my days here. I gained a real insight into academic health care centers, but after ten years decided I didn’t want to spend my entire career working within them. Even so, while at Stanford, I had the distinct pleasure of learning about university politics. Professor Enthoven probably doesn’t know this, but I was on the University Parking Committee at the time that paid parking was instituted for faculty and employees. On that committee, I saw how decisions were made. The University Parking Committee was comprised of tenured professors who could say what they wanted to say and nobody challenged them, and young executives starting their careers who had nothing to say. It was a wonderfully enlightening experience.

After leaving Stanford, I went down the road to El Camino Hospital, one of the first fully computerized health care organizations in the United States. There, I began to struggle with the roots of health care reform. When we discovered that voluntary controls didn’t work, and that hospitals were worried about physicians who controlled the patients, we saw a cycle of what were called joint ventures. We tried to present economic incentives between hospitals and physician groups that kept the latter in the corral, so the former could control the patients. However, after losing tens of millions of dollars nationally on joint ventures that didn’t work, into the 1990s we began to emulate so-called integrated models of care. When it became evident that neither doctors nor hospitals controlled the patients, and maybe it was the patients’ insurance that did so, we scrambled to create integrated models of care to bring health plans, doctors, and hospitals together. Looking back in the 1990s, there were few success stories in reshaping and reforming the health care system. I think tens, if not hundreds of millions of dollars were lost in the process. In my cynical view of the world, the only ones who profited were consultants and attorneys who put these groups together in the 1980s, and are now taking them apart in the year 2000. When you look at where we’ve been over the course of thirty years, there has been little true success.
I’ve had the honor of being affiliated with Kaiser Permanente for four years. I competed against Kaiser Permanente for twenty-six years before realizing there was truth to their model. In my anti-Kaiser tactics, I would often try to get the doctors to engage in competition and to pull together integrated models. I used to take photographs of the new Kaiser buildings coming to town and say, “This is the enemy.” Then, we tried to organize ourselves to deal with Kaiser’s emerging force in the community. We would have town hall meetings, at the end which the doctors would be thumping the tables and exclaiming, “We have to go after Kaiser Permanente!” It pains me to think of it now, because I believe that most physicians, and health care and insurance executives are well-intentioned people trying to find solutions in a complex industry. Accordingly, I’ll try to shed some light on where Kaiser Permanente is, the next level of challenges we will face as an organization, and other things that will come up on the radar screen that could create another wave of potentially misdirected reform. I am most concerned with the new wave of reform that involves emerging competitors in the virtual world.

Where was Kaiser Permanente during the past decade? As Professor Enthoven mentioned, Kaiser Permanente can distinguish itself through our successes; we’ve been at it a long time. We go back to the 1930s, when Henry Kaiser talked about fundamental ideas regarding affordable health care. From the outset, Kaiser Permanente has focused on prevention and integration, so that doctors and hospitals can be brought together to perform more efficiently and effectively. Henry Kaiser partnered with Sidney Garfield, and they brought Kaiser Permanente, an employee-based health organization until after the war, into the open marketplace.

As an organization, we have had our own set of difficulties, and we have been in an interesting spiral in observing our organization. We had phenomenal growth in the late 1980s and into the early 1990s, but then—as we raised rates in double-digit numbers—we saw our growth freeze. We then led the industry by rolling back and freezing prices, and for several years we saw significant moderation in the price of health care. In 1997 and 1998, we discovered that we didn’t effectively manage our cost structure—the costs went up and we didn’t respond. We as an industry and certainly Kaiser Permanente as an individual case could have anticipated and managed these rises more effectively. One question I am often asked about our purchasers and our relationship is whether we have fully derived the value of the distinctive capabilities and integrated model of care that Kaiser Permanente represents. My answer is no. We have not, but I do think that in the years ahead we will begin to see those values emerge.

Many people don’t know what Kaiser Permanente is. Kaiser Permanente is not, in and of itself, a corporation. It’s a partnership with a financing arm, Kaiser Foundation Health Plans; a delivery system, Kaiser Foundation Hospitals; and a medical group side, Permanente Medical Groups. Kaiser Foundation hospitals and health plans are not-for-profit organizations. California represents the largest part of Kaiser Permanente. We have different models throughout the country, but the basic model is built around the group practice.

What concerns do we face as an organization? What strategies will we use to address those concerns? First, there’s no doubt, in my opinion, that there will be growing numbers of consumers who are more informed and more demanding for health care services. This will be driven, in large part, by the culture and diversity of the communities where we serve as a not-for-profit organization. In Los Angeles County today, for example, 65 percent of the children under the age of seven are Latino. We certainly attempt to understand notions of
cultural diversity, but we have to do a better job of that in future, and shape the provision of health care services around consumer segments and demands.

Second, we have heard a great deal about political action. I am a member of the California Association of Health Plans, together with other CEOs of health plans in California. I think it is unfortunate that within the managed care arena we have got ourselves into a difficult predicament. We lack a sense of public confidence and trust in what we do. I spend a fair amount of time in Sacramento talking about Kaiser Permanente, and how we differ from the rest of the industry. I do think we are different, because we offer an integrated model of care, associated with financing and health care delivery. We are also a not-for-profit organization. At any rate, I was up in Sacramento two weeks ago talking with an author of a bill that seeks to do away with our ability to use arbitration as a means to resolve disputes. This bill would have an impact on the industry on the order of hundreds of millions of dollars. Many elected officials in Sacramento are Kaiser Permanente members and they often tell me about what our distinct capabilities say about us as an organization. At the same time, they recognize that reform is before us. And what concerns me about political action and health care reform is that I’m not certain that anyone has the master plan.

The third major concern we face as an organization—both in terms of the upside and the potential downside—is the evolving e-world. I think there are wonderful opportunities there. The future of Kaiser Permanente is exciting, as we envision the 70 percent of our members that already have access to the Internet. KP Online gives our members direct online access not only to information, but also to transactions. For example, we’ve recently started online appointment settings so members can check their doctor’s appointments. We are beginning to transform the organization to organize ourselves around our members, rather than around our providers, which should be significant. In the future, I see a Kaiser Permanente member scheduling an appointment. The member will go in to see the physician. By the time the member returns home, the physician will have the results of the lab up on a desktop or a TV. The patient will see that pharmaceuticals have been ordered, and that they’ll be delivered tomorrow. If there is another follow-up examination, say, in radiology next week, KP Online will send a reminder the evening before. We’ll get your test results, and automatically schedule your next appointment, and tell you when it needs to be completed. As we see new members—babies, for instance—coming in we will seek to develop proactive information, and get it out to our members. Your child will be two years old, for instance, so these immunizations are due, and we’ll schedule a convenient time for you to come in. We have a lot of work to do in this area. We also need to improve our service orientation. I’m trying to educate our organization, and I’ve been sharing, by way of example, the instances in which we are or are not consumer-centric.

Fourth, I believe we will see a significant impact from new technology. Biotechnology will challenge all of us with respect to pharmaceuticals, which are bringing wonderful innovations to the industry. However, we as an industry have not been able to extract the benefit from these innovations and apply them to improved operating structures. Our challenge at Kaiser Permanente is to take the potential opportunities and to realize the benefits that emerge from them.

Unfortunately for us as an industry, we will soon face significant labor force shortages. The average age of a registered nurse in California today is 45. The average age of an operating room nurse in California today is 54. You can’t run a system when people are exhausted. How do I think Kaiser Permanente is positioned to deal with this challenge? I
believe that we did a good job of managing significant financial losses in 1997 and 1998. In California in 1998, we lost $350 million. In 1999, however, because of our renewed focus on the fundamentals, we reported an operating income in excess of $250 million. For our first quarter of this year in California, we’re at a 4 percent operating margin. We need to get to 6 percent, because we’re a capital-intensive organization, but we’re still doing well. I believe we’re returning to what has worked for us for a long time. When Kaiser Permanente was founded, its goal was to manage the integration of health care. Today, we have seven thousand physicians in Permanente Medics across California and our new challenge is to manage knowledge. Once we can capitalize on managing knowledge, and on transferring it consistently across the enterprise, we’ll truly be able to distinguish ourselves in clinical effectiveness and outcomes.

I call this transfer of knowledge across the organization “systemness.” Many people at Kaiser Permanente call it “centralness” in bureaucracy, but that’s not what it’s about. It’s managing knowledge, delivering on our promises to our members. We’re doing an outstanding job understanding about our market segments, and our different consumer groups. My son, for example, falls into the group we call “basic consumers”—he will pick a health plan with the lowest dollar amount, regardless of where his dad works. We know that we have proactive people on the one hand, who don’t want a strong relationship with a health plan, but simply want to have confidence in their treatment. We also know, on the other hand, that we serve a population that suffers from chronic diseases. We need to segment our products and services to go out and get those populations.

Kaiser Permanente is unique in that we have grown up with unions, and view unions as our partners. It’s part of our history. Seventy percent of our workforce—including 82,000 employees in California alone—is unionized. We view our unions as strategic partners, and we bring them around the table with us to solve complex problems. As we’re talking about the impact of technology on our workforce over the next five years, we bring our union partners in to plan the changes in the organization. In so doing, at the end of the day we’ll do a much better job of addressing our service and access issues. It doesn’t do you any good to have an online appointment scheduling system, for instance, if you don’t have appointments available for your members. Last week, I was talking with the leader of our medical group, Dr. Robert Pearl in Northern California. He said, “Not only can I tell you the appointment demand management in Northern California for all of our medical centers for the past several months; I can also tell you today what the appointment demand will look like in sixty days.” When our members call for appointments, we have them available.

I have confidence that Kaiser Permanente will be able to distinguish itself further in the areas of clinical quality, customer value, and clinical outcome, all of which will enable people making health care choices to understand what makes of Kaiser Permanente different. I’m excited about the future. That’s not to say it will be easy. We all have our challenges, and we live in a complex world. But I see the re-emergence of Kaiser Permanente, and I believe we can realize our full potential over the coming years. Thank you very much. It’s been a delight being here, and I’ve enjoyed the afternoon with you.
Day Two: The Effects of Market Forces Overseas

Six International Case Studies
Morning Moderator: Paul F. Basch, Professor Emeritus, Department of Health Research and Policy, School of Medicine, Stanford University

Afternoon Moderator: Alan Garber, Director, Center for Health Policy, Stanford University

Panelists:
ENGLAND
Alain C. Enthoven, Professor, Graduate School of Business, Stanford University
JAPAN
Koichi Kawabuchi, Chief Senior Researcher, Japan Medical Association Research Institute
NETHERLANDS
Hans Maarse, Dean, Faculty of Health Sciences, University of Maastricht
NEW ZEALAND
Roger Bowie, CEO, Southern Cross Healthcare
SCOTLAND
Harry Burns, Director of Public Health, Greater Glasgow Health Board
SINGAPORE
Choon-Yong Loo, CEO, Raffles Medical Group

Closing Remarks
Daniel I. Okimoto, Professor, Department of Political Science, Stanford University
INTRODUCTION
Paul F. Basch, Professor Emeritus, Department of Health Research and Policy, School of Medicine, Stanford University

Good morning again to everyone. Today is May fifth, Cinco de Mayo, the National Day of Mexico, as well as Children’s Day in Japan. We have a distinguished panel here to talk about health issues among people of all ages. Yesterday we had a very stimulating discussion, and I’m looking forward to more of the same today. This panel represents governmental systems that differ widely. Even so, these disparate systems share many of the same actors, including governments, health professionals, labor unions, and employers in different mixes. All countries have the same issues of efficiency, effectiveness, governmental regulation at various levels (including decentralization to the provincial or state level), public–private mixes of services, equity, and management of technology and market forces. I look forward to your presentations.

Our first speaker, Professor Alain Enthoven, needs no introduction. He has been at Stanford’s Graduate School of Business for many years. He has been an economist with Rand Corporation, assistant secretary of defense, and president of Litton Medical Products, among his many roles. I won’t go through his extensive biography, but would say only that Professor Enthoven is perhaps the world’s leading expert on the British National Health Service (NHS) and has just published a book, *In Pursuit of an Improving National Health Service*, through the Nuffield Trust. Professor Enthoven will speak today about the British NHS.

ENGLAND
Alain C. Enthoven, Professor, Graduate School of Business, Stanford University

Thank you very much, Paul. The British NHS is extremely short of the resources needed to do its job. This is apparent in the buildings, in the nurse staff shortages, and in the very short times that doctors spend with patients. Last year, while I was on sabbatical at the London School of Hygiene and Tropical Medicine, some of my colleagues there did a study on the amount of time that surgeons spend with patients. They discovered that there are lots of one-minute visits. Accordingly, I’m going to talk today about the bureaucratic incentives that were holding the NHS back, and attempts to put in some market incentives.

When I visited the NHS back in 1984 and 1985, I found a system that reminded me a lot of the U.S. Department of Defense—locked in all kinds of perverse bureaucratic incentives. If you do a good job, for example, that proves that you don’t need more resources. Similarly, the way to get more resources is by doing a bad job with what you have. Generals would come to see me in the Pentagon and say, “Mr. Secretary, I’m sorry and embarrassed to tell you this, but do you remember that $1 million you gave us for shoes? Well, it’s pretty dumb, but we spent it all on left shoes. Now we’re going to look bad—and you will, too—if you don’t give us another $1 million to buy the right shoes.” If a hospital greatly improved its services through better quality, reduced waiting lists, and the like, they would get more work—more patients without more resources. No good deed goes unpunished. In the bureaucracy of the NHS of the 1980s, it was important to please the people above you and especially to avoid making waves and being identified as a troublemaker.
The idea of the internal market was to recast the characters. Health authorities would be recast as purchasers, instead of bureaucratic superiors. These authorities would be charged with studying the needs and wants of the people in their population. They could buy services wherever they thought best, which might be from hospitals in neighboring areas. In turn, hospitals would be recast as freestanding hospital trusts that would make their living by offering and contracting their services to health authorities. In the resulting situation, there would have been people sitting across the table actually defining what was being bought and sold—the beginnings, in other words, of some accountability. Then general practitioners (GPs) in sufficiently large practices could accept a bigger capitation to become purchasers in their own right, and pay for things like elective surgery and outpatient care.

In 1997, the Labour Government came to power and abolished the internal market. They abolished GP fund-holding by generalizing it. That is, the government decreed that every GP would be part of a newly created primary care trust (PCT), which would have total control over the vertical slice of budget for its patients. The government seemed to believe that simply by waving the magic wand, PCTs could be ordered into existence.

It takes much more than merely saying, “Let there be markets” for something like this to work. Much of my recent work has focused on the many institutions and capabilities that must be in place for this kind of transition to happen successfully. For one thing, the actors on the scene need some political space. There will be trouble as soon as a GP, hospital, or health authority stops buying from, say, an orthopedics department because of bad quality or bad service. The GP, hospital, or health authority may tell the hospital management all manner of things—that the situation will destabilize the hospital, that the budget won’t balance, or that other disasters will ensue. Then, the members of parliament (MPs) get particularly involved, and procurement issues become politicized right away.

It may be appropriate, in some cases, to handle such problems politically. A market will not work effectively, however, if there is no political space. There must also be information on cost and quality, especially since markets are supposed to lead to lower cost and better quality. But there is no systematic information on quality in the NHS, and only weak information on cost. The NHS did try to analyze hospital service costs, and in 1998 published a report, which was deficient in that it only covered about 40 percent of hospital costs.

For health care markets to work, motivated purchasers must be allowed the freedom to buy selectively. Health authorities should have powerful incentives to go out, overcome resistance, and buy from the best sources of supply. I first wrote about this problem in 1985, and no one has yet figured out a way to solve it. Providers, too, must be able to respond to market forces. English hospitals generally consider that 80 percent of their costs are fixed costs, and they have a terrible time adjusting to a loss of business. A regulatory framework, or capital market, is also needed so that the winners can generate capital and finance expansion in order to take business from the losers. This is not in place. A common language and currency are required, so that participants can communicate with one another over units for purchasing. One study I read, produced by the British equivalent of the General Accounting Office, found that in a single health authority that was buying specialized services in ophthalmology, seven different “currencies” (that is, concepts of what is a product) were used. What units are bought and sold? How are local wages fixed? Wages are determined by central agreements, which makes it difficult to take advantage of local variations in supply and demand. Such agreements also psychologically establish the idea that workers’ gains in pay come from centralized political action, and not from doing a good job in their own hospital.
During my sabbatical year, I observed a crisis of confidence in the quality of care in the NHS in England. Just before I arrived there in 1998, an awful tragedy occurred in Bristol. Two heart surgeons at the Bristol Royal Infirmary—who were not fully specialized in pediatric heart surgery—performed fifty-three arterial switch operations on newborn infants whose great arteries were congenitally transposed. It turned out that these doctors killed twenty-eight of the fifty-three cases and caused permanent brain damage in four more. These numbers beg the question: what is par for the course? The answer is that it’s hard to know, especially since so much confusion exists about the data. But one surgeon did a similar number of cases with only one death. In another big medical scandal, thousands of botched cervical cancer screens were discovered at the Kent and Canterbury Hospitals Trust. And in yet another, Queen’s Hospital in Nottingham performed twenty-seven operations for blocked bile ducts on infants and killed seventeen.

Serial deaths took place without anyone watching the data, and then acting to do something about it. In Bristol, the anesthesiologist (or the anesthetist, as the British call them) finally decided to blow the whistle. He tried to talk to various people, and no one was willing to do anything about it and so he went to the press. The first thing that happened, of course, is that he lost any semblance of a private practice. Second, he was fired from his hospital. Third, he could no longer get any job anywhere in Britain, and he consequently emigrated to Australia. Later, people realized that he was, in fact, the hero, and tried to bring him back. He’s reported to have said, “There’s no way I’m going back.” But these events highlight a large part of the problem in the NHS: no reporting, and retaliation against those people who do tell the truth. There are inadequate quality assurance processes, and a high quality clinical database in England (though not in Scotland) is desperately needed to bring about continuous improvement and transparency. The government talks about these measures, but I doubt that the prime minister will be able to get them simply through personal exhortation.

The NHS always has bad winters, but this year (2000) they had a particularly bad one. These periods are called winter crises. The health authorities run at zero excess capacity. That’s their idea of efficiency, although queueing theory states that if there is no excess capacity, together with fluctuating demands, infinite queues will result. Elders in particular get sick from the flu in winter, so people are overcrowded, in hallways on gurneys. This phenomenon relates back to inadequate resources. There were some highly publicized personal disasters during these winter crises. First, Lord Winston, a surgeon and a member of the Labour Party, had his mother, who was in her eighties, in an NHS hospital. She fell out of bed and spent the night on the floor. In his first reaction, he was furious and truthfully expressed his anger. Then he was called into Ten Downing Street and suitably worked over by the prime minister. He came out sheepishly, retracted his previous statements, and apologized. The proceedings had a slightly Soviet air. Then, Cherie Blair’s sister went public with the fact that she had received some bad advice, which led to her having a miscarriage. I think these anecdotes got through to a lot of people. In England now, there is a growing recognition of the NHS’s quality problems and a greater willingness to speak the truth.

A heavy overlay of ideology has been, I believe, one of the NHS’s main difficulties. If anyone says anything negative, they’re immediately thought to be an arch right-winger or, even worse, a Tory. Their comments would certainly be deemed unpatriotic—like insulting the Queen. Given this climate, something was needed to clear the air, to recognize the facts, and to start figuring out what to do about them. So in March 2000, Prime Minister Blair acknowledged that the system doesn’t have enough money. Accordingly, the prime minister promised a 35 percent increase in real per capita spending, to be phased in over the next five
years. That’s a huge increase in spending. The goal is to bring the UK percentage of gross domestic product (GDP) spent on health care up to the European Community average. But the prime minister also said that money alone wouldn’t work miracles, and that fundamental change is needed in the NHS.

One problem with that speech—and, for that matter, with other pronouncements and press releases by the prime minister and secretary of state for health—was that there was no plan for how they would make this fundamental change. They convened a meeting of thirty-six of the great and the good to formulate a plan by July 2000. But none of the government’s pronouncements gave any insight into what the plan might be. The British Medical Journal—whose editor is a graduate of Stanford Business School—asked health care pundits and practitioners to offer their opinions. Here are my thoughts. I hope someone will call them to the attention of the prime minister. The first point is that quick fixes are bound to fail. No matter what you do, you will not make a visible, noticeable change in a short period of time. Many politicians race to make changes in time for the next election, but I think they need to focus on changes and reforms that will have a long-term impact. Forcing a politician to think about the long run may be like asking a cat to bark. But that’s point one.

Point two is that information is fundamental. One of the great deficiencies of the NHS in England is the lack of gathering and reporting of systematic information. A fair amount of unreliable information exists, but people don’t believe, and therefore don’t use it. Current and accurate data are vital. Progress is impossible without an information-rich environment in which people are willing to look at variations, measure outcomes and costs, and identify different, better ways to tackle given problems.

Point three is that incentives are fundamental, especially incentives to gather and report information. The internal market was an attempt to create incentives. Now, the prime minister is moving toward centralized management of the whole NHS, and personal centralized management. He met with a group of doctors, and then he gave a talk about how to do primary care. I don’t wish to be disrespectful to the prime minister, but I wouldn’t look to him for expert knowledge and experience on how to do primary care. Decentralized decision-making can be extremely valuable in the context of appropriate incentives. In centralized decision-making, a few people spread dumb mistakes out to everyone. Far better, when some new idea comes along, to let people in local areas examine it and adopt it if they think it makes sense, while holding them accountable for quality and cost effectiveness.

A big buzzword in the Labour government’s writings has been “modernization.” A recent excellent White Paper on modernizing government proclaimed (otherwise forbidden) ideas about how the British people have become used to competition and consumer choice in the private sector, and how public services will have to match that performance if they want to survive. I recommend that the author of that White Paper be added to the NHS task force. If the NHS wants what we think of as modern services—user-friendly systems, responsive staff, and attractive up-to-date facilities—then it will have to find a way to inject consumer choice and competition into its model. Thank you.

JAPAN

Koichi Kawabuchi, Chief Senior Researcher, Japan Medical Association Research Institute

Before I make my presentation, I would like to thank the Asia/Pacific Research Center for inviting me to speak. I don’t much like giving presentations in English, but fortunately we
have a prestigious professor from Tokyo here today, Professor Ikegami, and a government official from New York, Mr. Ihara. If you have any difficult questions, please ask them. [Laughter]

Today I would like to explain what has been going on in Japan’s health care field, from a micro and macro perspective. First, let me talk about Japan’s general profile. The country’s total population is 125 million—almost half that of the United States. Japan currently faces the serious issue of aging among its people: the rate of aging was more than 15 percent in 1997. The Japanese are workaholics, as borne out by the fact that 25 percent of those over 65 are still working. Both the mortality and fertility rates are low.

What about the structural analysis of Japan’s health care system? Who pays the costs? In fact, Japan follows a Bismarck model, as do Germany and France. People pay compulsory insurance premiums out of their salaries. Government subsidies cover approximately 30 percent, and the rest of the expenses are out-of-pocket.

The next question is, who gets the money? The hospital receives about 60 percent. In Japan, the term “hospital” includes clinics, which are health care facilities with approximately twenty beds. Clinics also provide ambulatory services. In the United Kingdom, these clinics are referred to as GPs.

The third and final question is, once paid, how is the money distributed? Fifty percent pays covers wages and salaries. Twenty percent goes toward medicine and drugs. The remainder accounts for medical supplies and other expenses. Cost containment continues to be one of the most serious health care issues in Japan.

Let me turn to the advantages and disadvantages of the Japanese health care system. Advantages include universal coverage, free access to health care, high life expectancy, low infant mortality, and low ratios of health care costs to GDP. Among the disadvantages are, first, the acceleration of health care costs due to the rapidly aging population. Second, there is little informed consent or disclosure of information. Third, lengths of stay in hospitals are long, approximately thirty-four days. Furthermore, the level of staffing is poor and there is a general tendency toward overprescription of drugs.

There is an increasing need in Japan for managed care. Providers have limited information to share with other providers. Consumers are increasingly demanding that health care data be disclosed. The deregulation and degradation of the health care industry points the way to managed care. For businesses, managed care presents great opportunities, including case mix index development, quality assurance programs, pharmaceutical benefit management, integrated delivery systems, disease management, and HMO/PPOs.

From a government perspective, a number of initiatives are called for; some are already under way. The Patient’s Rights Law must be enforced, and health care must be deregulated. A nursing care insurance system, like those in Germany and the Netherlands, was recently established. Co-payments must be increased, even though some economists doubt the effectiveness of such payments. The Japanese government is interested in research produced by the Rand Corporation, and in particular, was eager to introduce different pricing systems, as Germany and the Netherlands have done. Unfortunately, the pharmaceutical industry and Japanese medical associations put an end to these reference price systems, and the government has now turned its attention to a Japanese equivalent of the Diagnosis Related Group/Prospective Payment System (DRG/PPS) system sometimes used in the United States. Most people here are familiar with DRG, a kind of patient classification scheme, which may also be used as a global budgeting payment tool. It contains eight primary components: unit of payment, selection of categories, relative weights, base rate, adjustments, outliers, transfers
policy, and transition strategy. In Japan, the government would use DRG, additionally, to measure quality, comparing one hospital with another, using the outcome measures so crucial for health care industries.

In the United States, DRG/PPS is out of fashion, but it remains popular in European and Asian countries. Portugal, Italy, Ireland, Belgium, and Singapore use the DRG to allocate global budgets to hospitals. Portugal and Ireland are interested in the quality assurance utilization review element of the DRG.

In the last minute I have remaining, I would like to mention the results of my own research. I received a grant from the Ministry of Economy, Trade, and Industry (METI) to do this work, and I’m currently attached to the Japan Medical Association Research Institute (JMARI), which was founded two years ago. Briefly, I obtained data from forty-two Japanese hospitals—approximately 280,000 cases in all—which included, among other things, information about patients and patient costs. On its most basic level, my research indicates that there is significant variation among hospitals in terms of performance. In some cases, the quality of the data was difficult to measure. Nevertheless, we undertook various comparisons—such as the difference between charges (which refer to the revenue of the hospital) and costs (which refer to expenses). We also examined drug costs and consumption, where we again found considerable variation, and of which we need a more detailed study. We made comparisons between various hospitals, including municipal, public, and private, and here, too, the next steps require that we expand the study and obtain more data. Thank you.

THE NETHERLANDS
Hans Maarse, Dean, Faculty of Health Sciences, University of Maastricht

First of all I want to thank A/PARC for inviting me—it’s a great pleasure to be here.

The title of my presentation, “A New Round of Health Care Reform”, is revealing. We have some experience with health care reform in the Netherlands. We had a reform in the 1970s, which focused on extending state intervention in health care. We had another reform in the 1980s—the so-called Dekker or Simons Reform. At that time, Dekker was the former chief executive of the Phillips Company, and Simons was the state minister of health. Today, the minister of health tells us that the Netherlands is on the brink of a yet another round of health care reform. This is unexpected, because when the minister took office in 1994 she told us that she opposed to ideology-driven reform, which she viewed as a ticket to misery. She preferred a more incremental approach. However, now at the end of her second term, she says that we should reform our health care system.

I won’t go into extensive details about the Dutch health care system, except to say that although health care expenditures have grown since the 1980s, they have remained stable as a percentage of the national income, through to the present day. At first sight, reform in the 1980s was a failure. The Dekker Report identified four main issues that needed to be addressed.

First, there was a lack of effective cost control at the systems level. Mr. Dekker said that if we didn’t change the system, the system would change itself and we would be unable to curb the costs in the future. He also wanted to implement a number of cutback expenditures through the market mechanism. Second, there was a lack of efficiency. For instance, we had a fee-for-service payment system for physicians. Most care was too expensive and could have
been done in a cheaper fashion. Health insurance had no powerful interest in controlling the
cost, because all expenses were reimbursed through a central front, which caused ineffi-
ciency. Third, the structure of health care finance was fragmented. It's commonly believed
that the Netherlands has a single insurance system, but that is not true. We have one social
health insurance scheme for long-term care—the so-called “exceptional medical expenses”
scheme. We have another scheme for acute care. Thirty-five percent of the population is
covered by private health insurance. If you exceed a certain income level, you must opt out of
the social health insurance and purchase private health insurance. These different schemes
coexist, which prevents optimal allocation of money. Fourth and finally, there was too much
state intervention. For instance, obtaining a license to start a hospital could take ten years.

That was the 1980s scenario. What does the picture look like today? Many people,
particularly the hospitals and insurers, continue to state the importance of cost control. At
the same time, we see employers, along with politicians at the national level, saying that we
need to give up expenditure cuts and give more priority to investments and spending. The
lack of efficiency and the problems of fragmented health care persist, however. There is also
new emphasis on the issue of fairness. For example, if you have social health insurance, you
may pay even more than for private health insurance. The situation may be reversed if a
woman is married to a very rich person, yet she has a part-time job. She may still be in the
social health insurance scheme though she could afford to go private. Furthermore, we continue
to have excessive state intervention. Not a lot seems to have changed from a decade ago.

What is interesting about the current picture of health care in the Netherlands is that new
problems have cropped up in the past ten years. Primary among these is the issue of waiting
lists. Thousands of people must wait for their care, whether it be acute care (e.g., in
orthopedic surgery) or long-term care. Many people have gone to court and said, “We are
insured, and health care services should be delivered when we need them.” This is a sensitive
political problem, and the government faces significant pressure to combat waiting lists.
Another emerging problem is the growing emphasis on individual choice. We have some
choice—of GP, of hospital, and of medical specialists—but much remains standardized
under social health insurance. Where patients have no options, calls for individual choice are
growing louder. The government introduced some innovative programs in the 1980s and
1990s to rectify these problems.

The European Union has a general policy of supporting and increasing the free move-
ment of persons, services, goods, and capital across borders. This policy should also extend
to health care. But if you look at the Dutch, German, Belgian, and English systems, it’s easy
to see that there are many obstacles to cross-border care. The European court of justice
recently ruled that these obstacles be removed, which led to discussions of Dutch health care.
These discussions concluded that it remains difficult for foreign hospitals and insurers to
enter the Dutch market.

The Dekker–Simons Reform contained an important proposal for a mandatory single
health insurance scheme, plus a voluntary complementary health insurance scheme. The
scheme was paid through income-dependent premiums set by the state, and flat-rate premi-
ums. These flat-rate premiums were to be determined by the insurers themselves. Everybody
was talking about managed competition, and I remember Professor Enthoven gave a lecture
to a packed house somewhere in Rotterdam at about this time. There was also a significant
emphasis on what we call the “contract model.” The insurers contracted with hospitals and physicians on prices, volume, and quality. Their agency function had to be strengthened. Finally, the role of the state was redefined. There was talk about the need for state withdrawal, but looking back, it’s clear that the state has withdrawn very little since then.

What will the new reform bring? Personally, I don’t think that we will get a basic single health insurance scheme. However, we will see a continuation of the universal insurance program for long-term care, through the so-called Exceptional Medical Expenses Act. But this is not the whole story. We will also see a reduction in the services package under this program. Many additional services have been brought in over the years and now we are discussing how to reduce the list of benefits. Universal insurance will be paid through income-dependent premiums. One of the reasons that this program will continue, we are told, is that the private market has a stake in it. We are talking here, for example, about psychiatric care, care for people who are mentally retarded, or nursing home care. All of these are truly long-term in their care structure.

With respect to acute care, a basic health insurance scheme will be introduced, which will erase the traditional distinction between social health insurance and private health insurance. We will have a single program. Of course there will be controversial issues. Should the package be small or comprehensive? What should the premium structure look like? Some people say it should be income-dependent, whereas others affirm that only a small part should incorporate income-dependent premiums, and the rest should employ a flat rate, so that the insurance can compete. There should be much more room for complementary health insurance under this plan, so many services should shift from the long-term and acute programs to voluntary health insurance. People can decide for themselves whether they want to purchase voluntary insurance or not.

Greater emphasis must be placed on competition among providers and health insurers. In the 1980s, politicians and policymakers at the central level advocated managed competition. Today, the people who favor competition are hospital managers and insurers. Medical associations are silent on this point. The role of health insurance must be upgraded if individual choice is to increase. We should stop our defensive strategy toward new private providers. For instance, I am the chairman of a home care organization. We work under social health insurance but we also have a private organization, which does everything that has been forbidden from the social health insurance. There is a market for this new private initiative, and many others are following in its footsteps.

Although health care reform in the Netherlands in the 1980s was not a success, some important changes were implemented. Is there any reason, then, to believe that health care reform will bring more change in the future than in the past? We still have very visible problems. In the 1980s, efficiency and cost issues were not a huge concern for ordinary people or managers. Today, both are more involved. The social landscape has also altered. We have more wealth, and there is a corresponding need for greater freedom of choice. The correlation between the wealthy and the degree of their freedom of choice has recently sparked considerable analysis. Employers, too, have become important consumers in health care markets. Most people in the Netherlands buy health insurance on their own, so there is no role for the health insurer. But that will soon change. Employers want to reduce medical waiting lists, because absent employees on waiting lists cost companies large sums of money. Employers have even begun to contract with private centers to keep their employees healthy and at work. For instance, for ambulatory mental care, employers can now have their employees treated immediately.
We have had a substantial change in health care finance delivery over the last decade, during which time market competition lost much of its ideological content. As the European Union continues to stimulate market competition in health care, new rulings of the European Court of Justice will force not only the Netherlands but also other countries in Europe to open their health care system for foreigners. We need to put an end to these cartels, which are abundant in each of our health care systems. Thank you very much.

NEW ZEALAND
Roger Bowie, CEO, Southern Cross Healthcare

Thank you very much. New Zealand’s health system is 8.2 percent of our GDP, which is around NZ$2,000 per capita. New Zealand has a dual system that has evolved over fifty years. Our public spend is 77 percent, our private spend 23 percent. Interestingly, Southern Cross did some work on this a couple of years ago, and discovered that New Zealand was in the mean of the countries of the Organization of Economic Cooperation and Development (OECD) in terms of public and private spending. All the other countries are actually regressing to the mean. Primary care in New Zealand is mixed between state funded fee-for-service—which is targeted, in the last ten years, on a socioeconomic basis—and GPs’ ability to charge at their own discretion. Secondary care, on the other hand, is segregated. Public is public. Private is private.

New Zealand’s dual system has a number of negative features. Many cross-subsidies exist, particularly with respect to payment to doctors. The private sector has historically paid doctors and surgeons much more than has the public system. Conversely, private sector hospitals have cream-skimmed. There is little infrastructure in the private sector in the areas of acute or tertiary care, although that is changing. As a consequence, both sectors have overinvested. The private sector overinvested by force of competition, and the public system by force of political pressure. I want to repeat what Alain Enthoven described in the United Kingdom, because it also applies to the New Zealand case. Subtly led by the profession, hospital-dominated in terms of the physical infrastructure, the system, over time, has been fundamentally provider and not consumer-driven.

In this context, Southern Cross is a mutual not-for-profit friendly society established in 1961. We have three branches. The Medical Care Society is the first, and biggest part of the group, which focuses on indemnity. I must stress that this is gap insurance—which focuses mainly on elective surgery—as it exists the United Kingdom and Australia. It is not total risk indemnity. What is different from Australia and the United Kingdom is that gap insurance also covers primary care, thus our health plans cover both major surgical risk and health maintenance. Our second branch is in health delivery, which is about 40 percent of the capacity in the private inpatient sector. Our third branch consists of a subsidiary of the trust in which we engage in many other activities, such as travel insurance. A year ago, New Zealand deregulated worker’s compensation from the state-funded, social insurance, no-fault accident insurance scheme. A year later, it was renationalized. Southern Cross played in that market for a year by introducing case management to our portfolio of health care delivery capabilities. We also did some research and development (R&D) through this vehicle. In New Zealand dollar terms, Southern Cross is a reasonably large organization; in US dollar terms, we are small.
Like most of the countries presenting today, New Zealand went through an extensive process of reform in the 1990s. In the 1980s, elected area health boards delivered health care. This is a case in point for what Alain Enthoven mentioned earlier; poor information, poor decision-making, and lack of accountability and objectivity.

The 1992 Reforms signaled the arrival of market forces. If New Zealand’s reforms were not designed according to the work that Professor Enthoven had done in the United Kingdom, they were certainly inspired by it. The funder–provider split was introduced. Four regional health authorities were established, and tasked with purchasing based on last year’s costs, minus 5 or 10 percent. We, too, were an information-free zone at that time. Public hospitals were corporatized in theory. In practice, however, little was contested in the purchasing environment between public and private providers. General practitioners in the primary care area were encouraged to make and create capital from newly instituted budget-holding contracts. Most of the GPs joined an IPA (independent practitioners association) to do just that. Today, about 70 percent of all GPs belong to an IPA. Targeted subsidies were introduced, based on socioeconomic, age, and utilization criteria. The final feature of the 1992 Reforms was a promise to define the core service. The whole system was set up, at that stage, to allow people to opt out. Regional health authorities were organized, ostensibly, to become insurance companies, but given the cultural issues surrounding privatization of the health system, that purpose was never explicitly described.

On the positive side, the 1992 Reforms brought about huge improvement across the board in the public and private sectors’ accountability and quality of information, though the latter remains heavily fragmented. More objectivity exists within the system, as does an acceptance that public systems cannot live beyond their means. There has also been considerable public debate about the inevitability of rationing. I sometimes think though that one tends to use the word “rationing” when “rationalization” would be more effective in the short term. An awareness and acceptance of the sanctity of contracts, which was totally absent in the 1980s, has increased. Consistency, integration, and equity across geography have also improved, particularly in terms of indigenous population and service lines.

On the negative side, the 1992 Reforms were introduced and managed with a spectacular lack of finesse. If you introduce change in a business context, I think we’ve all learned that the people issues are the most important, and that governments often deal poorly with culture. As a result, doctors felt hugely disenfranchised and battles ensued between doctors and managers. An adversarial atmosphere between purchasing and provision exacerbated the cultural issues. There was political mischief and disenchantment with the notion of profit. The hospitals were set up to make a profit. None of them ever did. As a result, that idea was softened by the introduction of a capital charge. This charge was the main point of contention because the prevailing belief at the time was that capital was free, and one didn’t need to embrace the full profit model. There were many cost shifts and the private insurers particularly suffered from them. In the end, the definition of the core services was deemed too hard, and so we are unfortunately left with uncertain parameters of what is or is not covered in the public system.

At the same time, the private sector’s gap insurance system was at risk. Fifty-one percent of New Zealanders had some form of insurance at the beginning of the decade, but only 33 percent had it at the end. Why? Put simply, for all of the reasons one sees in indemnity systems worldwide—lack of honesty about the definition of what is provided, by the government health plan and consequently consumers’ lack of understanding and perception of risk before they need access. Southern Cross had to respond dramatically to these
problems, which threatened our survival. We’re now about halfway through the process. We have a new mission to achieve greater access to better health care. With advancing technology and an aging population, we need better health care in the context of more best practice, and reduced variation in the way medicine is practiced.

Recently, some delegates from Kaiser Permanente came out to work with Southern Cross. In particular, Bruce Bowen, one of the leading proponents of risk-adjusted pricing, helped us to outline funding streams. We put together a chart, which we sent to the Ministry of Health. They spent two weeks on it and felt proud about adding a few points, but it’s essentially as we submitted it. Our system’s primary problem is that the funding streams are fragmented. What plagues us in New Zealand is that everybody has more than one insurer, and so risk managers spend considerable time avoiding risks being shifted from one to another. In the American system, by contrast, one can associate all the risk with the individual and work proactively to improve their health status. Another insidious feature of the New Zealand system, however, is the uncertainty over whether people are adequately covered or not. We cannot accurately say, for example, that 15 percent of our population is uninsured. We just know that a lot of our population is underinsured.

We are working on these problems. A couple of years ago, we made a bold attempt in conjunction with a particular community called Marlborough, one of New Zealand’s many Napa Valley-type regions. Marlborough started off as a community of people who were up in arms about the threat that their hospital would close. After a while, they realized that retaining services was more important to them. So they made an effort. They saw that the government was encouraging innovation at this time, and they decided to take responsibility for administering the public health plan effectively in their own backyard. They stated that they didn’t want bureaucrats to run the fort, and Southern Cross stepped up to help. Here’s what we told them. You will undoubtedly succeed, because you’ll start by integrating service delivery. But then you’ll undoubtedly fail because as you succeed, the expectations of your population will grow. Your premium will come down, because the government will risk-adjust you and allocate more money to less innovative areas. To prepare for this chain of events, you not only need help defining and building the infrastructure to control your health system locally, but you also need a system with capacity to provide new funding streams when the money runs out and people’s demands move from need-based to want-based. Thus, the concept of a three-tiered set of plans emerged.

Southern Cross designed a consumer mandate model with an elected local board; it was also to be a 50 percent joint venture owner of the system’s management organization. Through all this work, we were able to build, with significant community support, a compelling business case. Unfortunately, it didn’t get through to the bureaucrats, and the community lost sight of its larger goal. A number of smaller projects were founded instead, which then moved toward integration. But the slower you go, the easier it is to lose sight of the big picture. Interestingly, our major competitor started a similar program, which was very provider-focused. Whereas Southern Cross concentrated on the consumer and the community, they worked through an IPA. We had marketing and communication experience, and suffered doubts on the provider side. They had significantly more clinical risk experience and faced doubts from the community side. We both ended up in the same place, which is the tragic part of this story.

New Zealand missed out on the experience of two similar but distinctive models of integration. One would think, when you run a business and you have a dilemma about the best way to do something, you often create opportunities to innovate and harvest the results.
Unfortunately, our government and our bureaucrats were unable to do that. Since that time, the situation in New Zealand has changed yet again. We have a center–left government trying to turn back the clock to old concepts of an efficient, effective public sector monopoly managed by local elected boards. Collaboration—not competition—is the key. There is no room for foreign-owned and private insurance interests. Their attitude to a locally owned mutual is unclear, but interestingly enough, they are now pursuing a model not unlike the one we devised for Marlborough. Of course there are some issues with their interpretation. Most notably, they are effectively dismantling the funder–provider split, which we think is dangerous. Our competitor, with their primary care networks, has transformed those networks to resemble our Marlborough model more closely, to render them more acceptable to the new government. Regrettably, our Marlborough Trust will probably disappear because it will become part of the district health board, a much bigger geographical entity.

In conclusion, New Zealand’s health sector has made considerable steps toward embracing market forces. Nevertheless, resistance to change in the dual system—both in the political arena and the health care profession—have conspired to limit further progress in the short term. What, then, are the main issues that we face? One, that it is difficult to transform a state system into a mixed system. Two, that it is difficult to introduce managed competition from a monopolistic perspective. Three, that ideology gets in the way. One wonders how ideology will compete with choice and consumer empowerment in the Internet age. Four, that the resistance to change is perennial. Given these obstacles, even more questions arise. If one is to pursue managed competition, how many integrated care organizations can New Zealand effectively support? How do you implement such a structure? Through a big bang, or a small integration approach?

It is a great pleasure to come to a conference such as this, and to hear challenges faced by others around the world. One returns home from these meetings with a dose of the one virus which we hope the health systems will never cure—the disease of optimism. Thank you very much.

SCOTLAND
Harry Burns, Director of Public Health, Greater Glasgow Health Board

I’d like to thank A/PARC for the invitation to this conference. It has been absolutely fascinating and I’d like to thank particularly yesterday afternoon’s speakers for their candor. It was interesting to me to begin to understand why managed care has attracted so much press in the past few years. I was disappointed, though, by the comments about the failure of the system in America and the clinical quality issue. I’ve been in the clinical quality game for seven or eight years, and all my gurus have been from this side of the Atlantic. It’s striking to find that the emperor doesn’t have as many clothes that you thought he had.

Most of my talk will focus on clinical quality, because I think there are a number of ways—clinical quality paramount among them—in which the health care system in Scotland is diverging rapidly from that in England. The issue of clinical quality is also relevant to what we heard yesterday. First, I’d like to give you some idea of what it’s like to work in the NHS. If you can tell something about a health care system by the structures that surround it, then clearly health in the United States is a commodity, because it surrounds itself with the structures and the language of the market. Health in Britain is a government service, exclusively driven by government and politicians. Every other public service in Britain is
local, including politicians, education, the fire service, the police, housing, and transportation. All of these fall under local government. Health is the only service that goes straight to the top. There are difficulties that appear every winter, as Professor Enthoven mentioned, and the government ministers and the prime minister get upset about them. We in the NHS are under intense political scrutiny.

The big event in Scotland over the past year has been the advent of a Scottish Parliament. Scotland lost its last parliament about seventy years before the American Declaration of Independence. Now, almost three hundred years later, we have our parliament back. Before we had that parliament, we had one part-time minister but a Scottish health minister always had two or three portfolios. He was never in Scotland because he was always in Westminster. That was a key point. We had only one parliamentary committee scrutinizing health, and it covered the whole of the UK. The secretary of state for health in England largely dominated the agenda, even though we received the committee’s policies with a suitably tartanized cover.

As of July 1999, in addition to the members of Parliament (MPs) that we send to the UK Parliament, we now also have 129 members of Scottish Parliament (MSPs). We have twenty-two ministers and two full-time health ministers. We have one Scottish health committee that is actually in Scotland all the time. And we have a medieval creation called the Public Petitions Committee. Remember how the king would sit before his people and the commoners would petition him? That’s the Public Petitions Committee. If anyone doesn’t like what, say, the Greater Glasgow Health Board, plans to do about a clinic, they can go to this committee and order an investigation. We have already felt that sting.

Health is a major budget item in the Scottish Parliament. A crucial difference between Scotland and England is that in Scotland, health care funding is 23 percent per capita better than in England. We are very close to the European average as a percentage of GDP. Therefore, we don’t have many of the waiting list problems, or winter bed pressures they see in England. Scotland’s biggest budgetary item is political scrutiny. I personally blame Mel Gibson and the makers of “Braveheart” for all of this. [Laughter] It’s worth noting, though, that the first thing that the parliament did when it arrived was to vote itself £50 million to build a new parliamentary building. Those in the know said, “You’ll never do it for £50 million, it’ll be £100 million.” Well, those in the know were wrong—at last count, the number was up to £200 million and rising. And frankly, this situation describes, fairly accurately, what it’s like to be in Scotland just now.

Health policy in Scotland has two major thrusts. First, it seeks the improvement in overall health status, with a particular emphasis on the health of the poor and economically deprived. Second, it encourages collaboration, not competition, to end the internal market and return to command and control. The present Scottish Minister of Health has threatened to bring all the trusts that are presently independent legal entities back under the government’s control if they don’t get their act together quickly. This reminds me of the days before the fall of the Soviet Union, because it used to be said that the British NHS was the second biggest employer in Europe after the Red Army. The only difference between the two was that the Red Army was a more caring and considerate employer.

As for the question of variations in health care, we have a very accurate system for establishing socioeconomic status, based on post quoting of sectors in which people live. Category One is the most affluent—the average life expectancy there is seventy-seven years. People who live in Category Seven areas—often just a few hundred yards away from affluent Category One neighbors—live ten years less. This is significant. In an international context,
deprived people in Glasgow have the same life expectancy as those in Central America. Affluent people in Glasgow have a high life expectancy by most developed standards. The government wants the Greater Glasgow Health Board to change that, and we’re struggling to learn new epidemiological skills. We have, for example, to begin to model the impact of new roads, new employment opportunities, and new housing opportunities on health.

I’d like to discuss two tools for improving quality. The first is clinical governance. Clinical governance is a new concept, which has been brought into the health service in England as well as Scotland. It is defined as corporate responsibility for individual clinical performance. Every clinician, nonmedical and medical alike, is responsible to the chief executive of his or her organization for the standard of clinical practice. The chief executive is now legally accountable for clinical standards, and can theoretically go to jail if a given clinician behaves improperly. To help integrate services, a whole range of other tools is being brought in, including health improvement plans and a joint investment fund.

The second quality improvement tool I’d like to mention is managed clinical networks. These networks refer to clinicians with a common interest in a single clinical problem, working across institutional boundaries. These networks create a system that fosters multidisciplinary care of patients. Likewise, they strengthen peer review of clinical outcomes and processes, and give the entire process some impressive teeth to change the way individual clinicians perform. This clinical governance structure, which is represented at an institutional level by a committee reporting to the board, receives reports from the managed clinical networks about how that institution’s doctors are performing. In this respect, we in Scotland are witnessing the development of a bottom-up, managed care, disease management approach that may lead to radical changes in the way the NHS delivers health care.

I have responsibility for cancer in Scotland and delivering changes to cancer care, so I’d like to talk about managed clinical networks in the context of cancer. Professor Enthoven eloquently told you about some of the public scandals that have hit the NHS over the past few years. Scotland’s Minister for Health told me to make sure that no cancer scandals arose in Scotland. So, two years ago, I was given the very focused task of identifying an adequate clinical practice. In the course of my work, I sought to understand how we can do our existing work better and make sure that everyone involved continues to improve quality. Crucial to this goal was getting the data infrastructure right, so that we are publicly accountable for what we’re doing. Today, the managed clinical network for cancer care brings together, on a tumor-specific basis, all the doctors who treat a given cancer. In the west of Scotland, for instance, all the surgeons, physicians, clinical oncologists, and radiation oncologists who treat, say, lung cancer, are part of the lung cancer managed clinical network, regardless of their hospital or institutional affiliation. We’re also adding in the various other professions, including nurse specialists, pharmacists, and physiotherapists.

What do you do when you’re in the managed clinical network? Prospective audit of care is compulsory. No audit, no cancer treatment. If you do not provide a full audit data set on every cancer you treat, you will be stopped from treating cancer. That’s agreed by ministers at the highest level. In addition to prospective work, you must contribute to regular review of audit results, which means sitting down with your colleagues and talking about what those results mean. And you provide feedback on the audit to the trust clinical governance committees. For example, the west of Scotland breast cancer network will write to its trust executive and say, in the past year your hospital has treated 150 breast cancers, but we only have audit results for 140 of them. We have reviewed those and they have been treated to an
acceptable standard, but the other ten cases have been treated by Dr. So-and-So. We suggest you find out what he's been doing with them. There are also prospective reviews of the latest medical evidence. Evidence-based medicine is alive and well in Britain, and it is being led by the doctors and the Royal Colleges of Medicine. There's a real appetite to participate in guideline development, and we ask the networks to be open to contribution to clinical trials. If your network contributes to a clinical trial underwritten by a national funding body, that's an important external mark of quality assurance.

The Greater Glasgow Health Board started off this year by setting up four cancer-specific networks—colorectal, breast, lung, and ovarian cancer—across the west, east, and north of Scotland. We are not yet saying who’s in the network and who’s out. At this stage we probably do have sufficient data to make choices, but we want to get buy-in from the clinicians. We want these networks to be inclusive; over the next two or three years it will become apparent, based on the data, whom we should exclude. The trust managers who hold these clinicians’ contracts know that they’ll have to change their contracts to get them trained to do this work.

We have evidence that this approach works. Professor Enthoven talked about the NHS as an information-free zone and he’s right, but he’s only speaking about England. Those of you who don’t know Britain should know one essential thing about England, which is that Scotland’s better. We have better weather, better beer, better golf, better sailing, and better health care data, and that’s all you need in life, isn’t it? In 1993, the Greater Glasgow Health Board conducted a study of Glasgow’s five teaching hospitals, which reviewed the survival rate of breast cancer cases treated between 1982 and 1988. Survival was risk-adjusted for histological type, for stage at presentation, and for a range of other factors, which allowed us to determine relative hazard ratios. Our results showed that if you had your breast cancer treated in hospital one you were 17 percent less likely to die within five years than if you were treated in hospital five. At hospital five, you were 40 percent more likely to die within five years. After considering these data, we wondered what to do. By rights, hospital five ought to be out of the breast cancer business, and all the attention should be diverted to hospital one. In fact, we decided not to take that approach. Why not? Our only goal was to improve care for patients, and we concluded that the best way to achieve this was not to divert cases, and instead to use this information to change the way doctors practice medicine.

Since 1993, a number of changes have taken place in this arena. First, we encouraged the doctors to create a network to do prospective audits, and to design their own guidelines. The process has changed quite a bit. For example, histological grade was routinely not reported in three out of the five hospitals in 1987, but it was reported almost 100 percent by 1996. Through this technique, clinical processes have begun to emerge. Clinicians get together and talk about what they’re doing. I often go along because sometimes we go for a beer afterwards, and it’s nice to see old colleagues. I drop in to let them know I’m still interested. In one six-month review of data, it became apparent that hospital three suddenly wasn’t giving radiotherapy to a large proportion of its patients following conservation surgery. The clinicians talked about it. In this case, 22 percent of their patients were going into a clinical trial but they concluded that the number of patients who weren’t in the trial and were still not given radiotherapy—17 percent—was unacceptable. The next six months’ worth of data showed that hospital three was back up at the same level as all the others. These discussions are nonconfrontational. People don’t lose their jobs, but clinical quality is maintained. And so far, the clinicians like the process, because it gives them power over their own clinical
practice. Even the regional groups are starting to open up these sorts of dialogues. Interestingly, however, the NHS managers don’t like these clinical roundtables, which require them to manage clinical processes, not institutions. NHS managers like bricks and mortar. They like managing the laundry and the heating and the catering, but they don’t like managing clinical care. Nor do they like the doctors having more power.

The Greater Glasgow Health Board has had a number of good successes in orchestrating and managing all this change. Notable among these is linear accelerator procurement. Part of the problem with a market system was that capital wasn’t free any more. Health care trusts avoided bidding for capital for big-ticket items because it would cost them more. A twelve-year-old linear accelerator was fully written down and it didn’t attract any capital charge. Suddenly you spend £1 million on a new one and you’ve got extra revenue requirements. Much of the inventory was consequently past its sell-by date. I organized decision-makers in the networks, and took them to see the director of finance at the Scottish office. We told him that half of the Scottish linear accelerators were out of date, and asked what he planned to do about it. He said, “Would £12.5 million be enough?” The clinicians were amazed. We’ve now replaced all the networks’ linear accelerators for £7 million, and we have a kitty of £5 million that they can spend on other things. The clinicians are delighted, and they are driving the system in a way that managers failed to do.

In generating managed clinical networks, we’re beginning to see something akin to a staff-model HMO. I believe that the next stage of development will be a budgetary carve-out for cancer. This is already a reality for oncology drugs. We know exactly what proportion of breast cancer patients receives expensive chemotherapy and what proportion doesn’t. The next calculation is what added value can be derived from giving it to them. We began to offer that data to the minister of health, to tell her that if she wants everyone to get these drugs, it will cost this much, and these benefits will result. We couldn’t do that under the old institutionally based system, because institutions were protective of their data.

The crucial element that could slow or stop this health care reform is the absence of management talent. There are simply not enough managers with vision, who to see this process as a new way of managing health and changing the pattern of care in Britain. Cancer, interventional cardiology, cardiac surgery, and peripheral vascular disease are all under way. There is also an exciting new program—a powerful system available over the Internet—called the Darts Project. It’s taking place in Dundee, and is aimed at managing diabetics. The publicly available part of the project provides, over the Internet, a lot of excellent patient information. The private part is comprised of patients’ daily data and blood tests, to which GPs have access.

In conclusion, let me say that if we hope to capitalize on our good data systems, we will have to use them to improve clinical care. With luck, these systems will bring about a radical change in the way we manage health care. We need a system more like managed care with clinicians very much in charge. Thank you.

SINGAPORE
Choon-Yong Loo, CEO, Raffles Medical Group

Thank you. I’m tempted to say that I agree with what everybody has said previously and just sit down. [Laughter]
Today, I would like to share with you a few general thoughts about health care reforms in Singapore. Singapore is known, among other things, for its active, problem-solving government. Sometimes we even have solutions with no problems, and we are currently exporting some of these solutions overseas. [Laughter] Singapore is an ex-colony. Since our independence in 1959, we have essentially followed the British system. We have a national, cradle-to-grave kind of health system, with a tax base administered through a ministry of health. The government is everything to everyone, including regulator, funder, and dominant provider. Private sector facilities are confined to general practice clinics and one or two small hospitals that cater to expatriates, and those who can afford it.

The public sector had long queues, impersonal service, dissatisfied staff, long waiting lists for elective surgery, and a chronic loss of well-trained manpower who moved to the private sector for better pay and better career prospects. In the early years of our independence, from the 1960s to the early 1970s, practically all of the management talent and all the resources focused on economic development and defense. Very little effort was put into reforming our health care system, which ticked along in maintenance mode. Fortunately, the population was relatively young and Singapore, as the hub of the British Empire in the Far East, actually enjoyed good sewage, drainage, mass immunization, mosquito control, and treated water systems. I think all of these factors helped the country to control costs. The government, then in its infancy, did not have to spend much money on public health, and health care costs were in any case acceptable in those early years—only about 2 to 3 percent of the GDP. Then, the economy was small.

The big reform took place in 1982, when the National Health Plan was introduced by our present prime minister. By that time, after about a decade-and-a-half of double-digit growth, the government had a chance to look at health care. It saw that health care costs were rising and that something had to be done. The National Health Plan began to talk about a public system in which people would help to pay for their care. There would be a co-payment system to eliminate future strains on the budget. The newspapers were also full of talk about preventive health care and health promotion. The most important reform in Singapore in the last fifteen to twenty years was reassessing health care financing. In a moment, I will describe what we call the three Ms: Medisave, a medical savings account for all working persons; Medishield, a catastrophic universal insurance that is very cheap; and Medifund, a social safety net that looks after the very poorest people.

Since 1985, the Singapore government has been restructuring the health care system. They began to empower the hospitals, hospital managers, and CEOs—giving them greater autonomy in hiring, firing, and changing some of the policies—and reorganized public hospitals to be more responsive to both the marketplace and to patient needs. A whole slew of national centers, such as the national skin center and the national blood center, were examined and altered one after the other. The restructuring exercise actually extended beyond financial and management control.

With economic growth, the government was also able to afford a whole new health care infrastructure. Today, some of Singapore’s public hospitals look better than the private ones. I’m in the private sector but I speak as if I’m part of the government. A problem arose, however, when hospitals were given independent boards, independent CEOs, and liberal funding. They each had their own vision, and there was a lot of competition, which resulted in waste, duplication, and fragmentation. Now, we are reining these groups back in, and creating competition. The government is trying to integrate primary, secondary, and tertiary care more sensibly, and I think these steps will yield results after the initial change.
1993 was an important year in Singapore’s health care system. For the first time, due to the drastic restructuring, people were coming home with hospital bills of not tens or hundreds, but thousands of dollars. There was tremendous public disquiet. The Ministerial Committee sat down and reviewed all the policies and re-established the government’s commitment to promote good health and personal responsibility for good health, and to provide good, affordable, basic medical services. The government also focused on competition, and the need for market forces to improve services and raise efficiency. Finally, it also decided to intervene directly in the health care sector only when necessary—such as when the market fails—to keep health care costs down. Remarkably, the government guaranteed all Singaporeans access to affordable basic health care services.

Singapore’s government reaffirmed its intention to control health care costs neither as a totally regulated national service, nor as a completely laissez-faire system, in which providers have full freedom to organize the enterprise. The government envisions more of a hybrid system, comprised of three levels of providers. First, hospitals are subject to controls in key areas of pricing and operations. Second, private sector patients using Medisave are subject to controls on amounts above reimbursement limits. Third, private sector patients on their own are subject to minimal controls. Across the board, there is one more or less one unified national health insurance system.

In 1994, after the 1993 White Paper, Singapore implemented the Private Hospital and Medical Clinics Act. Before this, practitioners had been registered under the Medical Registrations Act, and there was no regulation of clinics or hospitals. Once and for all, this act licensed hospitals, clinics, and empowered the government to require minimum standards of quality, audit, and transparency of professional fees and hospitalization fees. As a result, there is now extensive counseling before a person is admitted to the hospital. Evidence must be provided, and the hospital and patient must sign a contract. The hospital actually counsels the patient, and the patient agrees to be counseled.

In 1997, Singapore realized that a problem was emerging with the growing population. An interministerial study was set up, as usual—a technique we learned from the British. Every time we have a problem, we gather together a few ministers to study it and then form a committee, which will eventually produce a report. Singapore’s population issues are especially worrying because of their demographics. The baby boomers are all retiring. As in other developed countries, we have a low fertility rate. Our women prefer not to produce too many children. Now we have another interministerial committee to promote a greater birth rate and to convince women to have more children.

Today, in the year 2000, Singapore has begun to register traditional Chinese practitioners, such as acupuncturists, along with others who practice alternative medicine. They have often been treated as if they don’t exist, but the government knows that patients visit the traditional Chinese medicine practitioners before they see a Western-trained doctor. Given this fact, these practitioners will be registered, and they will be regulated.

What effects do all these changes have on consumers? Simply put, consumers are not unhappy. Of course, as costs shift, there is always outcry about being asked to pay more for health care. In Singapore, we have a saying: Nothing is free. Sometimes it seems that, as citizens, all we do is pay taxes and co-pay for education, health care, and housing. In Singapore, the government is keen that there be an even larger shifting of cost. People are prepared to accept it because they have been doing better, and can afford more as a result of economic growth. In 1992, the National Trade Union responded to rising health care costs—which, incidentally, the government created by reducing subsidies—by starting to run
pharmacies and to introduce managed care to Singapore. Since then, managed care has grown very little. With an overall population of three million and a working population of one million, only 60,000 people in Singapore belong to an HMO plan. Raffles alone covers 30,000 of those lives. People are not interested in managed care because of the full employment that exists in the country. The health care costs are about 2 percent of the whole payroll. When translated to operating costs, that number represents less than 1 percent of the total enterprise cost—the cost of doing business. Employers tend not to want to change the system in a way that will upset the workers and cause employee attrition, which is even more costly. As for the effect on providers in the public and private sectors, they will have to compete with one another, as well as with the government. The new health minister prefers that more patients go voluntarily to the private sector, so that their coverage will be off his budget.

Singapore faces a number of health care challenges. We must provide the right level of service and financing for a growing population. We must maintain the level of subsidy as economic growth plateaus and slows down, and preserve cost efficiency for a more informed and increasingly vocal population. We must retain trained manpower and skilled staff in Singapore within the public sector. Finally, we must encourage academic training, research, and development in the quest of cost efficiency and subsidy reduction.

In my last few minutes, I’d like to give you an overview of Singapore’s three Ms—Medisave, Medishield, and Medifund. Our national health care expenditure is about 3 percent of the GDP. The total amount is about four billion Sing dollars, or about $2.5 billion of the U.S. government expenditure. How does the government spend this money? Seventy-five percent of it goes to hospital services. The government provides 80 percent of the hospital beds, but in the primary care sector, the government actually provides only 20 percent of the capacity—there, the remaining 80 percent is provided by the private sector. Moreover, 42 percent comes from out-of-pocket payments for primary care. Employers don’t provide coverage, so people must visit a private GP and pay from their own pocket.

Medisave is the medical savings account. Introduced in 1984, it is an integral part of our compulsory public sector, social security system. It is a universal medical savings account. Everybody has one, and the whole idea is to cost-share among the people. Money can be pooled for use by immediate family members. You can pool your Medisave with your children, your parents, brothers, and sisters. Medisave is a Chinese-style family—it enables people to look after one another. Medisave comes from 20 percent of the compulsory savings portion (like social security) of employee wages. In addition, 10 percent of employer wages is contributed to the account. Previously, this number was 20 percent, but because of Singapore’s recession and the Asian financial crisis, the government cut 10 percent of costs from all employers.

The central Medisave fund, appropriately, is called Medifund. Twenty-four percent of each person’s account may be invested; 6 percent comprises the medical savings account. Medisave can be used for hospital bills, and for limited outpatient care. It can also be used for the Medishield premium. The Medifund money contribution is fixed at an income level of $6,000—the average person in Singapore earns about $1,000 per month—so 6 percent works out at about $360. The accumulation maximum is $25,000, and Singapore’s retirement age is 55. So you are supposed to keep a minimum balance there. Some of the money may be withdrawn upon retirement, but a minimum balance must be kept to cover the patient’s part of the fees when he or she goes to a government hospital. Some employers are encouraged to contribute to Medifund.
Medishield is catastrophic insurance, created on a voluntary basis. Because it is voluntary, many elderly poor—about 61 percent of this group—are opting out. Soon the government may make the program compulsory. The program is affordable, and it provides a safety net—a social security system for times when patients cannot afford care. If you cannot afford to pay for your health care, Medishield will cover your costs.

The three Ms are an interlocking framework, which allow for the reduction of reliance on budgetary resources. There is no intergenerational transfer, so people are actually using their own money. Thank you very much.

CLOSING REMARKS
Daniel I. Okimoto, Professor, Department of Political Science, Stanford University

Thanks to the panelists and to you, the audience, for your participation in this conference. We have had an exceedingly fruitful dialogue throughout the day. In these closing remarks, I would like to highlight some of the central issues and themes that emerged both in the panel discussions and in the questions that were asked afterwards.

There are ten. The first, of course, is the issue of efficiency with respect to medical services and financial assets. How can health care services be provided more efficiently? This leads to the second major issue: cost containment. The challenge of containing the cost of medical services is one that all advanced industrial countries must address, given the aging of their populations. The third theme is that of ensuring accountability and transparency. How do we improve these aspects of health care? The fourth point, which was not addressed systematically, is the problem of organizational dysfunction, particularly organizational fragmentation and segmentation. The fifth task is enhancing the quality of medical services. The sixth task is making sure that there is healthy competition, especially as it relates to the division of labor and specialization of function. Are the barriers to entry for new actors low enough? Are there market niches that can be more efficiently provided by new players? Will this competition stimulate old actors to become more efficient? The seventh point is dealing with the problem of path dependency. How do we overcome deeply embedded problems in the existing institutional structures of various countries? Eighth is the relevance of ideology, with respect to the government’s role in health care. Ninth is the legal framework, which ranges from a system like that of the United States—where cases of medical malpractice are common and trial lawyers represent a powerful interest group—to that of Japan, where malpractice lawsuits are less common and lawyers play a far less salient role. The tenth theme may be the most important of all—the impact of different political systems. I’ll turn to this topic later.

Having identified the ten major issues, let me hasten to add that the solution that everyone seems to have identified—insofar as there is one—is the availability of accurate, comprehensive, and up-to-date information. The tasks of cost containment, accountability, efficiency, and so forth, are closely tied to the availability of high quality information—its accuracy, accessibility, and speed of transmission. David Apter has formulated a theorem in political science. It states that there is an inverse relationship between coercion and information. That is, under a coercive political regime, the availability, accuracy, and flow of information will be severely restricted. If, on the other hand, there is a free flow of information, a coercive political regime will be difficult to maintain. This inverse relationship might be extended to the concept of organizational hierarchy. But the theme of high-grade and free flowing infor-
information—its value and indispensability—ran through all of yesterday and today’s discussions as a key part of the solution to the ten tasks enumerated above.

Those political systems that have successfully adopted market institutions and incentives appear better positioned to address the ten major tasks associated with the provision of health care services. However, market-based structures and processes face the dangers of market failures and distortions. We could have focused more attention on the problem of market failures, especially where they are likeliest to occur and how they might be prevented. Another area that generated little discussion here, but which lies at the heart of political science, is the balance of power and competition among actors in a given policy arena. In the health care policy arena, the relevant actors include doctors, hospital staff, bureaucrats, politicians, journalists, academic analysts, and consumers. Who wields disproportionate power? What are their interests? Are these interests in alignment or in conflict? If they are in conflict, how might they be aligned in ways that advance the welfare of consumers? The complex interplay of these actors in a competitive policy arena—and the implications for efficiency and effectiveness in health care delivery—merits further discussion.

What are the prospects for constructive change in health care? Relying again on the political science literature, it may be said that significant change—deserving of categorization as health care “reform”—tends to happen during or in the aftermath of a crisis. A crisis is the catalyst. It draws attention to underlying problems in a system, but provides neither the rationale nor the conceptual principles on which to undertake far-reaching reforms.

What crises in health care have functioned as catalysts for change? Three come to mind. First and foremost, the fiscal crisis of health care delivery, viewed in light of a rapidly graying demographic profile, is one that all advanced industrial countries have faced or will be facing soon. But the fiscal crisis is one that is bound to engender a degree of politicization and partisanship higher than almost any policy issue. It would be interesting to compare political systems based on the extent to which elected politicians (as opposed to government officials) deal with the crisis of runaway health care costs. A second crisis worthy of mention is medical malpractice. We have heard dramatic evidence of it presented today, and the problem of malpractice is immediate, graphic, costly, and tends to outrage the public. However, it is difficult to convert a single case of malpractice—no matter how egregious—into a sustained catalyst for reform and change, unless the problem persists over a long period of time. A final crisis is the problem of unequal access to quality health care and health insurance coverage. Broadly speaking, these are the three main issues that promise to generate the momentum for introducing significant reforms in health care systems.

Having looked at crisis as a catalyst for change, how, then, is crisis converted, through the institutions and processes of the political system, into concrete change? Does national responsiveness to crisis vary significantly, reflecting the type of political system in place? By “types” of political systems, I mean differences in the degrees of centralization of power and authority. Marked differences exist on this count among advanced industrial states: centralized Singapore and Japan, for example, versus the decentralized United States. Further, the types of party systems also differ. Singapore and Japan have single-party dominant systems. Japan, although no longer a single-party dominant system, is still dominated by a large party, which maintains its power through a coalition with smaller parties. The United States and England have two-party systems, and a multiparty system exists in the Netherlands. The strength of market ideology, together with the power of various interest groups, determines the impact of politics and political actors on health care. Is there a correlation between types of political system—concentrated versus decentralized, competitive versus hierarchical—and
health care policies and outcomes? In what areas is health care in a decentralized, competitive system (e.g., the United States) more efficient and effective than, say, in a centralized, more heavily regulated system (e.g., Japan)? In what specific areas is the reverse true? Is it politically possible for the comparative strengths of one system to be adopted by the other? Or are there inevitable trade-offs in efficiency and effectiveness that simply cannot be avoided?

It was a fascinating day-and-a-half of discussion, and I’d like to thank everyone, again, for coming.
About the Speakers
(listed in alphabetical order)

Michael E. Abel
Director and Senior Advisor, Brown & Toland Medical Group
Michael E. Abel received his M.D. from Case Western Reserve University’s School of Medicine in 1977. That same year, Dr. Abel joined the United States Navy and completed his general surgery internship and residency at the Oakland Naval Regional Medical Center’s affiliated program of the University of California, San Francisco.

Dr. Abel served as president and CEO of Brown & Toland Medical Group, the largest independent practice association in the San Francisco Bay Area from 1993–99. Brown & Toland is a partnership of physicians from California Pacific Medical Center and the University of California, San Francisco, with over 14,000 physicians and 240,000 capitated lives. Dr. Abel currently serves as director and senior advisor to Brown & Toland.

Dr. Abel is a diplomate of the American Board of Surgery and the American Board of Colon and Rectal Surgery. He is a surgeon in private practice at California Pacific Medical Center, San Francisco; an associate clinical professor of surgery at the University of California, San Francisco; and serves on numerous local, regional, and national committees. Dr. Abel is a founding partner of an international health care consulting firm—Healthcare Redesign International. Dr. Abel also serves as director and advisory board member to several healthcare information technology startups.

Paul F. Basch
Professor Emeritus, Department of Health Research and Policy, School of Medicine, Stanford University
Paul Basch was born in the village of Kirchstetten, Austria, and emigrated to New York as a small child. He obtained a B.S. in biology from the City College of New York, and a Ph.D. in zoology from the University of Michigan, where he began his research on the worm parasites that cause the tropical disease schistosomiasis. He conducted research in parasitology for
eight years, based at the International Center for Medical Research and Training at the University of California School of Medicine, San Francisco. During this period he spent about five years overseas, primarily in Malaysia and Brazil, and obtained a masters degree in epidemiology at the School of Public Health at the University of California, Berkeley. In 1970, he joined the Stanford University School of Medicine to teach courses in medical parasitology and international health and to continue research on schistosome parasites.

With an interest in broader aspects of health he published his first book, *International Health*, in 1978. His focus gradually shifted from laboratory research to health policy issues. In addition to many research papers, he has published books on schistosome biology, vaccines, and world health, and the *Textbook of International Health*, a new edition of which appeared in 1999. He has been a consultant on various health-related programs with national and international agencies domestically and in many developing countries.

Roger Bowie  
**CEO, Southern Cross Healthcare**
Roger Bowie is a New Zealander who graduated with a B.A. in German and French from the University of Otago in 1974.

In 1976, he joined DHL Worldwide Express in London as a courier, and worked around the world for nineteen years. Postings included Dubai, Bahrain, Athens, Tunis, Dakar, London, Singapore, Hong Kong, and Brussels. His final position was Worldwide Services Director, reporting to the CEO and based in Brussels.

In 1995 he returned to New Zealand and took up his current position as CEO of Southern Cross Healthcare in late 1995. He is also a deputy president of the International Federation of Health Funds, a multinational networking group of over one hundred health plans representing twenty-five countries.

Southern Cross Healthcare is a nonprofit group comprising indemnity health insurance (830,000 members, 22 percent of the population, and 65 percent market share); healthcare delivery (13 sub-acute facilities, 550 beds, 31 theatres); workers’ compensation (injury prevention, claims processing and case management); and travel insurance. Group turnover is NZ$450 million (US$235 million).

Harry Burns  
**Director of Public Health, Greater Glasgow Health Board**
Harry Burns graduated from the University of Glasgow in 1974 with a degree in medicine. Over the next fifteen years he worked as a general surgeon and for the last six years of his surgical career was a consultant surgeon at the Royal Infirmary in Glasgow.

He entered health care management and was, for a time, medical director of the Royal Infirmary in Glasgow. Since 1993 he has been director of public health for the Greater Glasgow Health Board, which is responsible for organizing health care and maintaining the health of one million people in the West of Scotland. In 1999 he was awarded a visiting professorship in public health medicine, University of Glasgow.
William J. Cox  
President and CEO, Alliance of Catholic Health Care

William Cox is the president and CEO of the Alliance of Catholic Health Care (ACHC). The Alliance is the advocacy and public policy organization for California’s Catholic health care systems and hospitals in Sacramento, California and Washington, D.C. The Alliance’s members comprise California’s largest group of health care providers under a single form of sponsorship.

Prior to joining the Alliance, Mr. Cox was executive vice president of the Catholic Health Association of the United States (CHA) in Washington, DC. In this capacity, he was responsible for all CHA operations including its government relations program.

Among his many accomplishments, Mr. Cox worked with CHA’s board of trustees to redesign the association’s mission, vision, and goals, and to revamp its strategic direction. He also streamlined CHA’s structure, management, and performance in response to changing health care markets, and in a manner informed by Catholic health ministry values.

Mr. Cox has testified before congressional committees, participated in presidential forums, and addressed health care groups throughout the United States, Australia, and Canada. During his nineteen years at CHA, he coordinated a number of CHA Board task forces which formulated CHA policies on systemic health care reform, the health needs of the poor, Medicare and Medicaid policies, preserving the not-for-profit tradition of community service, and continuing care for the chronically ill.

Among his community contributions, Mr. Cox is a member of the board of Mercy Medical, a coordinated continuum of care organization that serves the Mobile, Alabama metropolitan area. He is also a member of the board of advisors of the Joseph Cardinal Bernardin Center for Theology and Ministry in Chicago. For eight years, Mr. Cox was on the board of SOAR!, a lay organization established to address the urgent needs of religious institutes of women and men. In 1995, he was the organization’s chair.

Mr. Cox is a graduate of the University of Notre Dame, Notre Dame, Indiana. He and his wife, Pat, have three adult children.

Alain C. Enthoven  
Professor, Graduate School of Business, Stanford University

Alain C. Enthoven is the Marriner S. Eccles Professor of Public and Private Management in the Graduate School of Business at Stanford University. He holds degrees in economics from Stanford, Oxford, and MIT. He has been an economist with the RAND Corporation, assistant secretary of defense, and president of Litton Medical Products.

In 1963, he received the President’s Award for Distinguished Federal Civilian Service from John F. Kennedy. In 1977, while serving as a consultant to DHHS Secretary Califano and the Carter Administration, he designed and proposed Consumer Choice Health Plan, a plan for universal health insurance based on managed competition in the private sector. He is a member of the Institute of Medicine of the National Academy of Sciences, and a fellow of the American Academy of Arts and Sciences. He is a consultant to Kaiser Permanente, the former chairman of the Health Benefits Advisory Council for CalPERS, and former chairman of Stanford’s University Committee on Faculty/Staff Benefits. He has been a director of the Jackson Hole Group and PCS. He is now a director of Caresoft Inc.
He was the 1994 winner of the Baxter Prize for Health Services Research and the 1995 Board of Directors Award, Healthcare Financial Management Association. In 1997, he was appointed chairman of the California Managed Health Care Improvement Task Force by Governor Pete Wilson. In 1998–99, he was the Rock Carling Fellow of the Nuffield Trust of London, and also visiting professor at the London School of Hygiene and Tropical Medicine. His latest book, *In Pursuit of an Improving National Health Service*, was published by the Nuffield Trust in November 1999.

Alan M. Garber
Director, Center for Health Policy, Stanford University
Alan M. Garber is the Henry J. Kaiser, Jr. Professor, and professor of medicine at Stanford University, where he is also professor in the departments of economics, health research and policy, and the Graduate School of Business (by courtesy). He is the founding director of both the university’s Center for Health Policy (in the Institute for International Studies) and the Center for Primary Care and Outcomes Research at the School of Medicine. He is a staff physician at the Veterans Affairs Palo Alto Health Care System and research associate and director, Health Care Program, of the National Bureau of Economic Research, Inc. (NBER). He serves as chair of the Medical and Surgical Procedures Panel of the Medicare Coverage Advisory Committee (Health Care Financing Administration).

After graduating from Harvard College *summa cum laude*, he received his Ph.D. in economics from Harvard and an M.D. with research honors from Stanford, and completed his residency in medicine at Brigham and Women’s Hospital. He was Health Services Research and Development Senior Research Associate of the Department of Veterans Affairs and is the recipient of numerous honors and awards, including the Young Investigator Award of the Association for Health Services Research, and the Henry J. Kaiser Family Foundation Faculty Scholarship in General Internal Medicine. He has served as a consultant to the Institute of Medicine, the Congressional Office of Technology Assessment, and the Clinical Efficacy Assessment Project of the American College of Physicians. In addition, he is a member of the national Blue Cross and Blue Shield Association Medical Advisory Panel, the American Society for Clinical Investigation, and the Institute of Medicine of the National Academy of Sciences.

Dr. Garber’s research is directed toward methods for improving health care delivery and financing in settings of limited resources. He has developed methods for determining the cost-effectiveness of health interventions, and he studies ways to structure financial and organizational incentives to ensure that cost-effective care is delivered. In addition, his research explores how clinical practice patterns and health care market characteristics influence health expenditures and health outcomes in the United States and in other countries.

Bill Gradison
Former President, Health Insurance Association of America
Bill Gradison held elected office for over thirty years, and was president of the leading national health insurance association for six years. He served with distinction on a wide range of commissions, boards, and task forces; currently serves as senior public policy
counselor at the law firm of Patton Boggs, LLP; and is an executive-in-residence at the Fuqua School of Business at Duke University.

As president of the Health Insurance Association of America from 1993 to 1998, Bill Gradison set the standard for issue advocacy during the national debate over the proposed Health Security Act. During his eighteen years in Congress, he was ranking Minority member of the House Budget Committee and the Health Subcommittee on the Committee on Ways and Means. He served as the vice chairman of the U.S. Bipartisan Commission on Comprehensive Health Care (a.k.a. the Pepper Commission), and was a member of the Pew Health Professions Commission as well as the Commonwealth Fund’s Commission on Women’s Health.

Bill Gradison currently serves as vice chair of the Commonwealth Fund’s Task Force on Academic Health Centers; is chairman of the Institute for Health Insurance Policy; and sits on the boards of the National Academy of Social Insurance, the National Hospice Foundation, Concentra Managed Care, Inc., Project HOPE, and the MedicAlert Foundation.

Bill Gradison began his career in public service in Washington, D.C. in 1953 as assistant to the Under Secretary of the Treasury, a position he held for two years. Before returning to his hometown of Cincinnati to launch his career as a successful investment broker, he also served two years as assistant to the Secretary of Health, Education, and Welfare (1955–57). While in Cincinnati he served as chairman of the board of the Federal Home Loan Bank of Cincinnati (1970–74), and was on the Cincinnati City Council for thirteen years (1961–74), including four years as vice mayor (1967–71), and one year as mayor (1971).

Born and raised in Cincinnati, he was educated in the city’s public schools, graduating from Walnut Hills High School in 1945. He received his B.A. from Yale University in 1948, his M.B.A., with high distinction, from Harvard University in 1951, and his doctorate from Harvard in 1954.

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Mary R. Grealy  
**President, Healthcare Leadership Council**

Mary R. Grealy is president of the Healthcare Leadership Council (HLC), a coalition of chief executives of the nation’s leading health care companies and organizations. The HLC advocates consumer-centered health care reform, emphasizing the value of private sector innovation. It is the only health policy advocacy group that represents all sectors of the health care industry. She was appointed to the position in August 1999.

Ms. Grealy has an extensive background in health care policy. From 1995 until she began her tenure at HLC, she served as chief Washington counsel for the American Hospital Association, a national organization representing all types of hospitals, health systems, and health care networks. In her position, she was responsible for the organization’s legal advocacy before Congress, as well as executive and judicial branches of government.

From 1979 to 1995, Ms. Grealy was COO and executive counsel for the Federation of American Health Systems, a trade association representing 1,700 investor-owned and managed hospitals and health systems. She coordinated legislative and regulatory policies as well as lobbying activities for the Federation.

Ms. Grealy has a bachelor’s degree from Michigan State University and a law degree from Duquesne University. She is a member of the American Health Lawyers Association and a frequent public speaker on health issues.
Koichi Kawabuchi
Chief Senior Researcher, Japan Medical Association Research Institute

Koichi Kawabuchi received his B.A. in commerce from the University of Hitotsubashi, Tokyo, in 1979. In 1982, he worked as a researcher at McKinsey & Company in Tokyo and analyzed the drastic time-series change of market share for leading companies in Japan. From 1983–85, as planner of the Hospital System Company, Tokyo, he managed an annual budget of $15 million for a 450 bed hospital. Professor Kawabuchi analyzed the results of this marketing research project, developed order systems for reimbursement, created revenue-forecasting models, and presented reports to upper management and medical staff. In 1987, Professor Kawabuchi received his M.B.A. in health administration from the Graduate School of Business at the University of Chicago, and served as managing director of Half Century More Company in Tokyo from 1987–89.

Professor Kawabuchi served as senior researcher at the National Institute of Health Services Management, an affiliate of Tokyo’s Ministry of Health Welfare. He was also involved in the following research projects: “Status Quo, Issues, and Prospects on Halfway Facilities for the Mentally Disabled” (1990); “Economical Incentives to Improve Regional Systems” (1991); “Features and Issues on Japanese Fee Schedules for Health Services” (1992); “The Role of Teaching Hospitals in the Japanese Health Care System” (1993); and “The Development of Medicare Part B’s Fee Schedule (Resources Based Relative Value Scale)” (1994). He also coordinated joint research on a DRG/PPS feasibility study with 3M HIS (1995–98).

From 1998–99, Professor Kawabuchi was a professor of health care economics at Nihon Fukushi University, Aichi-ken, Japan. He has been chief senior researcher of Japan Medical Association Research Institute from 1998 to the present. On April 1, 2000, Professor Kawabuchi was appointed to the position of professor, Center for Health Care Economics, at the Graduate School of Medicine and Dentistry at Tokyo Medical and Dental University.

Choon-Yong Loo
CEO, Raffles Medical Group

Dr. Choon-Yong Loo was educated at Raffles Institution and obtained his medical training at the University of Singapore, graduating in 1973 with M.B.B.S. He completed his postgraduate training at Singapore General, Toa Payoh, and Alexandra Hospitals.

On August 1, 1976, Dr. Loo founded the Raffles Medical Group and built it into an integrated healthcare group with forty-eight branches and a freestanding SurgiCentre with multidisciplinary Specialist and Emergency Care Centres. The group has expanded into the region, setting up its first overseas operation in Hong Kong, where it now has several branches. Raffles Medical Group was listed on the Singapore stock exchange on April 11, 1997 and is currently developing its 380 bed flagship tertiary hospital in Singapore.

Dr. Loo is a diplomate member of the College of Family Physicians—M.C.F.P. He also received training in cardiology at National Heart, Brompton and London Chest Hospitals, and was awarded a Diploma in Cardiac Medicine with distinction by the Cardiothoracic Institute, University of London. In addition to his medical training, Dr. Loo read law and has been admitted to the Inns of Court, Middle Temple. Dr. Loo is a part-time clinical teacher for medical undergraduates at the National University of Singapore. He lectures to professional groups on medico–legal, healthcare management, healthcare financing, and healthcare delivery issues. He has contributed to lay and professional publications. He served in various
capacities on the Council of the Singapore Medical Association; was its honorary secretary in 1980; and chairman of Constitutional Review and Community Health Education Committees (1982–84). He was on the Council of Association of Private Medical Practitioners of Singapore from 1979–84 and served as president of the Association in 1982. He was a delegate to the Parliamentary Select Committee on the Private Hospitals and Medical Clinic Act and sat on the Committee that formulated the Regulations for Private Hospitals.

Dr. Loo has been the president of the Singapore Anti-Narcotics Association (SANA) since 1996, and a council member of the National Council Against Drug Abuse (NCADA) since 1995. He has been a volunteer physician at the Kim Seng Community Centre Clinic since 1981, helping to serve the poor and needy. Dr. Loo is currently a member of the Board of Trustees of Singapore Management University, Singapore’s third and newest university.

Hans Maarse  
Dean, Faculty of Health Sciences, University of Maastricht

Born in 1948, Hans Maarse has been the dean of the Faculty of Health Sciences at the University of Maastricht in the Netherlands since 1995. The Faculty of Health Sciences is a broad faculty with about 2,200 students. It has teaching and research programs in biological, behavioral, and social health sciences.

Professor Maarse is a graduate of the Catholic University of Nijmegen in political science. He is now a full professor in Health Policy and Administration, which is one of the teaching programs in the Faculty of Health Sciences. Before he was appointed to his current position at the University of Maastricht, he worked for ten years at the University of Twente in the Faculty of Public Administration in the field of political science.

Professor Maarse is the author of numerous publications on health policy and administration. In 1993–94, he was a member of the board of the European Healthcare and Management Association (EHMA). He also worked as an advisor for the Dutch Ministry of Health. Furthermore, he frequently served as a temporary advisor for the World Health Organization and as a result traveled to several countries in Eastern Europe.

Among his community contributions, Professor Maarse is the chairman of the local community nursing organization in Maastricht. He has also helped complete several mergers in the field of welfare and education.

Yumiko Nishimura  
Associate Director, Comparative Health Care Policy Project, Asia/Pacific Research Center, Stanford University

Yumiko Nishimura organized and coordinated the Health Care Conference 2000. She has been the associate director of A/PARC’s Comparative Health Care Policy Research Project since May 1997, before which she served as the assistant director. A sociologist from Ochanomizu University in Tokyo, and a specialist on American and Japanese health systems and policies, she has lectured and written extensively on these topics in both countries. Ms. Nishimura introduced the Japanese health system to American readers in the 1993 book *Japan’s Health System: Efficiency and Effectiveness in Universal Care*, co-edited with Daniel I. Okimoto and Akihiro Yoshikawa. For Japanese readers, she published *America Iryo no Nayami* (*Health Care Reform in the United States*) in 1995.
Following the publication of her comparative study on variations in physician clinical judgements regarding hysterectomy cases (A/PARC Occasional Paper, 1998), Ms. Nishimura has most recently studied the applicability of U.S. health promotion programs in the Japanese health care market. Based on this research, she developed a computer program to help medical staff provide health promotion services in the workplace. The idea was licensed to NTT Corporation for further development in 2000. Ms. Nishimura and her team are now focusing on information technology and health care. They have been given access to comprehensive hospital data in Tokyo and are currently analyzing the data set. Research outcomes will be published through A/PARC.

Daniel I. Okimoto
Professor, Department of Political Science, Stanford University
A specialist on the political economy of Japan, Daniel I. Okimoto is senior fellow of the Institute for International Studies, director emeritus of the Asia/Pacific Research Center, and professor of political science at Stanford University. During his twenty-year tenure at Stanford, Professor Okimoto has served as a research fellow at both the Center for International Security and Arms Control and the Hoover Institution. He has also taught at the Aspen Institute for Humanistic Studies, the Stockholm School of Economics, and the Stanford Center in Berlin. In 1976, Professor Okimoto co-founded the Asia/Pacific Research Center. He has been vice chairman of the Japan Committee of the National Research Council at the National Academy of Sciences, and the Advisory Council of the Department of Politics at Princeton University.

Professor Okimoto’s fields of research include comparative political economy, U.S.–Japan relations, high technology, and Asia’s regionalization and security relations. He received his B.A. in history from Princeton University, M.A. in East Asian studies from Harvard University, and Ph.D. in political science from the University of Michigan. He is the author of numerous books and articles, including Between MITI and the Market: Japanese Industrial Policy for High Technology; co-editor (with Takashi Inoguchi) of The Political Economy of Japan: International Context, and co-author (with Thomas P. Rohlen) of A United States Policy for the Changing Realities of East Asia, Toward a New Consensus and Inside the Japanese System (new edition forthcoming).

Professor Okimoto was born in 1942, in one of the U.S. Government’s Assembly Centers for Americans of Japanese ancestry and first generation immigrants. In 1970, he married Nancy E. Miller, recently retired deputy director at the Institute for International Studies at Stanford. The Okimotos have two children, Saya, a 1993 Stanford graduate currently working in San Francisco, and Kevin, who graduated from Santa Clara University in 1999.

Richard R. Pettingill
Executive Vice President and COO, Kaiser Foundation Health Plan and Hospitals
President and CEO, Kaiser Permanente, California Division
Mr. Pettingill is the executive vice president and COO, Kaiser Foundation Health Plan and Hospitals, and the president and CEO, California Division. In his primary role, he leads the overall performance of the 5.8 million-member health plan throughout California. He is responsible for overseeing the performance of a twenty-eight hospital delivery system located in major communities throughout California. He works closely with the leadership
of the Permanente Medical Group in Northern California and the Southern California Permanente Medical Group, which collectively have over 7,000 practicing physicians. Kaiser Permanente provides over 25 million outpatient visits, 60,000 births, 600,000 hospital admissions, and an operating budget of over $12 billion. He is also responsible for the national human resource activities for Kaiser Permanente, which has over 100,000 employees. In his current role he successfully led the turnaround of Kaiser Permanente’s operating performance in California. Before his appointment to his current role, he served as the COO of the California Division and was the service area manager in the Golden Gate Service Area when he joined Kaiser Permanente in early 1996.

Prior to joining Kaiser Permanente, Mr. Pettingill was president and CEO of Camino Healthcare, a community-based, integrated delivery system. Camino Healthcare resulted from a merger of El Camino Hospital, Sunnyvale Medical Center, and Shoreline Medical Group. As the founding CEO, Mr. Pettingill led the development of new managed care and clinical effectiveness programs, launched a comprehensive clinical information and decision support system, and instituted a new strategic planning process for Camino Healthcare. Mr. Pettingill’s extensive healthcare experience started at Stanford University Medical Center, where he served on the executive staff for ten years.

Mr. Pettingill serves on a number of community and professional boards. He serves on the boards of directors of the California Healthcare Association, California Association of Health Plans, California State Chamber of Commerce, and the California Business Roundtable. He is a fellow in the American College of Healthcare Executives. Mr. Pettingill has a master’s degree in healthcare administration from San Jose State University, where he was recognized as a distinguished alumnus in 1995. Mr. Pettingill is married, has two college-age sons, and resides in Marin County.
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