



The 12<sup>th</sup> annual Hilde and Bill Birnbaum Endowed Lecture

"Paradise lost, Paradise deferred? The role of integrated health plans in today's changing health care system."

Robert G. Evans, PhD

Professor of Economics

Centre for Health Services and Policy Research

University of British Columbia



Scott Armstrong, Group Health President and CEO: Of course, we're very proud at Group Health to be demonstrating how innovations work, how we can bring the synergy of research and our great care delivery system together to show to the rest of the country – actually the rest of the world – how our health care industry needs to change. And in fact, we've gotten great recognition for the work that we've been doing. Through this work, we are demonstrating to an industry, in fact, that is desperate for these improvements. How? Through better quality care we can create sustainably lower medical expense. And of course, that is really at the heart of the huge challenges facing our nation's industry. How do we have an impact that's sustainable on these relentless increases in medical costs and then of course how do we go about financing those increases? This is why today's speaker is such a relevant speaker for all of us. This issue is at the heart of our industry's issues and Dr. Bob Evans, as an economist, is well known as an expert on speaking to them. He is an economist and director for the Centre for Health Services in Policy Research at the University of British Columbia. His ground breaking comparative studies on health care systems and on funding strategies have shaped policy both in Canada, in our country, and frankly, all around the world. He's the author of many publications with titles such as "Strained Mercy: The Economics of Canadian Health Care." Or, "Why Are Some People Healthy and Others Not? The Determinants of Health of Populations." As you'll see, he has a way with words. Bob has served as a member of the British Columbia Royal Commission on Health Care and Costs and on the National Forum on Health, chaired by the prime minister of Canada. He's an educator; he's a mentor to some of the greatest minds in health care, including our own Rob Reid and Eric Larson. And, he's received many honors for his work, including like our own Ed Wagner, who is the winner of the prestigious grand prize for research in health services. In fact, he received this award in 2001. He became the first Canadian to receive this; the first non-American to receive this award. Bob's an undergraduate from the University of Toronto. He has his PhD in economics from Harvard University. Please join me in welcoming Dr. Bob Evans.

Audience: Clapping.

Robert P Evans: Well, thank you very much, Scott. And thank you all for coming. So, I'm to sort out the American health reform debate.

Audience: Chuckling.

RPE: (clears throat) And we don't have long, so we'll have to concentrate here.

Audience: Laughing.

RPE: But I did bring along a clock, so I have some hope of ... ah. Now that's interesting. If you create a podium with a slant like that, you can't actually keep a clock on it. I wonder if it'll stay here.

Audience: Laughing.

RPE: Or, you can put it down here, but then ... hard to see. Ah, well. We will continue nonetheless. Without myself having had any direct engagement with Group Health, I've been an admirer from afar for a very long time. And that's going to be a theme that I will touch on in various ways in the course of this talk. There's going to be a fair amount of historical dimension to what I plan to touch on. And, I think that's necessary because before focusing on the current state of health care reform in the United States and anywhere else for that matter, I think one has to have a deeper historical sense. And I think that's also why it's particularly appropriate to be at this memorial for the Birnbaums. You have to think about how we got here and what's happened along the way. And the processes that we went through – that you went through, particularly, and people here in Seattle went through – in getting to where we are today. And I think as I reflect upon that, there are quite a number of different themes one could pull out of that. But one of them is ... a bit blunt. Professor Donald McCloskey as he then was at the University of Iowa, formulated what he called the classic American question. And the classic American question is, “If you're so smart, why ain't ya rich?”

Audience: Laughter.

RPE: And in translation into the present context, it would be, “If you're so great, why haven't you spread?” Now, I think you are so great. I think it is an interesting question. In fact, a very powerful, very important question precisely because I do think you're so great. I think that the achievements here reflect fundamentally, the ideas. Getting the ideas right at an early stage. And then carrying those ideas forward with energy, with diligence; with just all the good stuff that makes things happen. So, the interesting question that I first want to address is the balance between getting the ideas right. And the power of the ideas. And at the same time, the extraordinary difficulty in spreading those ideas more broadly in an environment which at times, as you all know, has been overtly hostile. Very hostile. I mean, some of the stories out of California from the early days are practically almost civil war. And I know about this because I had the great privilege of coming into this field as a graduate student before there was much economic literature. So, you had to go and read the earlier historical and health services literature and read a lot of stuff from the medical libraries. The later generations of economists did not have that privilege and so they had to spend all their time reading economics literature and that means they came out with a much more limited and shrunken view of what was actually going on.

Audience: Chuckling.

RPE: If you're going to do health economics, don't spend your time in the medical library. I'm going to try and give you some more specifics on that in a little while. But, I would also like to mention, speaking of health economists, a point made by Len Nichols, in quite an extraordinary talk that he gave to the annual meeting of Group Health in this year, which was sent down to me and I had a chance to look at it. Ah, boy, that was a whale of a talk. He did a terrific talk. It was classic Americana. You know, the sort of thing no known American could ever give. But ... let me try this on. “I'm just a little old country health economist.”

Audience: Laughter.

RPE: You see, it doesn't work in Canadian.

Audience: Laughter.

RPE: But, if you've got a good sound Southern accent and you're playing it up to the hilt, it's brilliant. And you mean that, it is brilliant, because it gets the messages across, it gets them with humor, it gets them in under the guard, and he was really funny. So, many of you may have seen that. Those of you who have not, you should. I think that it's time well spent both in terms of being a thoughtful talk and a whole lot of fun. And one of the things he emphasized right up front was a sense of humility in giving this sort of talk in the presence of, as here, a whole lot of people who actually do stuff. A whole lot of people who you might actually want to meet after you've been hit by a truck. Okay?

Audience: Chuckling.

RPE: Now, stand back. I'm a doctor. I'm a doctor of economics, actually.

Audience: Laughing.

RPE: Yeah, no. You didn't want that.

Audience: Laughing.

RPE: So, I think on the one hand, one does have to recognize, one has to be honest with one's self about the amount of critical, the things that are really critical to people, to patients that go on as a result of the skill and the dedication of people in this room. And, I'm a bit of a kibitzer. My job, it seems to me, is to reflect upon that experience and see whether I can send back any mirror images that are helpful in understanding what's happening. But, I don't want to be overly humble about it. I thought Len Nichols was, I think, a little over humble. After all, Hilde Birnbaum was, in fact, an economist, right? So, occasionally, when economists get the ideas right, they can actually be quite useful. Extremely useful. When they get them wrong, mmm, not so useful. Not really very useful at all. So, I did want to sort of nod at the beginning to the work that Len did because I think that's worth your viewing it. So, I'm talking about ideas. One of best pieces of writing on this actually is at the end, the very end of John Maynard Keynes' book from the mid-thirties, *The General Theory of Employment, Interest, And Money*. And he says, "The ideas of economists and of political philosophers are more powerful than is commonly understood." Now there's a frightening thought for you. Indeed, "in the long run, the world is ruled by little elves. The practical" ... I'll amend it from "practical men," "practical people in authority who think themselves totally immune to any form of intellectual influence are commonly the slaves of some defunct economist." Madmen in authority who hear voices in the air are distilling their frenzy from some academic scribbler of a few generations back. This was published in '36. That particular madman would have been Adolf Hitler, and remember in political science classes tracing back who the academic scribbles were that he picked up on and

got his ideas. The ideas are more powerful both when they are right and when they are wrong. And there is no guarantee that the powerful ideas are going to be the ones that are right. I probably hardly need to remind you of this when you look over some of the ideas that are being brought forward in the health reform debate in the United States at the present time. Those are wrong ideas and they will not tend to good. But, I think what is interesting to me is a counterpoint between the Keynesian, what you might call a statement of the idealist position. Not idealist in the sense of holding ideals that will work out for the good, but the strengths of ideals, good and bad. That that's what drives the world. I think it's ultimately sort of a Hegelian position. The counterpoint, which you could call the materialist position – if I weren't in the United States, I might call it a Marxist position, but I think that would be dangerous to do in the United States so I'll just call it a materialist position – is that ideas arise out of material conditions, or we might say economic interests. That what is really fundamental are the economic interests that dominate in a society and the ideas are superstructure. They are the ideologies that serve to justify the material interests, that serve to advance the material interests. So, they're not fundamental in themselves, they're derivative principles. In short, principles have their roots in interests. Whereas the idealist position is that the ideals have a life of their own. And what I think I see as I think about the history of Group Health and of other economists' experience of thinking about it, is that the idealist position is more successful in explaining the phenomenon of the development of integrated health systems. And I'm going to switch around my notes a little bit on this because I think that's the way it's flowing. On the other hand, the difficulty in expanding the scope of the Group Health systems is explicable in terms of the material interests of the society in which you're imbedded. Now, it isn't a result of the cooperative model itself. There is nothing in the cooperative model that prevents expansion. Some of you, many of you, will be familiar with an organization called REI. With considerable generosity, REI assisted in the formation of a thing called the Mountain Equipment Co-op in Vancouver forty years ago. That co-op, our co-op, now exists coast to coast. I think we have store in Halifax. We have a membership in the millions. By the way, I'm member number fifty-eight. Those of you connected with REI will know what that means.

Audience: Laughing.

RPE: So, there!

Audience: Laughing.

RPE: I'm planning to leave it to my son in my will. The people at the co-op say you can't do that but we'll see them in court.

Audience: Laughing.

RPE: My point being that there's nothing about being a co-op that makes it impossible to expand. But, in this context, there has been. Without taking anything away at all from Scott's comment about the leadership role in many respects of this organization – that's real – but why is it still not dominant in the country? I mentioned the American question; I've also gone back to baking a bit of bread. And what the yeast ... everybody knows what the yeast does, right? And in this case, you proof the yeast and if ... You folks are the yeast, boy that's a powerful yeast.

That's working really, really well. And I've just gotten a little more familiar with kind of looking at it and saying, "Hmm, that particular yeast is not looking very healthy at all." But this one looks pretty healthy. So, why does it not leaven the lump? Why is the whole – after all these years – why is the whole health care system of the United States not dominated by organizations like Group Health? I'm not going to give you an answer, but I think it does come down to the material interests in the structure in which it's imbedded. Okay. So, here's the counterpoint. The idealistic Keynesian approach, what drives the world, seems to work in explaining Group Health. It does not work in explaining the failure to expand Group Health. If you've got a better mousetrap, why isn't the world beating a path to your door? You do have a better mousetrap. If I were living down here, that's the one I'd join. But, the world is not beating a path to your door. Picking up ideas, sure. So, that's sort of part of the basic structure of the talk. And, I'm going to then reflect a bit more on how that phenomenon has unfolded historically. But first, the idealistic versus the materialistic. In 1968, Victor Fuchs gave a seminar at Harvard. And he talked a lot about the emerging information on the relative success of integrated group practices of the GH model. And, much of his audience, young graduate students were already on this. We'd been reading some of this literature. We were very gung-ho about all of this. And the real question was, "How does it spread?" And we were all properly trained economists and we said, "Well, look. What's really going on here is the economic incentives." The way this works, and by the way, Len Nichols talked about aligning the economic incentives properly. He used that phrase a couple of times, I think. And he's right. The trouble is, I used it in my thesis, too. People have been using it for the last forty years, we just haven't figured out how to *do* it. Jim Marone, a political scientist at Brown has a very nice set of laws for policy analysts, one of which can be summarized as, "never, never underestimate the power of incentives." Never overestimate the inability of an economist to tell you which way they're going to go because there's a host of unintended consequences in every time you fiddle with incentives, and so it's a very dangerous game. And, I think on the whole, I think Jim's probably right. But, yes, the incentives are critical. So we all said, being young, green, would-be economists, we said, "Well, yeah. Get the economic incentives right." The reasons those places work right is because they save money and they feed some of the money back in economic incentives to the doctors and the other people who work that way. And so it's a pretty straightforward problem with incentive alignment. We've got to just find a way to make it profitable for the people in that system to practice medicine and to provide health care more generally in a way that's cheaper. Hmm. Well, that's straightforward enough. It wasn't for quite a while, maybe another ten years that we actually began to talk more regularly to people in these sorts of systems that said, "No, no, no. You're not right at all. What makes these places different and better is that the people there have a different idea of how medicine is to be practiced. And within that framework, you try to get the economic incentives out of the way so that people don't end up being messed up by economic incentives that run counter to what they really want to do and what the organization does best. And it actually is exemplified by an English economist of a generation or two back, Sir Dennis Robertson, who said that the business of the economist is to economize on love. And you may feel that's yeah, they're doing that pretty well. But what he meant was you don't want people to do the right thing solely because of their determination to do the right thing. You want to try to keep the economic incentives from getting in their way, from running counter to what they want to do and ought to do. I think that's really pretty important in the practice of medicine and more generally, the practice of health care. But of course, our naïve economic understanding from '68, went on to become, you know, Paul

Elwood and the health maintenance organization, take this lefty, practically communist idea, repaint it as a market competition environment and bingo, we've got something that will sell and something that will spread and we'll solve the health care problems of the United States. And that's why the United States' health care problems all pretty much disappeared in the late 1970s.

Audience: Chuckles.

RPE: It was an example of what Ted Marmor calls persuasive definition. Call it managed care and people think you're actually capable of managing something ... and that you actually care.

Audience: Laughter.

RPE: No. No, no, no, no, no, no, no. For profit. For profit means exactly what it says. It means for a profit. It doesn't mean a whole bunch of other good things that the PR people put in the ads. It means *for profit*. And the most profitable thing you can do to look after, to provide health care, is to look after people who aren't sick.

Audience: Laughter.

RPE: And the insurance companies know this very, very well. So, they spend a great deal of money trying to figure out who is not sick and insure them and make sure that, in short, dump the dogs. Dump the dogs. Now I can say this quite comfortably because man, I'm a dog. Nobody wants to insure me, nor should they. If we didn't have a public health care system in the Canadian environment, I'd be totally uninsured. And afterwards, I can give you a long discussion of why, but you probably don't want to hear it.

Audience: Laughing.

RPE: Well, and some of the technical details are fascinating.

Audience: Laughing.

RPE: Wal-Mart, a couple of years back, had a board retreat that put out a document, that commissioned a document, basically, on what to do about the health care costs of our organization as our "associates" grow older. Not our employees, our "associates," yeah. They're growing older; they're costing us more. What do we do? Well, they were serious, these people. They were serious and there was not a lot of posturing and flaffing about. And the report back to the board said essentially – and it got leaked, as they do – "We could sort of increase the user charges. Yeah. That might save us a little money. But, it makes everybody angry and it doesn't really do anything useful. It doesn't really solve the problem at all unlike some of the folks who are advising the unsuccessful candidate for the presidency last time whose name I of course forget now.

Audience: Light laughter.

RPE: Yeah, I know who he was now; I was kidding. “They got to get more skin in the game! Charge the patients, that’s the way to solve the problems!” Oh, God, that’s the finest thinking of the 1940s. It never goes away. But the Wal-Mart people are smarter than that. They said, “Yeah, you could do that and it’d save a few bucks. And we could kind of try to contract for more efficient health care delivery and so on and so forth. Yeah, you could do that. (Sighs) But you know what really works? It’s identifying that small minority of people who are really very expensive, and that’s true in every health care system in the world and turns up every time. You know, five percent of the people make ninety percent of the cost. If we can get rid of those, we’re safe. We’re home free. That’s the important thing. Figure out the dogs in our organization and dump them. Eeh, it’s political dicey.

Audience: Laughing.

RPE: So, here’s what we do. We say it is our policy that we would want all of our associates to understand all the parts of our business. And we will rotate them through the different divisions of Wal-Mart so they all get a chance to understand how each piece works and to participate in it, and so on and so forth. And when the folks with disabilities find themselves out there on the loading dock trying to move large parcels around, well, gee. I mean, if you just can’t do the job, we can’t keep you, can we? Yeah. Well, that should work.” I don’t know how it actually worked, but it was a very clear-eyed understanding of what the real issues were here. Now, let me ratchet back a bit. We got it wrong at our little seminar in ’68. But what we did see is we saw that this was really something important. And what we were seeing, although I don’t think we really understood at the time; the stuff was coming down the pipe from, say, Milton Romer and Max James. In the late ‘50s, looking at HIP in New York saying, “Hey, how you organize makes a big difference to utilization rates and costs.” Well, there was a lot of resistance to that. There were a whole pile of “yeah, buts.” There were people who said, “Well, now that’s not really true. What’s happening is that they’re being squeezed out of the hospital system because the other doctors don’t like them so it’s not really a voluntary choice to use less hospital care. It’s kind of quality deterioration.” There were people who said, “Nah. It’s not ... there are a whole bunch of other reasons for this.” But, as you undoubtedly know, one of the key studies on this was done under the health insurance experiment and done with Group Health. But you say, “Well, why don’t we do a randomized trial? Why don’t we send some people to ... and we’ll assign people to get their care from Group Health, and assign them to get their [care] in the regular community under equivalent insurance conditions. Let’s see what happens. Well, my recollection is what happened is that the rates of hospital utilization, age adjusted, all that kind of thing, randomized trial, forty percent lower in Group Health. And total costs twenty-eight percent lower. Wow. Okay. That’s pretty impressive. You apply those numbers to the current levels of per capita expenditure in the United States, 2009, about \$8,100 per person. Huh. I think you saved about seven hundred million, seven hundred – sorry, billion – that’s just the U.S. A billion dollars.

Audience: Laughing.

RPE: Some of you are old enough to remember Senator Everett Dirksen. A billion here, a billion there. Pretty soon you’re talking about real money.

Audience: Laughter.

RPE: But that was quite a while ago. It'd have to be ten billion now. But, the point is that it was then demonstrated rigorously that different care was being provided differently here and it made a lot of difference. And it made a lot of difference to costs, apart from anything else. And the quality measures held out. It wasn't that people were cutting corners. Well, this, I think, is part of a more general phenomenon because it links up with the other major strand of interesting research in the U.S. that everybody in the world pays attention to. There are really two things that the world pays attention to apart from clinical and biomedical and all that kind of stuff. But, the health services research in the United States that really interests people outside it is the experience of integrated health plans like Group Health. That interests everybody and has for years. And the second is the Dartmouth studies. The clinical variation studies, okay? And they are, I think, aspects of the same thing because they both show substantial variations in patterns of care and cost. Big variations in care and cost depending on essentially location. And one is geographic location in the Dartmouth studies. The other is organizational location in the case of Group Health and its ilk. And what they tell you loud and clear is that you get these variations and the medical myth that care levels and costs are all driven by advancing needs is just wrong. It just isn't true. And those two very well done and progressing over years ... John Wennberg, the godfather of the Dartmouth stuff was, a couple of years back, named the most important health services researcher of the last twenty-five years and I think that's probably right as somebody who's been watching John's career unfold over a long period of time, yeah. I think that's probably right. Because it challenged, sort of, this fundamental ideology of the medical system is that we respond to needs, and needs are constantly advancing, and so what can you do but raise more money? And it also challenged a fundamental ideological tenant of economics which is that it's all driven by patient demand. Now those two fundamental ideological tenants are radically inconsistent with each other, but they manage to coexist because they both point in the direction of nothing can be done, send more money. Okay? And that's always a popular thing to say because that seven hundred million I mentioned ... billion. I said million. Did it again. You can't get the Canadian out of the lecturer.

Audience: Chuckling.

RPE: We're a smaller country. That seven hundred billion is all being earned by somebody as a matter of accounting definition. That's not an economist theory, that's an accounting law. So, when you talk about reducing costs, you have to say, "Well, whose income are you removing? Because if you aren't removing anybody's, you're not doing anything." Well, that creates a certain amount of cognitive dissonance, you might say.

Audience: Laughing.

RPE: And of course, again, good research here in the States has shown pretty clearly where the answer lies. The answer lies in the fact that the private health insurance industry is horrendously inefficient. If your purpose is to provide care, why are you spending that huge amount of money paying people to push paper back and forth? Something like must be now in the neighborhood of four to five hundred billion – I do mean billion – dollars a year wasted on paper pushing. Not on actual administering contracts, although some goes on that, as well. It goes, really, in two

places. It goes to figuring out who not to insure, because as I say, that's extremely important. Get that wrong and your insurance company's going to lose a lot of money. And you're not in business to lose money. Insurance companies are not in business to provide health care. They're not in business to spread risk except as a way of achieving profit. So, you don't spread risk. You identify risk and you dump the risk. Insure the healthy people. So, that's one big chunk. The other big chunk is the excess administrative costs that are incurred, and you people in this room know them far better than I do, that are incurred engaging in the arms race with the insurance companies. As they try to figure out better and better ways of not paying you, you have to figure out better and better ways of making sure they do have to pay you. All of that overhead costs money. And it turns out it costs a lot of money, so that you could knock I'd say somewhere maybe four to five hundred billion dollars out of your health care budget, which is currently about 2.5 trillion. You could do that overnight by eliminating any private insurance companies. Now that's radical. That is so radical that it was suggested back at the beginning of the Clinton years by a lefty red rag out of the UK called *The Economist* magazine.

Audience: Light laughter.

RPE: Yeah, yeah. It says, "Advice to the new president. First thing you've got to do, you got to get rid of the private insurance company. You just can't carry that extra weight." Private insurance companies read *The Economist*. "First thing we gotta do, we gotta get rid of that guy, Clinton." Well, they pretty much managed, didn't they? And what's happening now? The insurance companies have got themselves in the middle – front and center – in the Obama reforms. What the hell do you need those guys for? Well, you need them because they're big and strong and because they say you need them. Okay? "I'm here to help you with your business." "Ah, do I need your help?" "You do if you want your business to survive." "Oh. Okay." So, they operate rather like the local mobsters, you know.

Audience: Laughing.

RPE: "You want your business? Yeah, I think your business is going to be a lot healthier if you pay us off."

Audience: Laughing.

RPE: Yeah. But of course the flip side on that is you wind up with really scary future costs. And then the forces of darkness can grab hold of that and say, "There's no way we can afford all this. Certainly not through the public sector. We don't mind if the costs go up, we just don't want them to land on taxpayers. We'd much rather have them land on patients." So, it's all basically about not how much you pay, not about cost containment, although that's where all the rhetoric comes in. But, if you're busy trying to privatize the funding of Medicare, then you're not serious about cost containment. You're trying to increase costs. But you're trying to flow the extra costs through the insurance companies so that they will not have as heavy a weight on people at higher incomes because it's a funny thing about taxes. They're always related in some way or other to income, even if you're trying to do the best you can to cut the burdens on the upper income group, of which there are more now than there used to be. You know, it's a remarkable fact that since 1980, the distribution of income in U.S., Canada, UK, I'm not sure

how many other places, Australia, certainly, has become radically more unequal. Almost all the economic growth benefit since 1980 have gone to the top half of the income distribution and a very high proportion of it has gone to the upper ten thousandth of the distribution. It's a really incredible thing. But, you know, income and wealth alone can't bring happiness. You need a good tax dodge, too.

Audience: Laughing.

RPE: And so rolling back Medicare in this country and in Canada, where it's underway ... a pretty good way of lowering taxes. That's one of your biggest public expenditure programs. So what is passing for reform is focusing on trying to shift not to lower, but to shift the burden of costs, probably to make them larger by increasing the role of private insurance. And that then points to the critical role of cost containment in the whole reform debate because if you can't figure that one out, you're going to lose. Not necessarily you, as this organization, but in the broader scheme of things. The broader health reform debate, you're going to lose because ever escalating budgets place weapons in the hands of the people who really never liked public insurance anyway and are now able to shout very loudly that it's simply fiscally unsustainable. "Resistance is useless," as the Vogons say in *The Hitchhiker's Guide to the Galaxy*. I don't know how many of you are familiar with that. It requires a certain very twisted British sense of humor. But you never know. You find the odd American, very odd American, who actually appreciates that, yeah.

Audience: Laughing.

RPE: Anyway, that "resistance is useless" is a large part of the rollback process. Now how am I doing here? Not too, not too badly. So, what I think, just to loop back to my historical story a bit is we have these two major unfolding phenomena. Stories, reports, research. These major streams. One, being the progress of the integrated systems like Group Health. The other being the steadily advancing sophistication of the studies of geographic variations and of their relationship to capacity rather than need. I'd say the latter reached its peak, that stream, with a pair of articles in February 18th of 2003, in the *Annals of Internal Medicine*. Magnificent stuff; really amazing articles. Really, I think, putting to bed the notion that clinical variations were associated with differences in quality of care. What came out of that is that where there is more intense servicing, higher costs among the Medicare population, the mortality rates are higher. *More care kills*. Hmm. Well, that's interesting. Not much. Small differences, but statistically significant ones, okay, because then we're dealing with huge numbers of observations. So, that was kind of intriguing. It is not associated with higher levels of patient satisfaction or any other jolly thing. Furthermore, it is associated, more care; when you look at what kinds of care, the differences between regions are not found among those forms of intervention which have very solid empirical basings for them. Where the evidence is sound, you don't get the big variations. Well, that speaks well for the competence of the medical profession, I guess. Yeah. Yeah. Where you know what needs to be done, you do it. Good. But where there are highly discretionary, not patient discretionary, but provider discretionary services that are very sensitive to whether there's a lot of doctors around or a lot of hospital beds are around, that's where all the variation is. So, that drilling down into the components and sources of variation, I think, is very important. And that pair of articles, I think, is magisterial. It's not the end of the story. On the

whole, there's a parallel study there on excellent academic health centers. Okay, let's see if we can't put the quality story to bed, more is better, by looking at what goes on in those centers. And Uwe Reinhardt summed up those findings nicely when he said that, "The finest medical care in the world is found in the United States and it costs twice as much as the finest medical care in the world, which is found in the United States." Hmm.

Audience: Light laughter.

RPE: And that was in fact, what the study showed. That little old country, Mayo Clinic, half as costly as Hopkins. Most people have not rated Mayo all that badly all the same. Cleveland Clinic, gone way down. Boston, well, Harvard. Well, what would you expect? Some people think that the Harvard crest has down at the bottom of it, you know, VE RI TAS? Ah, actually, it looks more like VE NI TAS ... speaking as a Harvard grad. Anyway, point is, excellence is not correlated with cost. Cost is not correlated with outcome. At least not at that aggregate level. And that, then, reinforces the notion that there is a lot of scope for just doing things better. So, what's the response from my economist colleagues, the iron triangle? Universality, cost containment, excellence. *Can't have all three*. You must trade off among them. So, Canada being universal must be poor quality, right? Well, I don't know. All the outcome stats are a lot better for Canada than they are for the U.S. But, that could be for other reasons. Americans like to shoot each other. That tends to raise your

Audience: Laughing.

RPE: That tends to raise your mortality rates. And you know, you look at it as an economist and you say, "Well, there aren't very many Canadians and there are lots and lots of Americans so ... so you can afford a few Americans anyhow." But, that hasn't sold really well as an economic theory. So, the high point, as I said, of the clinical variations stuff was the brilliant little essay in ... well, it wasn't all that little; essay in *The New Yorker* by Atul Gawande. Now Gawande is one of those people that you know, Christ. There he is, he's a ... medical person. He's on the faculty at Harvard and he's a very good prose stylist. Damn! (Laughs)

Audience: Laughing.

RPE: (Laughing) You know, one or the other, but do you have to be both? Oh, well. There it is. And this was his essay that I expect almost everybody in this room is familiar with in looking at McAllen, Texas. In the course of ten years, McAllen has vaulted to second place as the most expensive Medicare region in the country, second only to Miami. They are, I think, it's about twice as expensive as El Paso, down the road, with basically the same kind of community. But, McAllen is just blowing money away. And they know they're ... and it's not ... You sort of say, "Well, it's economic incentive." They have a lovely cartoon of a patient superimposed upon an automatic teller machine where you can go and get your money out of the patient. But it isn't happening in El Paso. And the problem with economic determinism models is that it's easy to explain why economics is determining the outcome in McAllen but it's a little harder then to say, "Well, why isn't it determining it in El Paso?" Ahm, er, ah ... cultural differences. Ah, yeah. That's the point. Different ideas. Different institutions. Different styles, different history; I don't know what. But what I do know is that it isn't a simple economic determinism story. It

can't be. Because otherwise, it would be happening everywhere. Now you may say, "Well, it is happening everywhere in the sense that the tide is rising steadily everywhere." Yeah, but you have these really big variations from one region to another which are not explained. The standard economic way of thinking is *just not good enough*. Okay. That seems to me to be pretty damned obvious at this point. But, the McAllen story leads in another direction. That article, so we understand, was on President Obama's desk within about a week of its writing, if not less. Brought there by his budget director, who is completely convinced of what was going on here and said, "Look. This is what we've got to fix." (Pause) Seen any fixes lately? I mean, that is research transfer. That is research translation. You write your article and it's on the president's desk. God! None of us would dream of that, I don't think. Maybe some of you guys, I don't know. Maybe. Not me, I can tell you. And what happens? What happens is we get Paul Ryan. Geez, why did you deserve this? I mean, I don't know what to do with that. You know, you have this wonderful expression of speaking truth to power. And you speak truth and the power says, "Yeah! You're right. We gotta do something about that!" Ah, ah ... nothing happens. And this is what I mean about the economic structure of the society that you're built into. What the hell do you do about that? And I don't have an answer to that. And I think it is the same process, the same phenomenon that says, "You guys came up with this brilliant way of providing health care in an integrated system. People are interested in it all over the world. And it took the United States by storm because it had the solution to the problems that were dogging the United States of inadequate quality and cost explosion and all that stuff, and there you are. You got the solution. Yeah. Mm-hmm. Mm-hmm. So, it seems to me that's the nut you've got to crack. And you don't ... well, somebody's got to crack it. Because otherwise, what happens is we roll back. And that seems to be the direction we're going. And we're going to do that in Canada, too, just as a very small digression. We put in place – I didn't put it in place; I just came along afterwards and said, "Oh, that's pretty neat." We put in place, universal public coverage for hospital and medical care for the entire population and it led to immediate bending the curve. You want to see a curve bend? 1970s; '71. We were following the United States precisely in terms of percent of our GDP spent on health care. Immediately the introduction of universal care for doctors, we'd been covering hospitals all along, the curve bends, bang. (Makes a popping sound.) Like that. It really does. It's amazing. A lot of people came along as usual and said, "It didn't. It had something to do with changes in inflation rates and so on and so forth. But, you know, thirty, forty years later, it's pretty hard to keep making those arguments. And, we did not go on to change the way the delivery system worked. That was phase two. We never got there. As early as 1970, and certainly by 1980, delegations were coming down from the Canadian providences to ask, I think it was McKaiser that Manitobans went down to see. "How do you do that? What do you do?" They were already doing in 1970, the clinical variation stuff. Thompson, Manitoba, okay? Mining town in the center north. You look at the hysterectomy rates and you say, "God, that woman would be unsafe to lie down beside a doctor.

Audience: Laughing.

RPE: You'd wake up in the morning without a uterus!" They were amazing. And about that was done ... I forget. I think pretty close to nothing. So, we also got to the point of a significant, really important reform that really worked. And then we stalled. And we stalled and we stalled and now with this far right wing federal government that we have ... there's an excellent chance as I pointed out in that, I don't know whether it got into the *Seattle Times*, that

little editorial; there's an excellent chance that by 2014 we could see the Canadian system starting to collapse at the direct initiative of our new prime minister because that would enable you, by transferring the costs from public to private budgets, to run through more tax cuts. And that's really all he wants. Are we in fiscal trouble? We are not. It's simply not true. Data are all there. I refer you to the finance scan of the tables. It is not like the States. We're not in a fiscal crisis. The contrary. But, we are probably going to lose Medicare because we didn't find a way to move forward. The system got locked in. As one of my colleagues called it, "A system held hostage." Which neither the government nor the medical people could move in the directions they wanted to move and the net result was really not much happened. And now we're in trouble. And so, you know, I don't have to tell you that you're at a crossroads. You know more about it than I do. I'd be a damn fool to come into a country and start talking to people who know far more than you do about their problems and what they should do about them. There are people who will do that. I try to avoid it. Mostly, audiences are polite. They just laugh at you after you've left.

Audience: Chuckling.

RPE: So, back in the '70s when we had introduced Medicare in Canada, there was a book published about "Can we learn from Canada?" Answer: No.

Audience: Laughing.

RPE: Again, I'll say the economists put it in that same little piece after Clinton was elected. If you want to talk about reform, talk about Holland. There's a nice healthy sounding place. Talk about Holland. Americans would rather lose their left foot than learn anything from Canada.

Audience: Chuckling.

RPE: Well, their left feet are safe. The bigger questions, which is the question that comes back to Group Health: Are Americans capable of learning from America?

Audience: Chuckling.

RPE: And I don't know the answer to that. And so that's probably, you know ... What's that Wittgenstein thing? "On that on which nothing can be said, it is better to keep silent." So thank you.

Audience: Clapping.

RPE: Now, I've sort of squeezed the question time but

Eric Larson, Vice President for Research Group Health, Executive Director Group Health Research Institute: No, I think we do have some time, and there are going to be some microphones around and I'm sure Professor Evans would be happy to take questions from the audience. I can't see very well, so if you'll raise your hand and stand up, we'll be happy to take

questions or comments on any aspect of the presentation or any aspect that you'd like to raise today.

Question (Q): Good morning, thank you very much for the talk. I appreciate it. I'm over here!

RPE: Doesn't matter, I (people at podium can't see well out into the audience because of the light) ...

Audience: Laughing.

RPE: Just keep talking!

Q: So, I was curious about a topic you didn't happen to cover, but I think would be important given some of your reflections and that's how much money we spend in the United States, and I'm imagining something similar in Canada on end-of-life care. And a lot of end-of-life care that turns out not to prolong life in either a quantity or quality kind of way. Kind of curious how you would approach thinking through how we might change the dynamic either in the U.S. or Canada or elsewhere about trying to focus a better way of handling end-of-life care where there's such an enormous amount of expense that quite frankly, appears to be wasted even though it's going into somebody's pockets.

RPE: That's a very good point you made at the last. Nothing is ever wasted. It always goes somewhere, every dollar, which is what makes it so difficult to bend the curve. Who's going to live? We did an analysis in British Columbia of end-of-life care and we found that some of the most expensive parts of it there were not the heroics, you know. Keep 'em alive another three days at all cost, but the people who wind up in long-term care and are there for a long time. So, that the implied focus from that is a lot more concern with home care, various forms of supports before you get into long-term care, because of course, once you get into long-term care, all sorts of processes are set in motion that make it very difficult for you to get out again. So, I think that is probably where we both need to focus our efforts is keeping people from getting into institutions and maintaining structures that will keep them out. The problem with that, of course, is that when you have people in institutions, you have a natural limit on how many people you can put in, which is the capacity of the institutions. There's really no natural limit on how much you could supply in the way of home care. I wouldn't mind a bit of home care myself if it comes to that. So, that managing the system, I think, becomes ... and determine who gets in and who gets out becomes much more important. But, I think in thinking about end-of-life care, that's probably the place we should be focusing more than on, "Oh, my God. How do we decide how to let this person go?" For that, I think there, I guess, the focus is on various forms of living wills and legal measures by which the patient can make his or her wishes known because I do not, myself, believe that these are things that patients themselves want. I'm pretty convinced of that. And I'm getting a little nervous because my wife keeps bugging me about, "Why haven't you gotten the paperwork sorted out yet? What am I going to do if you keel over with a stroke? I want the legal cover to let you go."

Audience: Laughing.

RPE: I think I got that right, didn't I, dear?

Audience: Laughing.

RPE: But in fact, that may be the right thing to do.

EL: Other questions or comments? Yeah, please.

Q: One big difference between the United States and Canada is the phenomenon of direct-to-consumer advertising in the United States. And a study has been done comparing the industry revenues subtracting per capita Canada from the United States. Could you speak to how much the direct-to-consumer advertising phenomenon drives costs in the United States?

RPE: I can't. I know that the principle study that I'm aware of was done by a PhD student, who got her PhD at our Centre, and I just don't happen to have the results in my back pocket. The results that she found were significant, there's no question about that. And as an economist, and I guess a person just with any common sense – those aren't necessarily the same thing – he'd say, "Well, if the industry is spending as much on it and, you know, what was it, five billion dollars, on advertising, it's got to make a difference. They're not stupid. Well, maybe they are. I mean, there are industries that make some awfully stupid decisions but I find that ... Consistent stupidity is doubtful. Again, Ted Marmor. "Nothing that is regular is stupid. If it keeps happening, there's a reason for it." So, yeah, I think it makes a significant difference. How much, I can't tell you. I'm sorry. But that's an example of just, just *stupid* decision making, yet which is not stupid. Which is politically driven. It's like your representative, Billy Townsend, who famously wrote up the legislation for Part D Medicare in such a way that the Social Security Administration wasn't allowed to negotiate prices. Just had to pay drug industries on a take it or leave it basis. What? Is that prudent purchasing? Why in hell would anybody do that? Answer: Because he then resigned from congress and got a job and a salary of not unadjacent to a million a year with the Trade Association for the drug industry. One of your problems is corruption. Not to put too fine a point on it.

Audience: Laughs, then claps.

EL: I think there's one more question.

Q: I had a question. I don't want to sound like Wal-Mart, but when somebody does have some skin in the game and they find out that the MRI they want for their knee is going to cost them thirty percent, forty percent, and they come to me and say, "Do I really need that?" And I'm happy to say, "No, as a matter of fact, I didn't think you needed it in the beginning." And then we pause on some of those things or the brand name drugs; is that inherently bad? When you talked in your model about the idea that only does a little bit to put people's skin in the game, could you talk a little bit more about why that isn't ultimately a good idea?

RPE: Well, it comes down, I think, to the question of how you reinforce the provision of appropriate care and the discouraging of inappropriate care. So, if we have, as we do, and it's coming back to a little bit of corruption in here, too. The BC pharmaceutical insurance program

has a scheme whereby they basically regulate the price of drugs. They have a reference pricing system that says, “If there are several different drugs on the market that will essentially do the same thing, we will reimburse at the lowest rate and if you really have a passionate desire to have your drug come out of a red box rather than a blue box, okay. You can pay the difference. No problem. Now, if you happen to have a condition that says, “No, there is something special about the red box that means you really do have to have this,” there are provisions for exemption. I’ve got one of those, actually. But, they are based on the clinical judgment and the evidence, the clinical judgment of the prescriber, obviously, and the evidence that he or she is relying on. There are also exemptions for say pediatric cardiologists, that they ... Some specialties where we don’t want to get in that business at all. If that’s what the clinician says, okay. Leave them alone. Don’t touch that one. But for broadly utilized drugs where there are either generic equivalents or even other non-generic equivalents with equivalent effect, we can specify that yes, you are perfectly entitled to pay extra if for some reason you think you personally believe the advertising of the drug company. But yeah, I don’t have a problem with that. What I have a problem with is the broad scale that says, “We’re just going to charge you because we like charging you and we think that may have an effect on your willingness to use an MRI, but the main thing is we want to cross the board because those are simply inequitable. We already know, and we’ve been told over and over again by anybody who’s ever looked at the data, that health care costs are heavily concentrated on a small portion of the population. So, the user charge story is if it is a way of helping you to discourage inappropriate use, it’s one that has some significant negative side effects and I’d rather look for some other mechanisms of doing the same thing. And if those came down to saying, “Well, yeah, okay. You want to have an MRI, but I’m not going to order it for you. But sure, go over next door and buy your own MRI. Yeah. Good luck.” Now, I understand that creates certain problems for you, as well, as a clinician. A bit of a breakdown in the relationship between you and your patient. “I’m not going to give you what you want. Maybe somebody else will.” On the other hand, if your relationship with your patient is really a good one, you don’t have that problem. You know, I feel like I talk to the various people who kind of try to keep me afloat and they say, “Well, you don’t need this.” “Okay, good. I don’t want it. You know, I only want it if you’re going to get some useful information out of it. If you’re not getting information out of it, I really don’t get a lot of fun out of it. So, sure; forget it.” So, it seems to me that the “skin in the game story” is a combination of a shifting of economic burden, and I think that’s really what it’s about. There is no question whatever in my mind having read the materials that people have previously published on this who were pushing that line, there’s no question in my mind that it’s an income redistribution move. But secondly, to the extent that it can work in some settings as a way of steering patients towards the more appropriate form of care, then I don’t have a problem with it providing the other form of care is accessible and available and that the patient has a reasonable chance of getting the information that he or she would need in order to respond to those incentives. Because the problem with financial incentives throughout the health care system is patients don’t know. They really don’t. And even if you try, I mean, I went online to look up the latest test that my ophthalmologist has me, the little picture he wants to take for this nifty gadget he’s now got in his office ... I don’t know what the hell they were talking about.

Q: I hear you saying it’s about the patients having the information.

RPE: Yep.

Q: And the other one is the educated. All those issues around how do you get this information out to people and whose responsibility is it for us to be an educated bunch of ... How do we have an educated citizenry as well as patient base?

RPE: You're not going to get there by pure patient education. That was my point about going to try to look up ... My ophthalmologist says he's got this new gadget; I want to take a picture of the back of your eyeball. Okay. Sure. So, I thought I wonder what the heck is this all about. Has he just got a new gadget that he likes? I don't know. I think I'll go online and look this procedure up and see what it does and what's it all about. I couldn't make head or tail out of it. Okay? And, so I said, "Well, I guess I'm stuck with this guy. Maybe I should think about changing." And I actually saw another ophthalmologist in Australia once when I had a bit of a problem and he had a look and he said, "Hmm." He said, "You know, I don't think anybody should go into your eyeball who hasn't been there before."

Audience: Laughter.

RPE: That makes markets a little tricky. Okay? Now, am I unique? Probably less than you might think. So, there really is continuity of care. Rob talks a lot about contin ... yeah.

Voice: Yeah.

RPE: Continuity of care is something that's been on your mind a lot and I think it is around this shop, too. I think it can be oversold. I mean, I can see walk-in clinics for a significant part of the population. Most of the population doesn't use most of the care. And I think that's the important point. So, and there are lots of basically healthy and worried well people wandering out there and they can perfectly well go to walk-in clinics and no great harm is done. A relatively small portion of the population, I think, does benefit considerably from continuity of care, but they also account for an awful lot of the money and an awful lot of the misery. So, it's very ... this is a game where you have to be pretty careful not to base judgments on the majority of the population, but rather on the majority of the care.

Q: But the majority of the population does make political decisions in this country. So, how do we get the majority educated around these issues?

RPE: We've just elected a strong majority right-wing government that's going to wipe out our medicine system. Why are you asking me?

Audience: Laughter.

EL: There are a few unanswerable questions, but I will take the chair's initiative here to say thank you, Robert. This is a fabulous talk and I think

Audience: Clapping.

EL: And I will tell you that in answer to your question, I think there are ways that we're learning how to design benefits such that it does educate people to higher levels but doesn't guarantee the success of the political process. I think that was Bob's point. And the political process is something where we continually need to work in sort of educating people that are sharing our values. So, I'll close our session this morning, thanking Dr. Evans for joining us. I thought his advice at the very end was very perceptive about what can he tell us about things. We have to tell ourselves and we'll continue to do that. And thank you all for coming.

**(End of recording.)**