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**M A N A G E D**

# Care

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## WELCOME MESSAGE

DAVID BRENNAN

Senior Vice President, Commercialization and  
Portfolio Management, AstraZeneca Pharmaceuticals

### Adding Some Perspective to the Debate About Health Care Issues

Thank you for your interest in the 13<sup>th</sup> annual symposium for health care professionals, *The Changing Landscape of Healthcare*. As the presidential election approached, health care became one of the major issues that helped to determine our next president. It was important to understand the effect of each candidate's health proposals on our industry and on the political environment for health care in Washington.



At the September symposium in Carlsbad, Calif., some of the foremost experts in the country were brought together to speak about, debate, and discuss important issues that concern you. Paul Begala, former advisor to President Clinton and co-host of MSNBC's *Equal Time*, engaged in a lively debate with Robert Novak, who is regularly seen on CNN's *Crossfire*. Their exchange, printed in this special continuing education supplement to MANAGED CARE, crystallized the issues that our new president will have to face. By reading this publication, you will have an opportunity to learn how health care issues are playing in Washington. A special panel of large employers and employer coalitions followed the debate and discussed those issues from their perspectives as your customers.

You also will have an opportunity to read what leading experts had to say about emerging issues that may determine the future of health care, and about how information technology is shaping its delivery. Finally, a blue ribbon panel of experts from different disciplines discussed possible solutions to many of these health care issues.

We hope some of the ideas presented here will be useful to you in your every day responsibilities.

PHOTOGRAPHS BY JAMES ARONOVSKY

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**Care**

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**Proceedings of the 13th Annual Managed Healthcare Symposium**

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**About this publication**

This MANAGED CARE continuing education supplement is based on information presented at "The Changing Landscape of Healthcare," a symposium in Carlsbad, Calif., Sept. 14-16, 2000, and attended by physicians, health plan medical and pharmacy directors, pharmacists, pharmacy benefit managers, employers, and quality assurance experts.

The opinions expressed herein are those of the symposium participants, and do not necessarily reflect the views of AstraZeneca, the University of Arizona Colleges of Medicine and Pharmacy, or the publisher, editor, or editorial board of MANAGED CARE.

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## KEYNOTE DEBATE

# The Presidential Election and Its Effect on Health Care

### ON THE LEFT

#### **Paul Begala**

Co-host, *Equal Time*,  
MSNBC  
Political Analyst,  
NBC News  
Former counselor to  
President Clinton  
Senior strategist, 1992  
Clinton-Gore  
campaign

### ON THE RIGHT

#### **Robert D. Novak**

Co-host, *Evans and  
Novak*, Cable News  
Network  
Syndicated columnist,  
“Inside Report”  
Co-author of four books  
Washington correspon-  
dent since 1957

### MODERATOR

#### **Gene Beed, M.D.**

President  
horses, zebras, &  
unicorns inc.



**Hammer time:**  
Paul Begala (left) and  
Robert Novak meet  
on the main stage.

Two Washington veterans talk about the implications of the November's presidential election on health care delivery, managed care, and Medicare in a friendly but sharply contrasting exchange of ideas.

### Opening statement by Paul Begala

It is troubling how many people have tuned out from the miraculous process of self-government. But if you think about the word “politics,” you get a sense of why. The Greek root for the word politics is *poli*, meaning “many.” And tics, of course, are blood-sucking insects. So as deep as our language is, so is our hatred for politics.

After helping Mr. Clinton get re-elected in 1996, I went back to Texas to teach. Later, he called me and said, “I bet you’re bored in academia.” I said, “Well, I could use more excitement.” He said, “Well, George Stephanopoulos is leaving, and I want you to take his job.” I said, “Yes, sir,” and moved my family back to Washington. About six months later, the Lewinsky scandal broke. And when I would whine about it a little bit, the President would say, “Hey, Begala, you asked for excitement.”

But it taught me something also about loyalty. Former House Speaker Sam Rayburn used to say this to young members of Congress: “Son, let me tell you how it works: You’re a Democrat, I’m a Democrat, I’m your speaker. You’re going to vote when I tell you, on what I tell you, and how I tell you.” And one guy straightened

up and said, “Mr. Speaker, no, sir. I am my own man. I’ll be with you when you’re right, but against you when you’re wrong.” And Rayburn said, “Hell, son, I don’t need you when I’m right.” And so they don’t. They need us when they’re wrong.

Every time I see the press handling a poll, I think of a child handling a gun: *This is a dangerous instrument. Somebody is going to get hurt.* They don’t know what they’re doing with it. What they tell you immediately is the head-to-head number — the least important number in the poll. Let me tell you what’s more important.

On almost every single important issue, people think Gore has got the right approach. Gore leads when they are asked who they trust on health care and who they trust about prescription drug issues. Bush has to decide how to change those numbers, whether by running an issues-based campaign, as he did against Ann Richards in 1994 — he never attacked her, and he won in a landslide — or by making it personal: “He’s a liar. He lacks integrity. I’ll bring honor and dignity to the Oval Office.”

It is going to be fascinating to watch which model the Bush people choose. They have a successful model that says, “Stick to issues like you did in ’94, governor, and you may win.” They have another model: the John McCain primary model. They ripped McCain apart. It wasn’t about issues; it was the most vicious, ruthless, amoral campaign since Lee Atwater died. I hope we can put that aside and talk about issues.

In 1994, people hated the government. Republicans like George Bush stood up and said, “The government will screw up a one-car parade. And I’m going to stop that.” And people liked that. But that is not the mood today. The *Wall Street Journal* asked people this question: “George W. Bush supports a limited patients bill of rights, creating a review panel that will decide whether people can sue health plans for denied services. Al Gore supports a patients bill of rights that would allow all people to sue their health plans for denied medical services. Which position comes closer to your point of view?” Gore, 57 percent; Bush, 37. On prescription drugs: “George

W. Bush supports giving government subsidies to low-income senior citizens, to cover the cost of private insurance for prescription drugs, and will have the government pay for all drug costs over \$6,000 a year. Al Gore supports creating a prescription drug benefit for seniors in the Medicare program, and would have the gov-

ernment pay for all drug costs over \$4,000 a year. Which position comes closer to yours?” Gore, 51; Bush, 39. So the terrain has shifted. Where once Rush Limbaugh got people nodding their heads when he said, “Name me one government program that works,” today, people look at him blankly and say, “How about Medicare?”

We’re going to have a big debate on this, I hope. At the end of the day, we have to resolve these issues. And what makes this country wonderful is that this is how we resolve them — Novak and I can get up here and debate and nobody gets shot. We can fight these things out in an honest debate. It is my hope that’s what we’ll have. I know we’ll have it here today, but that’s what I hope we’ll have in the election.

### Opening statement Robert D. Novak

I’ve been in journalism all my life, and I’ve been a Washington correspondent for 43 years. I’ve never had an offer to work in government. As an outsider, I have a less elevated view of politicians than Paul does. And a less elevated view of government.

**BEGALA:** In 1994, people hated the government. But that is not the mood today. Where once Rush Limbaugh got people nodding their heads when he said, “Name me one government program that works,” today they say, “How about Medicare?”

[As an issue,] health care has very little to do, in my opinion, with politicians' desire to provide better health services for Americans. The deal is to use it to win elections. In the *American Prospect*, in 1991, Stan Greenberg described the problem of the Democratic Party: It had become the party of people who make very little money. Greenberg said Democrats would never become the majority party until they made middle-class Americans feel dependent on government. That has been an eight-year proposition by the Clinton-Gore Administration — and it has been done brilliantly.

The irony is that the main element in the campaign to make ordinary Americans dependent on government was a failure: the Clinton health care plan. The American people didn't want to remake health care in the image of the U.S. Postal Service.

The Founding Fathers were very much against government, and they put in so many checks and balances that they hoped nothing would get done. They succeeded beyond their wildest expectations. The Clinton health care plan, as flawed as it was, would have passed *like that* in Britain, Germany, or any other parliamentary democracy. It was a central factor in the Democrats losing control of Congress in 1994.

Immediately after the debacle of 1994, President Clinton — who's a very smart politician — regrouped and said, "We can't take this huge health care plan and stuff it down the throats of the American people. So we'll slice it, dice it, and slip it in before they know what happened." The two largest morsels are now coming up. One is the Patients Bill of Rights, which is a means to enable people to sue HMOs, and that will benefit one special-interest group: lawyers. The other, which has just come up like a whirlwind, is prescription drug [coverage in Medicare]. These are two proposals to make people feel they can't get by on their own and need government — that taking care of yourself and your health is an entitlement. The idea that anybody might have to give up a vacation home or a hunting trip to pay for medications to keep oneself alive is something that's very difficult for them to swallow.

In my decades covering Washington, the political parties have changed dramatically. They used to be coalition parties. There was a huge right-wing Southern Democratic element. And there was a huge left-wing liberal Northeastern Republican element. And as a result, the two parties worked much more closely and were much less polarized than today's liberal Democratic Party and conservative Republican Party. Therefore, you don't have situations like you used to find, where a conservative Republican senate leader like Everett Dirksen of Illinois would work with liberal Democratic presidents and get things done. Now it is a dog-eat-dog proposition: Win elections, show up the other side, and make them look bad.

Last year, the Breaux Commission came out with substantial bipartisan Medicare reform recommendations that would have become law, were it not for four Clinton stooges on the commission who were instructed by the White House to vote no. The White House didn't want it to pass because it wanted this issue [for the campaign].

In 1993 and '94, the Democrats controlled Congress, but Republicans took a tough course on the huge Hillary-care bill and said, "There is no health care crisis. We'll pass nothing." The issue played in favor of the Republicans. But on these issues, particularly prescription drugs, Republicans can't say today there isn't a crisis, so they have to play the game. Is their program better or worse? Well, it's cheaper. And a lot more oriented toward private insurance, rather than the government.

### **Begala's rebuttal**

I feel like a mosquito in a nudist colony — I don't where to land first. But wherever I do, I think I'll find fruitful terrain.

Let me begin first, by agreeing that we have moved away from coalition politics, and I think Bob's analysis is spot-on. I saw it when we were trying to pass a health care bill. The president's proposal was closely modeled on one sponsored by Bob Dole on behalf of the Nixon Administration. It was not the position [Minnesota Sen. Paul] Wellstone and others in the left wing of my party wanted. The idea was, "We'll throw out something that's moderate. Dole is a reasonable guy. We'll cut a deal and have some progress. It won't satisfy the left, but we'll have progress." The president was stunned at the intransigence of the Republican Party. I think that was bred by this new politics we now have that frowns on compromise and coalition building. That's unfortunate. What troubles me as a Democrat is that a few in my party want to go that way, too. We should beat them fair and square on the battlefield of ideas.

If I were advising Bush, I would say, "Let's have an honest debate. Stand up there and give us your strikingly antigovernment views," because he's couching it in all this garbage about how he's compassionate — and I think it's not working for him.

He ought to say what [Texas Republican Rep.] Dick Armey said: "Medicare is incompatible with a free society." He said it's socialized health insurance. He's right. And Americans love it. Democrats want to expand it. Republicans want to reduce it. Let's have an honest debate about that.

### **Novak's rebuttal**

Paul, you ought to listen to the candidates to find out what's really going on. Both are talking about issues. Al Gore has a mean streak, as Bill Bradley can testify, and it almost sunk him in the primaries. But they have sublimated that, and now he talks about issues. The dirty stuff is coming out of the Democratic National Committee.

On the question of health care, Bush has set forth, very clearly, the differences between his prescription drug plan and that of Vice President Gore. The big difference is money. His costs \$158 billion, Gore's costs \$297 billion. Another difference is the amount of freedom by the individual to make choices. Under the Gore Medicare plan, you will have a one-time choice at age 64. You either do it or you don't.

The American people have had a steady diet, from one party, of bashing corporate interests. Go back, Paul, to the 1820s and look at Andrew Jackson — I wasn't around to cover him; he came just before me — but read his speeches and then read Al Gore's from the Los Angeles convention, and you'd say, "Nothing has changed. The Democrats have been bashing business all these years." Sometimes it takes. There's no question that pharmaceutical companies have been put in the same position as



**NOVAK:** The Clinton-Gore Administration is trying to demonize the pharmaceutical industry and put the Republicans in bed with it... the American people have a choice between a free lunch or freedom.

the tobacco or the gun industries. These are legal industries, but the American people don't care much for them. The Clinton-Gore Administration is trying to demonize the pharmaceutical industry and put the Republicans in bed with it. Those are the real issues. I think Americans have a choice between a free lunch or freedom.

### **Question-and-answer period**

**GENE BEED, M.D.:** If he ever gets to Washington, you can bet Bush will be a shameless suck-up to HMOs. Considering that most people here work for HMOs, why shouldn't they vote for Bush?

**BEGALA:** They *should* vote for Bush. You are right. In Texas in 1995, the Democratic legislature passed a patient-protection act that wasn't all that strong. And Bush vetoed it. Today — in a supreme act of audacity — Bush claims he vetoed it because it was too weak. That's not true. The veto message doesn't say that. It says the bill was an infringement on corporate interests and so forth.

The Democrats then introduced another one, which was stronger and included a right to sue, and passed it by a veto-proof majority. The Democrats came to the governor and said, "Look, we're going to override you, and you're going to look bad. You need to sign this bill." Bush attacked the bill, but allowed it to become law without his signature. And now he campaigns as though it was his.

*[Beed takes a question from the audience.]*

**QUESTION:** I can't understand the logic in Medicare. For a patient with congestive heart failure, Medicare will pay for hospitalization for as long as that patient needs to recover. They'll give him all the medications he needs. But then when that patient gets out, he won't get the medications he needs to keep out of the hospital. Would we rather pay to keep him in the hospital? Unless we find a way to make sure that patients are given subsidies for drugs, get the right drugs, and continue to take them, all that money [put into hospitalization] will be wasted.

**NOVAK:** I think your points are well taken. One of the problems, doctors say, in getting people to take their drugs is not that they can't afford them, but because [adherence] is uninteresting. And you're quite right, there's no governing proposal for Medicare. But campaign strategists are not interested in these kinds of problems. They're interested in putting something before the public that will sell. Medicare is a miserable program. Paul says Americans love it and love the fact that they can get free medical care. But it is a bad program. Newt Gingrich said the Health Care Financing Administration ought to wither on the vine. And it should. HCFA is one of the last agencies that believes you can set prices from Washington. Did you know that in the front room of HCFA, there's a picture of V.I. Lenin?

**BEGALA:** Oh, puh-leeze.

**NOVAK:** No, I'm just kidding. But there ought to be, because they follow his economics down to the letter. But your points are well taken. And they are not addressed by either campaign, because they're too complicated and too realistic.

**BEGALA:** Actually, they are being addressed perfectly by Al Gore and Bill Clinton. Clinton says, "If we were designing Medicare today, we would include prescription drugs." Conservatives will say just what Bob said: Government is the enemy of freedom. We have an honest debate. Gore says Medicare should be expanded. Republicans say "We want to fix Medicare." Beware of people who want to "fix" Medicare. At least Democrats are honest when they say they want to expand it.

*[Beed takes another question.]*

**QUESTION:** The Institute of Medicine report showed that [the fatality rate from medi-

cal errors is] the equivalent of two 747s crashing every day, and yet there's no real talk about quality issues. I sense from both of you that it's probably about keeping things on a simple level, like suing HMOs. But I'm wondering if you see quality of care becoming an issue at any point in politics?

**BEGALA:** I think the problem is so diffuse — errors by individual people — that it's difficult to address, except to say you have a right to sue an HMO if it makes the wrong decision. Even a liberal Democrat is not going to say, "We need more government policing of the medical profession." I think it's a matter of isolated mistakes, accidents, and bad actors, and it's difficult to give that a systemic solution.

**NOVAK:** Both parties are afraid to raise this issue. I don't know what the answer is. I agree that federal regulation of physicians is not the answer. We all have anecdotal evidence that this quality question is difficult. But let me tell you something: Organized medicine has put itself in a beautiful political position. Thirty years ago, the AMA was attached at the hip to the Republican Party. It used to give all its contributions to the Republicans. Now it is a free agent, and though the AMA supports a lot of the work of the Clinton-Gore Administration and gives a lot of contributions to Democrats, it is not in bed with the Democrats. So, Republicans are afraid to say anything about this issue, too. You find much less criticism of physicians than ever, because they are in play as a political factor.

*[Beed takes another question.]*

**QUESTION:** Paul, most experts say the pharmaceutical industry, probably within the next few decades, will develop drugs that will treat, prevent, and cure most of the diseases that affect us today. Al Gore has chosen to demonize this industry, but most experts think it's a crown jewel of this country. If Gore becomes president, do you think his promises of price controls and to ruin what he calls a greedy industry are just political posturing — or should this industry head for the hills?

**BEGALA:** That's [Pharmaceutical Research and Manufacturers Association Senior Vice President] Alixe Glen Mattingly, who is one of the most brilliant Republican strategists in the country. Well, how do I begin? Gore doesn't want to ruin any industry, particularly not the pharmaceutical industry, Alixe. He has laid out a thoughtful and substantive prescription drug program that essentially extends the Medicare system. Governor Bush has laid out a thoughtful program that essentially gives subsidies to insurance companies. Gore has struck a nerve with this.

**NOVAK:** With all due respect, Paul, you didn't answer Alixe's question. As I understood it, if Gore gets in office, will he really put in price controls? That is a tremendous problem for him, because once in office, he has to decide what he's going to do about drug prices. Price supports are disastrous. They don't work in oil; they didn't work when Mr. Nixon put in price supports for the whole country. So what will Gore do about prices? Will he try to follow the example of Franklin D. Roosevelt, in his Pittsburgh speech? Are you familiar with the Pittsburgh speech, Paul?

**BEGALA:** No, I'm not.

**NOVAK:** In 1932, Franklin Roosevelt pledged a balanced budget. And immediately, he went into deficit spending. Sam Rosenman, one of his aides, said, "Mr. President, what are we going to do? You pledged a balanced budget. You made that speech in Pittsburgh." And I like to think of FDR tipping up his cigarette holder as he said, "Sam... tell them I've never been to Pittsburgh in my life."

**BEGALA:** The forerunner of "Read my lips."

**DR. BEED:** Well, I think we could go on and on, but we are out of time. Let's have a big hand for our two debaters.

PANEL DISCUSSION

# The Employer's View Of Health Care

THE FACULTY

**Arleane Soto Baltrusitis**

Vice President, Human Resources Benefits  
American Express Company

**Paul Begala**

Co-host, *Equal Time*  
MSNBC-TV

**Becky J. Cherney**

President/CEO  
Central Florida Health Care Coalition

**Pamela Krol**

Director, Health Programs and Benefits Administration  
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**Robert D. Novak**

Co-host, *Evans and Novak*  
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**Dale Whitney**

Corporate Health and Welfare Manager  
United Parcel Service

MODERATOR

**Gene Beed, M.D.**

President  
horses, zebras,  
& unicorns inc.



**Dale Whitney**, **Becky Cherney**, **Pamela Krol**, and **Arleane Soto Baltrusitis** discussed the ramifications when employers back away from active involvement in health care purchasing.

Employers are frustrated by their inability to measure the quality of the health care they purchase. Couple this with increased costs and potential government intervention, and one understands why some employers are beginning to view defined contributions as a viable approach.

**GENE BEED, M.D.:** What's the takeaway from what you heard from Begala and Novak?

**BECKY J. CHERNEY:** [Health care issues are] not a political problem, but a system problem — and until we deal with such issues as quality and access and other things that employers deal with daily, there are no solutions.

**PAMELA KROL:** My employees do not see the private sector as a solution. We get hundreds of complaints weekly about claims payments and understanding their benefits. We carve out prescription drugs, we have a plethora of programs... and so, it's not an easy system to navigate. Looking to the private sector makes me nervous, because my employees are only in the 50- to 65-percent satisfied range.

**BEED:** So do you think the political sector would be more successful?

**KROL:** We need a wider debate, because we are talking about people who are frustrated, about having [a system of] insurance based on employment, and about changing the way that is financed. I don't know that employers have the solution.

**ARLEANE SOTO BALTRUSITIS:** One of our struggles is that we are not in the health care business, yet we are constantly being asked to pass judgment on it. And every day the defined-contribution approach to health care looks more attractive to us.

But that is probably five or six years down the road, because the market is not there.

**BEED:** How would a Medicare drug benefit play out with what you do for retirees?

**DALE WHITNEY:** We offer our retirees prescription coverage, and we would continue to do so. We would be interested in a bill that would give us a tax or other benefit for that, or else we would have to change our plan so it would work with the new plan.

**BEED:** If retirees get pharmacy benefits from Medicare and employers want a tax break if they are going to continue to give them benefits, Mr. Novak, how does that square with what you said about increasing dependence on government?

**ROBERT D. NOVAK:** I think that is precisely the case. We have almost reached a point where we are not talking about whether — we are talking about how much from government.

**PAUL BEGALA:** I disagree. I think markets are often ruthless and far too efficient. People want a society as well as an economy. They don't want the government running big enterprises in the economy, but they also want to make sure the government has a check so it smoothes some of the ruthless efficiencies of the market. I was struck that Pam said her folks are not as happy with the private sector as others might be, because people are very happy with Medicare. And in a societal way it works. The only positive health statistic in which we lead the world is life expectancy after age 65. Once you get into Medicare, you are better off than anybody in the rest of the world.

**WHITNEY:** The problem with politics and why it cannot solve health care issues is that in politics you have to have villains and heroes. Health care is not an issue with villains and heroes. This is an issue of trying to provide the best benefits we can at a reasonable cost. That is what each of us tries to do on a daily basis. Politics gets in the way.

**BEED:** Is it going to get in the way in the next four years in a way that it has not in the last four?

**WHITNEY:** There is a possibility of that. If some current bills pass, the effect could be employers like ourselves getting out of health care altogether.

**BEED:** Pam, you were nodding your head. What are you worried about?

**KROL:** Whether employers can be named in lawsuits. That is a liability that we are not going to

be willing to take. And under the Patients Bill of Rights, we are going to have to offer retirees the same benefits they had when they were active employees, according to the recent Pennsylvania ruling that found discrimination there.

**BEED:** What of that, Arleane? The Congressional Budget Office projects a 5-percent increase in premiums from the Patients Bill of Rights.

**BALTRUSITIS:** This is not the business we are in. We are in the credit card and financial services businesses, not health care. So I will say to employees, "I have a 27-percent fringe budget. Here are your health care dollars. Go out and get it. I am not going to manage this any longer."

**BEED:** You have brought this up a couple of times. Pam raises the specter that some employers might drop benefits if the cost gets too high. And yet, as an individual, I cannot deduct the cost of my self-paid health insurance. So, why are we debating whether to let people make their own coverage choices? You seem to think tax cut is a dirty phrase, Mr. Begala, but what about the individual deducting some cost of his health insurance?

**BEGALA:** I would not be adverse to that. But we have a tradition in this country that pay and benefits come with jobs. If companies want to get out, they are free to do so — but there will be ramifications. Government will step in. It does not sound to me, from this discussion, that the private sector is doing such a great job, frankly.

**BALTRUSITIS:** I disagree. Many employers of fewer than 25 people do not offer benefits. We are the ones who offer benefits and carry their families, even though they may not be employed with us.

**BEGALA:** Which means that until we get to universal coverage, big employers will get hammered.

**WHITNEY:** I would argue that big business saying that it's not in the health care business is silly. Yes we are, because we have made decisions for our people and, ergo, we do not have consumers who are informed. We have allowed subsidized behavior. People get prescription drugs but do not take them. A Medicare doctor does open heart surgery and gets \$2100 whether that patient lives or dies. And we allow that kind of nonsense to flow through the system. So if we have to have a villain, business is the villain. We [in business] get three bids for a \$50 file cabinet but don't question anything we pay for in health care. Business has

to use what it has learned in quality purchasing and apply it to health care.

**BEED:** Becky, what approaches to this is your coalition looking at for the next four years?

**CHERNEY:** We are trying to align incentives — to say, “Here are the doctors who provide good health care. We need to pay them more.”

**BALTRUSITIS:** We are going through annual enrollment right now. We have put out tons of information on providers. And yet, all people ask is: “What’s it going to cost me?” We say, “Look at quality. Look at providers’ records.” That does not matter to them — what it costs is all they want to know. So we can try to educate employees, and yet we have gotten them so entrenched in cost that it is very difficult.

**BEED:** So did you hear anything from either side of the debate that leads you to conclude that something in this election will affect your business and your issues of quality and education?

**BALTRUSITIS:** If the Patients Bill of Rights passes, that is definitely going to push us out and just do a defined-contribution approach.

**KROL:** My biggest issue is activating consumers. I get between this paternalistic view that employers will make providers follow guidelines and make patients follow prescription protocols, and this other side that says patients have to become involved. They are not engaged in, “What hospital should I go to, based on its error rates? What is my cardiologist’s error rate? What beta blocker should I take?” That is what consumers need to do to change the system and make it cost effective. We were not effective with managed care, because we did not engage and get buy-in from the consumer. Doctors and consumers aren’t using quality information together.

*[Beed takes a question from the audience.]*

**QUESTION:** We have touched on the patient getting more involved in health care, yet as a nation, a high percentage of us are obese. We smoke. Our cholesterol is too high. We are couch potatoes. When are we going to say to the American people, “You want a Cadillac health care system, but your lifestyle is not conducive to that. If you want

to remain 50 pounds overweight, your premium is going up.” Is that an option?

**WHITNEY:** Some companies have attempted that, and if I remember correctly, that has not stood up in court. Health plans have not been able to do that. As for quality and how you measure it, I think quality really is [a matter of examining] what you do systematically. But the health care system does not learn from mistakes the way the air traffic control system does. Or even the way we do at UPS. Our drivers have one accident every 1 million miles. We do things to make that happen. We analyze and report every accident. You don’t see that in health care, so it’s not getting better.

**BEED:** What can an employer do to make us analyze our errors in health care?

**CHERNEY:** A lot of things. We have been able to reduce the

renal failure rate in our Level 1 trauma facilities from the national average of 20 percent to 1 percent by getting doctors together to talk. We reduced the amount of prostate surgery 32 percent by educating [primary care] physicians about new pharmaceuticals. In Florida, a second-year licensee in real estate has to have more continuing education than a doctor. When you get out of medical school, you have a license to practice medicine forever. And no one has residencies to teach them about 100 new drugs a year.

**KROL:** I am frequently discouraged when I go to a



**Beed:** We are talking about what we get for our dollar. Americans pay 15 percent of their wages for Social Security and Medicare. Is that 15 percent enough? Are we getting value for that 15 percent?

hospital and ask about outcomes or whether they have automated drug-entry systems. They look at me like, “Why are you asking?” HEDIS is a minimum measure, and it makes me nervous that many health plans can’t even meet that minimum standard of reporting. It is frustrating to know that the tools are there to measure performance and yet this industry is just so reluctant to try to do it and give the data to consumers.

**BEED:** I am a pediatrician by training. Someone switched away from me years ago, and I asked why. She said, “You don’t give my kids enough antibiotics to make me happy.” Her perception of the quality of my practice was that it was poor. So what *is* quality? Some people will say, “I am not getting what I need, so I am going to sue my health plan.” How do you measure quality when your employee does not really care about HEDIS numbers? Employees want to know that a practitioner is doing what they want done.

**CHERNEY:** The answer is to support the physician. We have access to employees. Give us the information, and we can educate them. When we saw that antibiotic usage was way up but did not make sense when we audited that, we went to doctors and said, “Why are you doing this?” They said, “It is your fault. You brought in managed care, and now when people want an antibiotic and we don’t give it to them, they switch at the next enrollment.” So I said, “Well, if that is your philosophy, let’s just put this stuff in vending machines. You are supposed to present the medical position. Do what is right, and we will support it.” So we did payroll check stuffers and other things to educate people. People are used to asking for it and getting it — and if physicians do that, the consumer will not change.

*[Beed takes another question.]*

**QUESTION:** I find these arguments, quite frankly, more distracting than helpful. If doctors played by the rules and there were no medical errors and patients took their medicines, we would still outstrip our ability to pay for care in 24 months unless there were continuing large increases in funding. We need to ask this question: “What is the quality of care you expect, and are you willing to pay for it?” Are we going to continue to provide Cadillac care to everyone? If we can’t afford that, then let’s have a national debate to decide

that. I find what is going in politics about HMOs distracting from the real issue: It will cost more.

**BEED:** We have a bunch of employers up here *[Beed gestures to the stage]* and a bunch of folks who provide care out here *[pointing to the audience]* who have struggled with very small rate increases. At the end of the day, at least for the last several years, employers walked away with the winnings off the table. A lot of folks in this room feel they are losing money because employers out-negotiated them in the ’90s. Is that true?

**CHERNEY:** I think it was. It was low-hanging fruit, but that’s gone. Now it’s going to cost more. The thing is to get as much efficiency as we can.

**BALTRUSITIS:** We will continue to accept reasonable increases. But if quality is not there, we do not see why we are paying. One thing American Express is looking to do is to have a smaller circle of providers with whom we can form partnerships and look closer at quality.

**BEED:** We are talking about value and what we get for our dollar. Every American pays 15 percent of their wages for Social Security and Medicare. What used to be the third rail of American politics — Medicare — nobody once wanted to touch, but now it is the opiate of the elderly and everybody is tripping over themselves to give them a prescription benefit. Is that 15 percent enough? Are we getting value for that 15 percent?

**WHITNEY:** I have always felt that we in private industry can do it better than the government. Donna Shalala, by the way, agrees; she thinks private industry is why Medicare+Choice is going down the tubes, because we have taken the cream and left Medicare stuck with the big bills.

**NOVAK:** Fifteen percent is much too high. This is a regressive tax. It is most unfair. So the question is, do you reduce benefits or increase revenue? You cannot increase that tax. You have to make a gradation of the tax rates, or invest that money so you can build revenue through the market.

**BEGALA:** The 15 percent goes to both Social Security and Medicare. The bulk of it goes to Social Security, and the big lie in Washington is that Social Security is in trouble. It is not. Now Medicare, which gets a smaller piece of that 15 percent, is in big trouble. And we talked ad nauseam about the things we need to do about that.

**BEED:** I want to thank you all for your comments.

## Continuing Education Section

*Continuing education is offered to physicians and pharmacists who read pages 12 to 22 of this publication, fill out the appropriate evaluation form on either page 23 or 24, and complete the self-test on page 25.*

### Course description

This activity is designed to educate health care professionals about technological and demographic trends in health care. The narratives in this section are derived from information presented at "The Changing Landscape of Healthcare," a symposium in Carlsbad, Calif., Sept. 14–16, 2000. The program is directed to medical directors, chief medical officers, pharmacy directors and other senior management levels in managed health care organizations.

### Educational needs assessment

A growing number of health care professionals at the senior management level seek information about advances in information technology and changing demographics in the United States. It is important that professionals understand how these two trends will shape the delivery of health care and national health care policy, because these factors will affect both the strategic directions of and care provided by their organizations. The individuals whose presentations appear in this section were chosen to participate at this symposium on the basis of previous evaluations and faculty perceptions of significant trends or issues.

### Target audience

Managed health care professionals.

### Educational objectives

After reading this publication, the participant should be able to:

- Describe the nature of e-commerce and e-business, as well as projections for their growth.
- Define ways in which your organization can better understand and identify e-business opportunities.
- Outline how emerging information technologies can improve communication between payers, providers, and patients.
- Illustrate ways that demographic changes will affect use of health care resources.
- Describe how consumerism affects the delivery of health care.
- Identify ways your organization can change or adapt to meet the needs of an aging population.

### Medical accreditation

This activity has been planned and implemented in accordance with the Essentials and Standards of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the University of Arizona

College of Medicine at the Arizona Health Sciences Center and of MediMedia USA. The University of Arizona College of Medicine at the Arizona Health Sciences Center is accredited by ACCME to provide continuing medical education for physicians.

The University of Arizona College of Medicine at the Arizona Health Sciences Center, for a period of one (1) year from the date of this release, designates this continuing medical education activity for 1 credit hour in category 1 of the Physician's Recognition Award of the American Medical Association, provided it is used as completed and designated. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Approval for category 1 credit by the University of Arizona College of Medicine should not be construed as endorsement of any product.

**Release date: December 2000.**

### Pharmacy accreditation



The University of Arizona College of Pharmacy is approved by the American Council on Pharmaceutical Education as a provider of continuing pharmaceutical education. This program is approved for 1 contact hour (0.1 CEU). Credit will be awarded upon completion of registration form, successful completion of assessment questions (70 percent or better) and completion of program evaluation. If a score of 70 percent or better is not achieved, no credit will be awarded and the registrant will be notified.

**ACPE program number: 003-999-00-046-H04.**

**Expiration date: Nov. 30, 2001.**

### Planning committee members

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### Conflict of interest policy in continuing medical education

In compliance with this policy, the faculty for this activity has disclosed financial interests, arrangements, and/or affiliations with corporate organizations offering financial support or educational grants for continuing medical education activities, as well as those organizations with direct interest in the subject matter of this activity.

### Disclosures of significant relationships

The faculty involved have declared they have no financial interest, arrangement, or affiliation that would constitute a conflict of interest concerning this CME activity.

SPECIAL PRESENTATION

# Health Care in the Information Age

JACK SHAW

The health care industry is beginning to recognize that we are rapidly running out of ignorant, uninformed patients. This is going to have a profound impact on every aspect of the industry.



**J**ack Shaw, an expert on electronic commerce, is founder of EDI Executive newsletter. He is also author of three books: *Electronic Commerce for Executives*, *Surviving the Digital Jungle*, and *Doing Business in the Information Age*. He has advised more than 100 organizations in 20 industries. Shaw discusses how health care delivery is likely to be affected by the transformation to a digital economy. For MCOs, the next round of cost savings can be found in this transformation.

FOUR YEARS AGO, my wife Debbie was diagnosed with breast cancer. Three days later she had a mastectomy, and on her release from the hospital, the surgeon said an oncologist would start her on chemotherapy. The oncologist described several chemotherapy approaches and the debilitating effects of each. I then laid a sheath of print-outs from the Internet on her desk and asked her about clinical trials in Australia, Ireland, and other locations indicating that for premenopausal women with Stage I estrogen-receptor positive tumors and no lymph node involvement, hormone therapy is at least as effective, if not more, as chemotherapy in preventing recurrence. She admitted she had heard a little about that and referred us to Dr. William Wood, head of the breast cancer clinic at Emory University.

We saw Dr. Wood, and he agreed there was no reason Debbie should have to un-

dergo chemotherapy and that hormone therapy was more appropriate for her. Debbie is doing well and, next month, we will complete the fourth of her five-year regimen. She has had no recurrence and has every indication she is going to live a positive life.

Four years ago, it was unusual for a patient to walk in with a recommended course of treatment in hand. But it is not unusual anymore. Forty million people visited health care sites in the first quarter of this year. By 2005, it is expected that 88 million different people will use the Internet for health care information. The health care industry is beginning to recognize that we are running out of ignorant, uninformed patients. And it is going to have a profound impact on every aspect of the industry.

### **Internet boom**

Internet commerce also is exploding. It was just \$600 million as recently as 1996, but by the end of next year it will have increased a thousand-fold. By 2004, it will hit at least \$2.7 trillion, according to the conservative estimates of Forester Research, and up to \$7.3 trillion, according to the Gartner Group. Either way, we are talking about a very substantial portion of our economy moving online.

We have entered a new age of human civilization: the information age. This age is proving to be as profoundly different from the industrial age of the 20<sup>th</sup> century in which we were born and raised, as that age was different from the agricultural era that preceded it. To survive and succeed in the information age's digital economy, one of the tools any industry must understand how to use is electronic commerce, or e-commerce. E-commerce is the digital transformation of any business that crosses trading-partner boundaries. A trading partner is any outside person or organization with whom you exchange information. For managed care organizations, trading partners include members, providers, pharmacy benefit managers, pharmaceutical manufacturers, other MCOs, employers, and other payers. They also include banks, the FDA, and anyone with whom you exchange information to conduct business.

If you ask the average person what e-commerce is, he will tell you it is selling books, flowers, or candy to consumers over the World Wide Web. But business-to-business e-commerce is four times the size of business-to-consumer e-commerce. It is not just about selling over the Web. It is about using the full range of e-commerce technologies to engage trading partners. An organization that uses those capabilities to rethink and reshape its business model is what we call an e-business.

[Along these lines,] some organizations in health care are doing interesting things. Drugmax.com has set up a model that allows it to collect small fees from the sale of drugs between manufacturers, distributors, and wholesalers, retailers and pharmacies, hospitals, and major end-users. It allows wholesalers to market their overstocks. One interesting thing it has done is to set up virtual trade shows, so that MCOs, PBMs, drug store chains, and pharmaceutical manufacturers can, in effect, attend a trade show without the expense and time of having to travel to a site.

Drugmax is an example of a vortal, short for vertical industry portal. Service vortals include such things as arranging credit and payment options, linking with distribution and scheduling systems, integrating with financial ledgers and ERP (enterprise resource planning) systems, and related services including customer service.

In health care, online-based customer service has positive and negative potential. A lot of people will say e-commerce is well and good, but if it comes down to a physician consulting with a patient or examining a new medical device, we need to talk to those people, see them, and interact with them in real time on a regular basis.

That is done through Internet video conferencing. Video conferencing is going

**We have entered a new age of human civilization: the information age.**

to have a profound impact on health care. Agilent Technologies, for instance, has a system to provide in-home monitoring for patients with congestive heart failure. Every morning, patients use a wireless in-home measurement device that operates either with a push of a button or automatically. This device includes a blood pressure unit that measures pulse, and a heart-rhythm strip recorder that takes an EKG. Results are transmitted to a server that forwards them to the provider's office. The provider uses software that resides on the server and that includes a patient database accessible by authorized users via a standard web browser. The software enables clinicians to track daily patient measurements, store and retrieve historical data, and generate reports. Patients whose daily measurements fall outside preset limits can be flagged for immediate follow-up.

This is just the beginning of a transformation of how technology will affect the way health care is delivered.

### Where health care fits

How do you plan for this change? Start by asking these questions: How will the future of health care be different? What is it going to take to succeed in health care in the digital economy, and how does that differ from what it took to succeed in the industrial economy?

Wellmed.com is a customized personal health information site. I went to Wellmed recently to try to find out how healthy I am.

It says my "health quotient" is 142 out of 200, but the average for males my age is 120

— so while there's room to improve, I'm doing better than average. It provides health information, allows me to create and store health records online, and sends me reminders about things I need to do — mine says my colon cancer screening is due. This is an excellent way to have access to information that, *if* it is accessible, is scattered in a lot of places. Wellmed also is setting up the exchange of data with electronic medical records and PBMs, and soon will provide patient access to lab results and medical records, handle prescriptions, and schedule appointments.

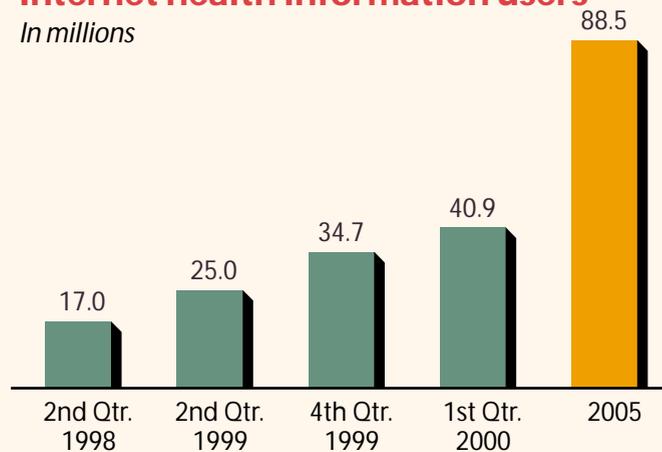
One area for tremendous growth is online pharmacies. Sales by online pharmacies in 1998 totaled \$10 million. By last year, that jumped to \$160 million, and by 2002 it is projected to hit \$800 million. Some experts believe that by 2010, 10 percent of drugs — about \$15 billion — will be sold over the Internet. I take issue with those projections; they are far too conservative.

There are 400 pharmacies on the web now. Why are consumers interested in them? First, easy price comparison means cost savings — and this is important to consumers without prescription drug coverage. Ease of use is another issue. If they are bedridden, disabled, or live far from a retailer, they can have something delivered by ordering it online. Success, to my way of thinking in any area of retailing but this includes pharmacies, will be found by organizations that combine clicks and bricks most effectively so that, for example, you can do things like order a prescription online, and then five minutes later go pick it up without having to wait for it to be filled.

One thing this will do is pressure PBMs and physicians to require that physicians create prescriptions electronically and transmit them directly to a pharmacy. One

### Internet health information users

In millions



SOURCE: CYBER DIALOGUE

tool for doing this — there are several on the market — is basically a Palm Pilot with appropriate programming on it. The prescribing physician selects the patient's health plan, then the drug. The system screens for interactions and enforces formulary compliance. The prescription is printed or transmitted electronically to a pharmacy.

### Implications for MCOs

What does this mean for managed care organizations? First Consulting Group identifies five phases of MCOs' use of the Web and the Internet. Stage I: Publish (put company profiles and news online). Stage II: Interact (offer provider directories, formularies, and member services online). Stage III: Transact (provide online enrollment, referral processing, and claims submission). Stage IV: Integrate (provide online medical management). Stage V: Transform, so all processes are seamlessly integrated downstream to the consumer and upstream through providers and business partners.

Only 20 percent of MCOs have reached Stage III, and most of those are just in pilot testing. Seventy percent of MCOs claim to have an Internet strategy, and yet only 30 percent make authorizations online, 25 percent allow members to change primary care providers online, and 20 percent provide for online enrollment. When you look at health care claim costs, processing a claim on paper costs an average of \$1.25. Via EDI (electronic data interchange), which has been around a few years, that cost is reduced to 25 cents. Over the web, that cost drops to a nickel. It is critical that MCOs take advantage of these tools to better manage costs.

One way to do this is member self-service. For instance, 26 percent of health care costs are linked to administration. Here's an opportunity to reduce costs. Healthweb provides services to MCOs, allowing them to offer such capabilities as web-based claims status, UR, eligibility, and benefit coverage. Five months after beginning to work with Healthweb, Humana implemented a system that cut its 20 million annual phone calls to and from members, at \$4 each, in half. Humana projects \$40 million a year in savings, and its customers are happier because they can check their records online at their convenience, rather than sit in a queue to talk to customer service.

Keep these questions in mind as you talk to providers of technology services:

What parts of my business does your service address? Is it a product we buy once, or is it ongoing? How does it lever current and emerging e-commerce technologies, such as Internet video conferencing? Does it support industry standards in areas

such as EDI or XML (extensible markup language)? How does it integrate my existing systems so I can take advantage of this technology now?

When it comes to whether your organization will use e-commerce technologies, your choices are to be reactive or proactive. You can let the competition do it first, and over the next few years spend money, time, and effort reacting to customer demands while gaining little

strategic benefit. Or, you can be proactive — and that is the challenge I issue. Take leadership in health care by leveraging these technologies to provide better service and value to patients, consumers, and customers. You will build relationships with trading partners to help you reduce costs, improve quality, and gain long-term strategic and competitive advantages. All it takes is the willingness to change.

## Stages of MCO business evolution

- **Publish:** Company profile, news
- **Interact:** Provider directory, member services
- **Transact:** Online enrollment, referrals, and claims processing
- **Integrate:** Online medical management
- **Transform:** All processes seamlessly integrated

SOURCE: FIRST CONSULTING GROUP

SPECIAL PRESENTATION

# Issues That Will Determine Health Care's Future

EMILY FRIEDMAN

The greatest miscalculation employers and plans made, when they sought to make managed care the dominant form of private health insurance, was to overlook the fact that managed care is an uneasy cultural fit with Americans.



**E**mily Friedman is an independent writer, lecturer, and health policy analyst. She is a contributing writer for the *Journal of the American Medical Association* and a number of other health care publications, and has edited several books on medical ethics and health care financing. She also is adjunct assistant professor at Boston University School of Public Health.

*In her remarks, Friedman singles out six sets of issues — not the least of which is the evolving demographic makeup of the United States, which will force changes in the delivery and financing of health care. Friedman foresees consumerism continuing to sweep health care — and while many experts predict that this will force people to become more sensitive to the ramifications of medical-resource use, Friedman predicts the first ones to face sacrifices will not be consumers, but health plans and providers.*

AS AMERICANS, WE THINK CHANGE IS GREAT — as long as we can control it. But of all the changes we can't control, the biggest is the future. I'm here to talk about the issues I think are going to determine the future of American health care.

The first is demographic change, which, to me, is going to be *the* most important force. The second is consumerism, followed by the fight over managed care. Next are a number of volatile financing issues. Then there is the politics of health policy, and, finally, the relationship of our health care system to society.

These trends are interrelated. Consumerism affects health policy. If you're talking managed care, you're talking about financing. If you have an aging nation, that gets mixed up with health policy and finance. It's difficult for Americans to understand that there are usually intermingled forces at work, when you try to solve a problem. We want a simple B for every A. But most of the time, it doesn't happen that way.

### America's changing face

The first factor with serious implications for the future is demographic change. There are three key trends here: an aging society; a growing female majority, particularly in older age groups; and increasing ethnic and racial diversity.

In terms of aging, it's simple. The share of Americans over 65 is going to rise from 4 percent to 22 percent by 2040. If the baby boomers keep eating vegetables and running around the block, there could be 18 million people over 85 by the year 2050.

There are two reasons for this. First, life expectancy went up 60 percent in the 20<sup>th</sup> century. Second, 76 million Americans were born between 1946 and 1964 — and they are turning 50 at the rate of 9,000 a day and will do so for the next 14 years.

There's another factor that feeds into this: Women outlive men by about five to seven years. Compounding this is the fact that men, particularly on second marriage, tend to marry women who are seven to 10 years their junior — so as aging progresses, you get a large disproportion of unmarried women to unmarried men. At the age of 65, there are 315 unmarried women for every 100 unmarried men.

Many women simply outlive their resources. We're already seeing that among women in their 70s. Many may have expended the family resources on the illness of a spouse who has now passed away. The implications of having a large and vulnerable group of aging fragile women are very serious.

The other major population change is diversity. Right now, 12 percent of the U.S. population is Latino. In 30 years, 1 in every 5 Americans will be of Latino heritage.

How are demographic changes going to affect health care?

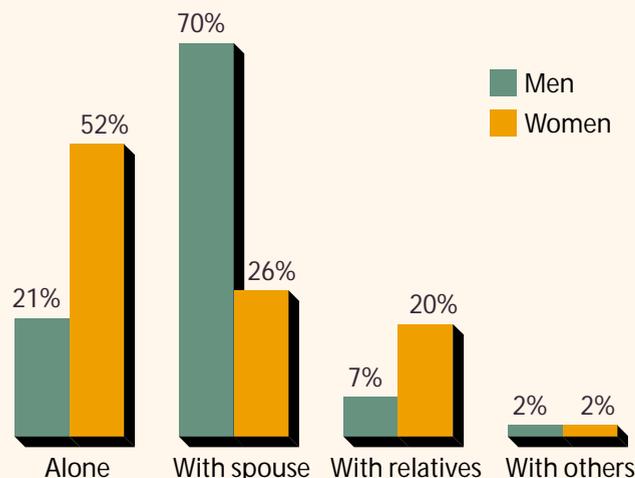
The biggest change, in my opinion, is going to be long-term care — the issue nobody wants to deal with. It's going to land on the policy table with a big, loud thump. We are going to see an extremely painful, contentious shift of resources from an overbuilt acute-care sector focused on cure and younger patients to a model that focuses on continuity of care and services for older and chronically ill patients.

Simply put, older people use more health care. They are the biggest users of pharmaceuticals.

Further, aging baby boomers are going to be an entirely different breed from the compliant elders of the past. They are not members of the "Yes doctor, no doctor" generation. It is going to be the most consumerist older generation in history — which brings us to the second issue shaping health care's future: consumerism.

**Lack of trust**  
How is consumerism playing out in health care? For one thing, people are becoming dis-

### Living arrangements for Americans 75 and older, 1994



SOURCE: POPULATION REFERENCE BUREAU

trustful of the health care system. According to the *Journal of the American Medical Association*, 42 percent of Americans seek alternatives to traditional therapeutic interventions. Millions of women are downing soy rather than using hormone replacement therapy. Many people are trying entirely different approaches to health care, from chiropractic to quartz crystals to homeopathy. They are especially using herbal remedies, for which there is an ever-growing amount of very seductive and persuasive marketing.

Part of this rebellion is leftover hippieism. Much of it is resistance to what is perceived as abuse of power. For health plans, pharmaceutical makers, and providers, the message is clear: It is necessary not just to have respect for the consumer, but to *demonstrate* respect for the consumer.

The third force is the fight over managed care. Currently, 104 million people are enrolled in some form of managed care. Everyone expects managed care to grow. The shift to managed care has been a revolution of unprecedented speed and scope — and yet, something must be wrong; most states have passed some sort of anti-managed care legislation. My favorite example is Alaska, which passed an omnibus managed care regulation package about three years ago — despite the fact that there is no managed care whatsoever in Alaska.

Patients' rights under managed care — even if many such proposals have more to do with providers' and attorneys' rights — constitute a major political issue.

If managed care is widespread, why has it become so unpopular? Part of it is a cultural thing. We live in the land of the Big Gulp soft drink, the never-ending pasta bowl, and the all-you-can-eat buffet. To Americans, more is better — whether you eat it all or not. Managed care encourages, in my opinion, correctly — conservative care, outcomes-guided therapy, and population-based medicine.

We also live in the world of fast food, drive-through funeral parlors, and e-mail. Managed care often encourages a watch-and-wait approach, urging patients to stop and think before they demand expensive marginal therapies or surgery.

The greatest miscalculation employers and plans made when they sought to make managed care the dominant form of private health insurance was to overlook the fact that managed care, by its very structure and principles, is an uneasy cultural fit with Americans. Telling people to wait or accept less goes against this culture.

### Cost savings shot?

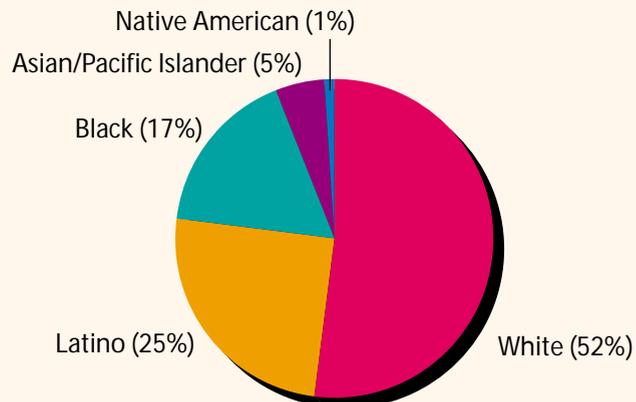
Managed care was embraced by payers because the health plan said, “We can stop runaway inflation.” And for a while, it worked. In the early '90s, the double-digit inflation in health care dropped, and managed care was quick to take all the credit.

A few of us whined that a lot of this was one-time-only savings created by plans, forcing providers to give discounts for the first time. Few people listened to us.

But plans' ability to hold down health care costs appears to be waning. If projections are accurate, by the end of this year, health care inflation over the last three years will have been 22 percent in an economy where general inflation is nearly flat.

## Nonelderly uninsured population, 1998

In millions



SOURCE: KAISER FAMILY FOUNDATION

The public's uneasiness is compounded by the fact that it doesn't understand managed care. The Employee Benefit Research Institute, in its annual Health Confidence Survey, found that of all the people who are in managed care plans, 21 percent know they are, but 54 percent swear they have never belonged to managed care.

In any such battle for hearts and minds, there is always an epiphany. In this case, it could be the introduction in 1998 of a certain prescription drug for erectile dysfunction — and Kaiser Permanente's subsequent announcement that it would not cover it.

By then, this was the most prescribed drug in the U.S. It was \$10 a dose, and that made people agitate for coverage. Kaiser said no. Then-California Gov. Pete Wilson sued Kaiser, claiming that the drug was medically necessary. Kaiser lost.

The Health Care Financing Administration, not to be outdone — and apparently having taken leave of its senses — then tried to force state Medicaid programs to cover the drug, at which point, Wisconsin, Michigan, and New York told HCFA to get lost. The National Governors Association passed a resolution opposing it.

This is what managed care is up against.

### **Code of ethics**

Well, health plans, of course, have done many things to try to improve their public image. But if managed care is going to flourish, it needs a code of ethics enforced by peer plans. The best plans are going to have to do something about the bandits.

I believe the managed care plan of 10 years from now is going to be much more influenced by public demand than the plans of the '90s were. If people feel they are being inconvenienced or endangered by managed care, they are going to express their displeasure. The laws shielding plans from suits in state courts will fall — probably not so much by legislation but by court action, as we are already seeing.

But managed care leaders aren't dumb. They need a scapegoat, and they've found a dandy one in big pharma. The argument I keep hearing from managed care is that the real culprit in cost increases is pharmaceutical prices. So I think the pharmaceutical industry has to be prepared to be the public's next target.

Which leads right into the fourth issue that could determine health care's future: financing. This includes pharmaceutical costs; the financial futures of managed care, public programs, and providers; the future of private insurance, and the uninsured.

The pharmaceutical-price issue, to many people, is real. One third of the population over 65 has no coverage for prescription drugs, and if you dig into the numbers, you find these are disproportionately low-income people. Even if you do have coverage, it has caps and restrictions, such as the common Medicare plan limit of \$500 a year — which, for that population, is woefully inadequate.

Resent it all you wish. The fact is, in a third-party payment world, people don't like having to shell a lot of money out for stuff they think they need. I think if fewer and fewer people can afford prescription drugs, then when enough of those people are middle-class, there will be outside intervention by government on a grand scale.

We're already seeing it on a small scale in Maine, and with a coalition of New England governors who are looking at group purchasing.

Another financing issue is managed care. Eli Ginsberg, the Columbia University economist, when discussing the shift to managed care in the early 1990s, said, "Yes, MCOs are doing great with their first round contracts — but 10 years from now, what are they going to do for an encore?" I think it's a good question.

As with the pharmaceutical industry, I see a day of reckoning coming for health

plans. Too many have betrayed the bright promise of managed care. I don't want to see that promise destroyed, because if managed care doesn't work — despite providers' fantasies — the road leads to a single-payer system, a prospect I find very unappealing.

A third financing point is about public programs. Medicaid is chronically underfunded, and states have been creative in drawing down federal money to keep these programs afloat. The massive increase in the aging population is going to force Medicaid programs to spend more of their limited resources on long-term care. In many states, 75 percent of Medicaid expenditures are already spent on the elderly.

With all the other demands on Medicaid, from protecting the destitute to subsidizing indigent care, I think Medicaid is in danger of collapse. Whatever you think of Medicaid, it is the insurance of last resort for 35 million people.

As for Medicare, if there is any program that people in this country want, it's Medicare. If spending takes off again, the solvency of the program is going to come into doubt. I assure you this will spark political action — and the money is not going to be taken out of patients' hides, but from providers and plans. And it will happen fast.

### Political landscape

Perhaps for a moment we should realize how vulnerable we are to major political intervention inspired by a frustrated and disillusioned public. Health plans are particularly vulnerable; if it comes to a fight, the public will always favor doctors and hospitals over insurers.

There are 45 million uninsured Americans. They are most likely to be Latino. Nearly 40 percent of American Latinos under 65 are uninsured. Most of these people are employed or are children, and the vast majority are legal residents of the U.S. This being our fastest-growing population group, we are looking at an acceleration of growth in the uninsured.

I have been anything but a fan of Clinton Administration health policies. I thought the Clinton health plan may have been the stupidest piece of health policy legislation ever. But I support the proposal that people of a certain income level over age 55 be allowed to buy into Medicare if they can't afford insurance.

Meanwhile, the ranks of the uninsured keep growing. The greatest threat to the independence of the health care system is the growing army of people who can't get in the door, combined with the diminution of available indigent care. How we address this is going to determine everything in health care finance. The answers are going to involve heavy rethinking of health policy. Many of you booed yesterday when Paul Begala spoke the magic words "universal coverage." That term does not necessarily mean single payer, but unless you are dying to have a single-payer system, we better look at how to cover the uninsured affordably before the roof falls in.

Which brings me to the fifth force: the partisan nature of health-policy making. In health care, there is always politics. Most other countries have determined the ground rules: *Is it going to be universal coverage? Is it going to be public or private? What is government's role?* Then they endlessly tinker around the edges.

In this country, we haven't decided any of those things. We can't even decide if we want everybody to have access to care. We can't decide if the system should be publicly or privately funded or controlled. We can't even decide if we want providers to be charities, businesses, or investment opportunities.

If you don't set basic ground rules, partisan politics will fill the vacuum. But in health policy, this has gotten to the point of being destructive. We have partisan wars



**In this country, we can't decide if we want everybody to have access to care. If you don't set basic ground rules, partisan politics will fill the vacuum.**

over Medicare and managed care. What I find interesting is that this is ideological. The gap is between people who hate managed care and people who adore it. Two of the most ardent opponents of managed care are House Republicans Greg Gansky of Iowa and Charlie Norwood of Georgia, who otherwise are very conservative.

The fights over managed care and the pharmaceutical industry are intertwined. The number one reason Medicare beneficiaries go to managed care is to get the pharmacy benefit. If Medicare gets a pharmacy benefit, we may see a lot of people going to traditional coverage, which will make for fascinating health policy discussions.

But extreme partisanship guarantees that the two biggest time bombs — an aging society and the skyrocketing number of uninsured — are unlikely to be addressed until they explode. And desperation does not make for good health policy.

### **Crystal ball**

Well, what are my predictions on this?

There's going to be more talk than action on a pharmacy benefit under Medicare. The states that are already acting are going to lead the way on this issue.

I do not foresee pharmaceutical price controls, but watch New England. There is an effort in Maine with several web sites where American physicians will write prescriptions that can legally be filled by mail in Canada, with drugs delivered to people's doors. Also, there is a lawsuit over price-control legislation in Maine.

The Patients Bill of Rights is all talk and no action. The big event is going to happen whenever the courts end HMOs' immunity from lawsuits.

There will be no federal action on the uninsured. Congress passed the Health Insurance Portability and Accountability Act four years ago to try to make a dent. The president said it would lead coverage for 25 million people. I have no idea what led him to think that. Some states are going to try to act on the uninsured. Watch Vermont and Oregon. But as we learned, when Hawaii tried it and failed, there were two big problems: Not everybody believes in universal coverage, and despite magical thinking on the part of policy makers, no one has figured out a way to cover large numbers of uninsured people without spending more money. Tennessee tried; it thought it would save so much money with managed care it could cover everybody.

This brings me to the relationship between the health care system and society.

First, I will make three predictions you can take to the bank:

The United States is going to continue to have a health care system.

That system will reflect and be supported by the society that gave birth to it.

That system, particularly if it is accessible to all, is going to be of higher quality and more effective than even today's good system.

There is so much doomsday thinking in health care now that we sometimes forget that people are going to continue to need health care, and that more than anything else, people want to be able to trust the system. These truths are very old.

What we have done has produced, in those we serve, both trust and fear. We must always try to honor the trust and calm the fear, but now more than ever, because this is one of those times when health care is bolting into the future. The question is, will this thrust be only technological — or humane and compassionate as well?

A century ago, a great physician, Sir William Osler, was talking to a group of physicians at the dawn of 20<sup>th</sup> century medicine. He said the opportunity to transform medicine is not given to every generation.

Our generation is one of those that, I think, has been given that chance. I hope we take it and run with it.

**CONTINUING EDUCATION ANSWER SHEET/CERTIFICATE REQUEST**  
**The Changing Landscape of Healthcare**

**CE Credit for PHYSICIANS**

See page 24 for answer sheet for pharmacists

**Sponsored by the University of Arizona  
College of Medicine  
at the Arizona Health Sciences Center**

Name \_\_\_\_\_  
FIRST MI LAST

Specialty \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime phone \_\_\_\_\_

**Physician** — Maximum of 1 hour in category 1 credit. This learning module may be used for category 1 credit through Dec. 31, 2001.

Complete answer sheet/evaluation form and mail to:

**Continuing Medical Education**

University of Arizona College of Medicine  
PO Box 245121  
Tucson, AZ 85724-5121

Alternately, you may fax this completed sheet to:  
520-626-2427.

Credit will be awarded upon successful completion of assessment questions (80 percent or better) and completion of program evaluation. If a score of 80 percent or better is not achieved, no credit will be awarded and the registrant will be notified.

Please allow up to six weeks for processing.

The cost of this activity is provided at no charge to the participant through an educational grant by AstraZeneca.

**EXAMINATION:** Place an X through the box of the letter that represents the best answer to each question on page 25. There is only ONE answer per question. Place all answers on this answer form:

	A.	B.	C.	D.
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PROGRAM EVALUATION**

In order to assess the value of this self-study program, we ask that you fill out this evaluation form.

**Overall Activity Rating**

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very good</i>	<i>Excellent</i>
1	2	3	4	5

**Were the educational objectives met?**

<i>Not at all</i>				<i>A great deal</i>
1	2	3	4	5

One of the purposes of CME is ultimately to improve patient care. With this in mind, please indicate your potential for implementing the information presented at this seminar.

<i>Very little</i>				<i>Very much</i>
1	2	3	4	5

**What other topics would you like to see addressed?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Did you detect any bias in this presentation?**

Yes \_\_\_ No \_\_\_

If "Yes," please explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CONTINUING EDUCATION ANSWER SHEET/CERTIFICATE REQUEST**  
**The Changing Landscape of Healthcare**

**CE Credit for PHARMACISTS**

See page 23 for answer sheet for physicians

**Sponsored by the University of Arizona  
College of Pharmacy  
at the Arizona Health Sciences Center**

Name \_\_\_\_\_  
FIRST MI LAST

Specialty \_\_\_\_\_

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\_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

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**Pharmacist** — This program is approved for 1 contact hour (0.1 CEU).

ACPE program number: 003-999-00-046-H04.  
Expiration date: Nov. 30, 2001.

Complete answer sheet/evaluation form and mail to:

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PO Box 210207  
Tucson, AZ 85721-0207

Alternately, you may fax this completed sheet to 520-626-2023.

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Please allow up to six weeks for processing.

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**EXAMINATION:** Place an X through the box of the letter that represents the best answer to each question on page 25. There is only ONE answer per question. Place all answers on this answer form:

	A.	B.	C.	D.
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PROGRAM EVALUATION**

To receive pharmacy credit, please answer all information requested below. This will assure prompt and accurate issuance of your continuing education certificate.

Please rate this program as follows:

	Poor	Fair	Good	Very good	Excellent
Overall quality of the program	1	2	3	4	5
Content	1	2	3	4	5
Relevance of content to objectives	1	2	3	4	5
Effectiveness of this format for learning	1	2	3	4	5
Value to me in my daily responsibilities	1	2	3	4	5

**How long did it take you to complete this continuing education activity?**

Hours \_\_\_\_\_ Minutes \_\_\_\_\_

**Suggested topics for future programs:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Comments:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Did you detect any bias in this presentation?**

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

## CONTINUING EDUCATION QUESTIONS

### The Changing Landscape of Healthcare

Directions: Please tear out the combined answer sheet/assessment form on page 23 (physicians) or 24 (pharmacists). On the answer sheet, place an X through the box of the letter corresponding with the correct response for each question.

- 1. By the year 2000, the percentage of Americans over age 65 had reached 4 percent. What percentage of Americans will be over age 65 by the year 2040?**
  - A. 10 percent.
  - B. 12 percent.
  - C. 18 percent.
  - D. 22 percent.
- 2. Sales among online pharmacies in 1999 was about \$160 million. By 2002, that figure is projected to climb to:**
  - A. \$400 million.
  - B. \$600 million.
  - C. \$800 million.
  - D. \$1 billion.
- 3. How does consumerism play out in health care?**
  - A. People are becoming more distrustful of the health care system.
  - B. People are turning to alternative therapies.
  - C. People want greater choice of physicians and care options.
  - D. All of the above.
- 4. Only 20 percent of health plans have reached a point where they transact business online. Examples of this include what?**
  - A. Online enrollment.
  - B. Claims submission.
  - C. Online medical management.
  - D. Answers A and B only.
- 5. Men have a shorter life expectancy than women, and tend to marry women who are younger than them. The result is a large disproportion of unmarried elderly women to unmarried elderly men. What is this proportion by age of 65?**
  - A. 415 unmarried women for every 100 unmarried men.
  - B. 315 unmarried women for every 100 unmarried men.
  - C. 215 unmarried women for every 100 unmarried men.
  - D. 115 unmarried women for every 100 unmarried men.
- 6. The primary public policy implication of an older population composed mostly of females is:**
  - A. Long-term care.
  - B. The solvency of Medicare.
  - C. Prescription drug costs.
  - D. Increased rates of renal failure.
- 7. Technological advances have fostered improvements in communication between payers, providers, and patients. Which of these advances are already in use?**
  - A. Electronic prescribing.
  - B. Internet video conferencing.
  - C. Virtual office visits via patients' home televisions.
  - D. Answers A and B only.
- 8. Forty million people visited health care Internet sites in the first quarter of the year 2000. By 2005 it is expected that how many different people will use the Internet for health care information?**
  - A. 60 million.
  - B. 88 million.
  - C. 133 million.
  - D. 175 million.
- 9. The number of uninsured people in the United States is expected to increase over time because:**
  - A. The Latino population, which already has a disproportionate share of uninsured, is rapidly increasing.
  - B. The Clinton health plan failed to pass in its entirety.
  - C. The concept of universal care is unpopular in the U.S.
  - D. The Internet is creating a gulf between health care "haves" and "have nots."
- 10. When health care claims are submitted via \_\_\_\_\_, the administrative cost is reduced from \$1.25 to 5 cents:**
  - A. electronic data interchange
  - B. fax
  - C. the World Wide Web
  - D. e-mail

PANEL DISCUSSION

# Solutions To Health Care Issues

THE FACULTY

**Richard H. Bernstein, M.D.**

Senior Corporate  
Medical Director  
Aetna U.S. Healthcare

**David Brennan**

Senior Vice President,  
Commercialization and  
Portfolio Management  
AstraZeneca  
Pharmaceuticals

**Becky J. Cherney**

President/CEO  
Central Florida Health  
Care Coalition

**Emily Friedman**

Health policy analyst

**Alixé Glen Mattingly**

Senior Vice President  
Pharmaceutical Research  
and Manufacturers  
Association\*

MODERATOR

**Gene Beed, M.D.**

President  
horses, zebras, &  
unicorns inc.

\* Since participating in this panel discussion, Alixé Glen Mattingly has left PhRMA.



*Emily Friedman, Richard H. Bernstein, M.D., Becky J. Cherney, David Brennan, and Alixé Glen Mattingly discuss how HMOs and drug manufacturers can build public trust.*

What defines quality of care in stakeholders' eyes? What would price controls on pharmaceutical products mean to research and development? Would cost-sharing lead to better consumer use of health care? A lively discussion.

**GENE BEED, M.D.:** Emily, what's the biggest issue among the things you talked about today? [See "Issues That Will Determine Health Care's Future," page 17 — ed.]

**EMILY FRIEDMAN:** Population changes. Our rapidly aging society, the growing percentage of vulnerable women, and greater diversity.

**RICHARD H. BERNSTEIN, M.D.:** I would conceptualize a lot of the factors Emily talked about by saying that managed care is something of a misnomer. What we're trying to do is manage financial risk and then, because we're a health organization, we also have the potential to enhance quality. So the biggest challenges are managing risk and addressing the issue of trust — a very important theme she emphasized.

**BECKY J. CHERNEY:** To me, the big issue is the delivery system. I think the demographics are a fact, not an issue. How we deal with them is the issue.

**BEED:** Becky, you have mentioned what you're doing in Florida with data [See "The Employer's View of Health Care," page 8 — ed.]. I think that's a big bugaboo for a lot of people in this audience — they have lovely data repositories that I call data motels, because data have a nasty habit of checking in but not checking out.

How did you build a data motel that allows them to check out?

**CHERNEY:** We don't believe in data. We believe in information. We have a system called Atlas. It is mandated in Pennsylvania — every hospital there has it — so that gives me a great comparative database to look at what they're doing there.

**BEED:** So did your coalition actually buy that?

**CHERNEY:** The hospitals did in partnership. We asked them to buy it, but they said "No, it's too expensive." We said, "Well, we'll create a billing line, and you can charge us directly," and they said okay. Then I said "Now, create a second line. We want to know the impact of your executive bonuses on each discharge," and they decided they'd bury it in the patient's records and the bill! That's how we got there.

**BEED:** It sounds like a strategy hospitals have used in hospital bills for years — just bury it somewhere in the bill and call it something else.

**CHERNEY:** Right next to the patient.

**BEED:** My! Well... we're going to come back to you. David! From what you hear, what's the big issue?

**DAVID BRENNAN:** The worst case, I think, is price controls, but the things we worry about most are outside of our control on the legislative side. Our customers hear about the price of pharmaceuticals, and our industry has not been effective in demonstrating the value pharmaceuticals bring to the equation. We see outcomes in terms of longevity, but we're not as good as we should be at showing what we do to make that happen.

**ALIXE GLEN MATTINGLY:** The political marketplace is not prone to liking this industry right now. The public does not understand fundamental issues, and, sadly, government officials who regulate this industry are woefully undereducated about them. I would agree with something Emily said this morning: Our society wants more, wants it now, and sees health care as an entitlement. We have the best health care system in the world, but people don't want to pay for it. Collectively, everybody involved in health care needs to work better at exactly what David said: Telling our story loudly and proudly, because it's a great one.

**BEED:** You said we have the best health care system in the world, but not everybody agrees with that.

**MATTINGLY:** We have the innovation. Part of that is because we have a competitive market that allows

for innovation. We have the technologies and the expertise. If anyone in this room got sick, I don't think he would rather be anywhere but America.

**CHERNEY:** I was in England when my husband had a heart event. I called one of the three ambulances available in the province, and it came in a half hour. There was not a telephone or anything in the ambulance to connect you to the hospital when you're coming in. My husband has an implanted defibrillator. They had never seen one! The ICU looked like a MASH unit from 20 years ago, and though the people are wonderfully compassionate, they simply don't have the resources. When he got out of the hospital, they said it wasn't safe to fly home. We decided the greatest risk he had was that health care system.

**BEED:** To stay there.

**CHERNEY:** Yes. And we flew home.

**BERNSTEIN:** Part of the discrepancy in being the best in some eyes but not others has to do with the index you're using to rate the system. In access to technology, I think we are the best, according to the World Health Organization, but in terms of ease of access to appropriate care by our socioeconomic strata, we're certainly not.

**FRIEDMAN:** That WHO study, where the United States came in 37<sup>th</sup> overall, was controversial because many factors were involved. The 37<sup>th</sup> ranking was attributable mainly to our high percentage of uninsured. The second thing we fell down on is preventive services, and our third problem is infant mortality. What we are best at is longevity and quality of life for people over age 65.

*[Beed takes a question from the audience.]*

**QUESTION:** As we've developed technologies and hygiene methods that have kept people alive, we are left with people who are chronically ill. I know there are physicians who say, "Well, this person is 65 years old. He's going to die soon, so we don't want to give it too much effort." But what makes old cells die? Nobody really knows. I think the science of aging needs to be addressed if we're going to avoid the catastrophe Emily described today. People won't get sick as rapidly as they do if we could figure out why.

**FRIEDMAN:** We have an interesting phenomenon in the United States: This is the healthiest set of elderly people we've ever had — and nobody really knows why. Possibly, it's genetic, but if you look

at long-term care, there are fewer elders per thousand in nursing homes today than there were 10 years ago, and their health status continues to improve. The need for gerontologists and an interest in aging patients, the need for an entirely different approach to prevention and maintenance of people with chronic illness, and end-of-life issues are still not prestige elements in medical schools. Medical schools, for the most part, are still in the stranglehold of fee-for-service medicine — specialists are obsessed with curative care for younger patients. If there's going to be a catastrophe, that may be where it starts — we aren't going to have a medical profession that knows how to take care of older folks.

**BERNSTEIN:** Well, to frame the issue as knowing more about the science of aging partly reduces the demographic issues into one of science, when I think there's also a cultural problem of understanding what people want. Not all older people want to maximize length of life if quality of life is compromised, and yet there is this almost intractable thrust to save, to treat, to cure — which is fine if that's what the person wants, but it is not appropriate for all. Ignoring living wills is a serious violation, in terms of trust.

**BEED:** Well, why do we ignore living wills?

**FRIEDMAN:** This bias for action — Richard is absolutely right — is strong. The feeling is that otherwise, you're abandoning your patient. But we waste a lot of money and emotion and trust when the physician refuses to let go. The physician blames it on the family, but, in fact, there's enough guilt to go around.

**BERNSTEIN:** Another important aspect of this is the need for more palliative care specialists. Physicians' [lack of] ability in pain management and in providing comprehensive palliative care at the end of life is appalling. This is a very active and complicated process that necessitates training. It isn't giving up, and it isn't doing nothing. It's doing something crucial and meaningful — as meaningful, if not more so, than a lot of other things that are done in the curative mode.

*[Beed takes another question.]*

**QUESTION:** Research and development is a foundation in the pharmaceutical industry, and many improvements have been delivered through those efforts. There is a sense in the media that

pharmaceutical companies' futures are not based on research and development, but on fine-tuning their marketing tools. I'd like your thoughts on the emerging perception of pharmaceutical companies as supermarketers and [thus placing] less emphasis on research and development.

**BRENNAN:** The pharmaceutical industry is, above all, research based. The ability to bring forward products that are based in science and that contribute to longevity or risk reduction will be the basis for our success in the future. I think we can adjust our marketing to adapt to whatever the environment is, but we base that first on research — so I think we will continue to be driven by research. The market values the highest-quality products and sorts itself out, so that pharmaceutical companies no longer develop the ninth proton pump inhibitor, or the 14<sup>th</sup> beta blocker. They can't create enough leverage with marketing to make those products break through. They either need to have an advantage, or they get out.

**BEED:** What about government price controls?

**BRENNAN:** I think that would roll back what you have left to invest. AstraZeneca's R&D budget this year is \$2.2 billion. That's a lot of basic research and clinical development. If we have controls that legislate a 25-percent price cut, then, the amount of money we have to plow back into that is significantly reduced.

**MATTINGLY:** Just to put some numbers to it, the industry will spend over \$26 billion on research and development this year, and less than \$2 billion on marketing. A lot of that marketing is to doctors, not consumers. The media hype direct-to-consumer advertising, and I think that is irresponsible, quite frankly. There is nothing to market if you don't innovate, and, from the pharmaceutical industry's perspective, this is the best time to be alive because of that innovation.

*[Beed takes another question from the audience.]*

**QUESTION:** I'd like to ask about reimportation of U.S.-made drugs from Canada. As a representative of a pharmacy benefit manager, I don't know whether we should develop a strategy for that.

**BEED:** Well, you know, there's another question behind this: Why are drugs so much cheaper in Mexico or Canada than in the U.S.? Why do the elderly in America board buses to go to Tijuana to buy things that they can't afford in San Diego?

**MATTINGLY:** The reimportation bill is probably the pharmaceutical industry's biggest threat before Congress recesses, because I think Congress feels it needs to go home and say, "We did something." They have to hold up one trophy, and Medicare drug benefits are probably too complicated to deal with [in a short period of time]. Reimportation is a frightening prospect. Eleven living FDA commissioners recently testified before Congress, saying this is unsafe. It's not just Canada you will get your drugs from. It's [other countries], you name it. And there will be counterfeit medicines coming into this country the likes of which we have never seen.

**BEED:** That's frightening, but I think the question was, what should folks do about this?

*[The person who asked the question interjects:]*  
Are prices going to come down in the U.S.?

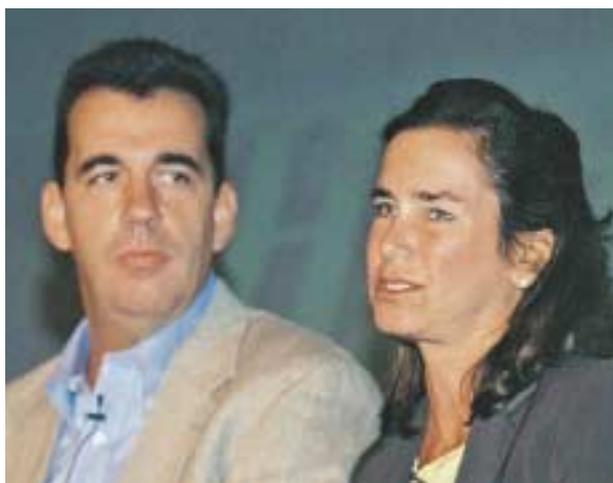
**MATTINGLY:** Well, I think the price increases that the media and politicians talk about are somewhat misrepresented. Prices of drugs — the increases in the whole market basket — have been below increases in inflation over the last couple of years. Utilization, however, is going up at great speed, and it's no wonder. People would rather take a pill than have surgery — or whatever — and so innovation is [driving increased] utilization. Drugs are cheaper in Canada and Mexico for one reason: price controls. With price controls, you get poor-quality health care. I don't think we want to look to Canada or Mexico for health care solutions. Canada — a very progressive, modern country — has health care rationing. Canadians do not have some of the innovative drugs available in America.

**BEED:** Alixe brought up something that's very interesting — this concept that the volume of pharmaceutical use has been increasing. We've improved detection and diagnosis, [which has

generated] appropriate as well as inappropriate increases in resource use. Becky, give us some examples of quality initiatives your organization is taking that actually increase utilization — perhaps screening for depression, hypertension, diabetes, or something else — because I think some of us are troubled that some employers define quality as resource-consumption reduction.

**CHERNEY:** We've done an *H. pylori* project, which really has turned out to be ethnic medicine. We started out by screening 1,000 people to see what we had. Seventy-five percent of people with a Latino-Hispanic background were positive for

*H. pylori* — 45 percent of whom were at a level, clinically, that said they should have treatment. Every person over 65 tested positive. Very few people with Caucasian background were positive. They were uninsured. And so we got money to get them treated. There was a tremendous increase in pharmaceutical use, but some day, somebody will say, "I wonder why Orlando has such a low rate of gastric cancer?" and it will be because of that.



**Mattingly:** With drug-price controls, you get poor-quality health care. I don't think we want to look to Canada or Mexico for health care solutions.

*[Beed takes another question from the audience.]*

**QUESTION:** I want to ask about appropriate utilization of medications. To use cholesterol treatment as an example, only 25 percent of people who have coronary artery disease have appropriate LDLs — so there's underutilization. At the same time, we see patients who don't fit the risk profile but are given cholesterol medication. There are studies that show the cost can be as much as \$600,000 to \$1 million per year of life saved when asymptomatic patients are put on cholesterol-lowering medications. Is there an opportunity for managed care, pharmaceutical companies, and providers to work together to improve and increase utilization where it's clearly indicated,

and then, in other areas, to be more circumspect about overutilization?

**BRENNAN:** I think it is in our interest to discourage inappropriate utilization. The approach we have to take, from a marketing perspective, is to focus on proper utilization, and I think that's at the heart of what we're trying to do.

**FRIEDMAN:** One of the great promises of managed care is the ability of good plans to back up physicians who say no. This isn't a cost issue, it's a quality-of-care issue. The system is the problem. As a matter of improving quality, you need a partnership through physician and public education so the public doesn't say, "Oh, it's just managed care trying to deny something again." Managed care, because of its conservative approach, should be waving the banner with its pharmaceutical partners, saying, "If they want antibiotics for a viral condition, you tell them no — and here is how you explain it to them." If plans and physicians were willing to team up on that, we would not see so many people dying helplessly of pneumonia and other conditions that we essentially created because we strengthened the bugs.

**BERNSTEIN:** When we talk about inappropriate drug utilization, there are three ways to think about it: over-, under-, and misutilization. If we're looking at underutilization — in other words, a compliance problem — the interests of the plan and the pharmaceutical industry are congruent, because compliance strategies are not typically the physician's forte. Physicians are less than 50-percent accurate in predicting who's taking the medication. The resources of drug companies can complement those of managed care to give members on long-term medications reminder strategies, especially when they're on multiple drug regimens. At the same time, research needs to be directed to simplifying the drug regimens. That will certainly help, at least, with that aspect of inappropriate utilization.

**BEED:** So there's some agreement on, at least, compliance and underutilization. Well, we're almost out of time... what's the one thing you folks would recommend to this group — the one thing they can start doing after this meeting?

**BERNSTEIN:** Well, it gets to a very fundamental theme that ran throughout Emily's discussion. It had to do with trust and with consumerism and

HMO-bashing. Trust is partly threatened by the use of denials, and the undermining and threatening of autonomy — both, at the physician and patient levels. The first two generations of managed care focused on controlling costs. We've put ourselves, as an industry, in the role of naysayers by defining rules and incentives that operate, primarily, at the physician level: withholds, capitation, quality-based or utilization-saving bonuses. The way out of that is to shift to a cost-sharing relationship with members and get out of the way of the doctor/patient relationship — instead of this mishmash of responsibility and autonomy that exists today. In other words, "Do what you want, but we're going to give you report cards on the quality and the relative cost of various alternatives you select, based on evidence, as well as our own analysis of the relative quality and cost-effectiveness of various hospital and physician providers." This model began in the three-tier formulary movement, and we've seen acceptance of that kind of cost-sharing mechanism.

**BEED:** So, you'd basically give consumers more information and come up with benefit structures that make them more price sensitive. Then, when they use a doctor who is very wasteful, that doctor goes into the second- or third-tier equivalent — still in network, but the system's cost differential of that doctor's somewhat inefficient practice patterns gets passed on to the consumer.

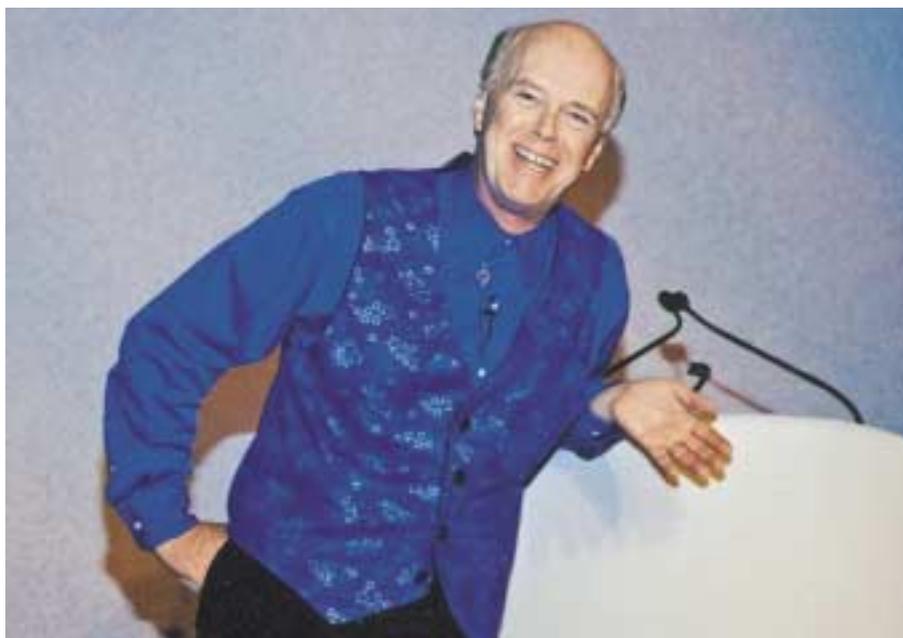
**BERNSTEIN:** They'd have a motivation to look at report cards, which they don't now. We've protected them, and that paternalism has been dysfunctional, inflationary, and politically unacceptable.

**CHERNEY:** Representing employers, who are ultimately the payers, we have the obligation to push this process forward — to get data, to turn data into information, and get that information into the hands of the people who deliver health care.

**FRIEDMAN:** I think we need to remember two very basic points: The first is that health care, any way you cut it, is about taking care of people who need you — so it is a trust relationship. The other thing is that anybody who works in health care is not simply under financial, logistical, and political demands. Anyone in health care is under a demand to act with ethics and with integrity and with honor. The people we take care of have every right to ask no less of us than that.

# Humor, Risk, and Change

C.W. METCALF



You have to be able to access absurdity in adversity. If you can't look at difficulty, pain, and trauma and see the absurdity in them, you will be enslaved by them.

**C**W. Metcalf is a motivational humorist. His Colorado training company, Metcalf & Associates (<http://www.litenup.org>), helps people and organizations thrive in environments of rapid change. His work with cancer patients and hospice groups prepared him for the field of motivational humor. In 1978, while writing a TV special about children with cancer, he quit his job to pursue the lessons these patients taught him. He and his wife, Roma Felible, coauthored the best seller *Lighten Up: Survival Skills for People Under Pressure*.

I'M HERE TO TALK to you today about humor — not jokes. According to my wife, the difference between a comedian and a humorist is that comedians tell jokes — and a humorist *is* a joke. I've been a testing ground for the things I'm going to talk about.

Most of what I have to share came to me through life experiences. You cannot spend as many years as I have in palliative care without being incredibly grateful for every breath you draw and without learning a lot.

Humor is a survival skill: a way to see, be, act, imagine, and adapt — “grace under pressure.” It is one of the common denominators of people who have seen, survived, and thrived in serious situations. Most of my interviews have been with POWs, hostages, and survivors of burns, rapes, and crashes. I have dealt with people who have seen the worst life has to offer, and who have been unbroken and unembittered by it.

Humor comes from the Latin *umor*. See? This is a real presentation! Latin! I use a lot of Latin when I talk to doctors so they know I'm hip and groovy.

*Umor* means “fluid like water.” Humor and fluidity are one and the same.

It's easy to get angry about the health care system, but remember that when you get angry, it's because you're afraid of something.

Four years ago, I was about to do a presentation in Ithaca, N.Y., and I got the Mother of All Headaches. I went to the ER, they saw I had a history of migraines, and they told me, “You need to rest.” I said, “Well, no, I’m a guy — I have testosterone poisoning. I’ve got a presentation to do.” And I went on and did it.

Afterward, I got on a plane, passed out, and drooled all the way to Portland, Ore. They couldn’t wake me up when we got there. The carotid artery in my brain had torn. Usually, when it tears, it shreds and you bleed and die. Mine tore at the exact angle to coagulate partially, allowing 10 percent of normal blood flow to my brain.

So I’m lying in the ER, and I heard *that sound*. I watch *ER*, and I knew *that sound* didn’t bode well. And then I heard the words, “He’s flat. Get the paddles.” I thought, “Flat? Paddles? I’m dead?” And then, as I was ready to fade away, I heard someone say, “We have three heart emergencies in the ER, and all the defibrillators are in use!”

Then a nurse walked by with that norepinephrine pump that almost never works. It’s a last-ditch effort. It’s like sewing on a decapitated head. She walked in and hit me in the heart with that needle. I bolted upright and went “Aaaahhhh!!” She yelled, “It worked!” Oh, that’s just what you want to hear! Very supportive.

Well, I knew I was going to make it because the first words out of my mouth represented the first lesson I had learned from all of those trauma and crisis survivors: You have to be able to access absurdity in adversity. If you can’t look at difficulty, pain, and trauma and see the absurdity in them, you will be enslaved by them.

I remember looking at the woman and saying, “If I live, I’ll buy you guys another damn defibrillator.” And I did.

That capacity is a learned ability. A lot of us grow up in environments that teach us that humor, fun, joy, and play are unintelligent forms of behavior. We hear things like, “Wipe that stupid smile off your face.” What a terrible thing to tell a kid! I was taught early on that life is a dangerous place and you have to outwork, outthink, and outsmart the next person to eke out a miserable existence in an unfriendly universe.

“Grow up.” “Get serious.” We get a lot of negative input over the course of our lives. No wonder kids tattoo dragons on their necks and put bones in their ears. When they move into a difficult work environment, their capacity for joy, which is essential to the creative problem-solving mind, has been repressed and put aside.

The only way you can redevelop that fluidity of mind, body, and spirit is to overcome your fear of embarrassment, foolishness, and failure. You’ve got to get past that fear, or you will fall prey to terminal professionalism.

### Does this sound familiar?

Indicators of terminal professionalism include Center of the Universe Syndrome — very common in this particular room. Another is fear disguised as anger and blame. It’s easy to get angry about the health care system, but remember that when you get angry, it’s because you’re afraid of something. Diminished creativity, fluidity, sanity, and health are also indicators. Terminal professionalism is not abstract. To overcome it, we have to overcome our fear of foolishness and failure.

Misery, pain, and change come for free. They are gifts that allow us to find what we’re made of. Let me give you the best example I’ve got.

I got a phone call a couple of years ago from the Shriners Burn Hospital in San Francisco: “Mr. Metcalf? My name is Keith. I’m 12 years old. I’ve had 11 operations in 18 months. Tomorrow is Socialization Day. I read your book, I really liked it, and I want you to be with me when I have to go out for Socialization Day.” I asked what Socialization Day was. “I have to get used to how people are going to look at me.”

Keith had been set on fire by a drunken parent. His face, throat, mouth, tongue, ears, nose, and eyes, had been burned so severely that all he had left was one eye with a wire running under his skin to a button on his hip he had to press once in a while to keep the tear ducts moving. He had a Velcro nose and ears because there was no tissue left to work with. His skull had been warped — that's how hot it had been. Before I walked in, I'd seen pictures of Keith but they didn't prepare me. The kid was hideous. I said, "Look, I've never worked with a burn victim as young as you, so if I make any mistakes, you let me know," because I was on the verge of tears.

The kid said, "Well, you've already made a mistake. I'm not a burn victim. Victims are dead people, Mr. Metcalf. I'm a burn survivor."

We went to Union Square. He bought popcorn and covered himself with it so the pigeons would sit on him and eat. He was having a great time. I thought, "He doesn't need me." Then, as we walked down the street, up came the typical businessman.

The guy had on a bandoleer of beepers. A Palm Pilot in every pocket. He had an 80-pound briefcase and he was on a cell phone. He looked at Keith and went, "Argh!" and just stared and couldn't move. Keith was getting uncomfortable. He turned to me and said, "What do I do?" I said, "Well, Keith, you've got to face this situation." And before I could say anything else, he went, "Oh, okay." To him, it was simple.

He looked at the guy and said "It's okay! I lost my spaceship." Well, I was on the ground! And the guy's response was, "Argh!" and he fled. After that, whenever anybody stared at Keith, he'd just look at them and go, "Mee meep, mee meep." A sense of humor, in part, is the ability to take yourself lightly and your problem seriously.

### Survival tools

I want to give you a couple of tools to develop skills to access absurdity in adversity.

**Photo funnies.** I developed this working for the Strategic Air Command. You want a high stress job? Work in a missile silo. Three days a week you go down there and wait to end the world. Anyway, we brought in photo booths. I told them to take four pictures of themselves looking as ridiculous and childish as possible. Carry them with you — you don't have to show them to people — but the next time you're feeling three inches shorter because your gut's so tight, take those photos out. Just access absurdity in adversity. It's an incredibly effective behavioral modification tool.

**Draw the line.** Come up with an exercise that says, "End of the work day, beginning of the rest of my life." One woman had to cross the Tappan Zee Bridge every day to go to work and back. She imagined a "crap net" hung across the bridge. As she drove home from work, all the crap from her work day got dropped into the net. It was gone! The next day when she came back, it was waiting for her, but this was something that said, "End of the workday, beginning of the rest of my life."

**Joy list.** I once worked with a kid who was dying of a basal-stem brain tumor. "Here," he said. "Give this to my parents after I die. It's a list of all the fun I've had. I think my parents forgot." If I asked most of you to make a list of things in the last six weeks that nourished and sustained your sense of joy, made you laugh, gave you hope, or allowed you to move ahead imaginatively, I'd guess most of you couldn't write down three things. If you're only going to pick one of these tools, do this.

Please, ladies and gentlemen, pick one of these things. Pay attention to the fact that humor is not about jokes and joke telling. I want you to think about humor as a skill that you can develop if you choose to overcome your fear of foolishness and failure; if you choose to avoid becoming terminally professional; if you choose to do some of the things that I've invited you to do.

There are things you can do to access absurdity in adversity. They're simple yet effective tools for behavior modification.