
**5 Fallacies About Healthcare
HealthCareFallacies
with Bob Smoldt, Emeritus CAO of Mayo Clinic
November 8, 2011 at 11:20 AM**

Male 1:

Okay. Let's get started with our featured speaker tonight. Two or three of you were here two weeks ago when Bob Smoldt spoke, but I want to make a special introduction because we have a special speaker tonight. His name is Bob Smoldt. He's originally from Iowa. He married his high school sweetheart before going out to California, getting his MBA from USC. He then did a stint with the Air Force here in Arizona for three years and then went on to Mayo Clinic in Rochester, where he spent 34 out of 37 years in his career at Mayo Clinic. When he retired, he was the Chief Administrator Officer Emeritus and that was in 2008, and today he works for Arizona State, and [that's he's known] as a think tank, and tonight you are going to hear a lot of the ideas that he has around health care and where things are going. This morning we had a very lively conversation with our group, so we're going to encourage questions at the end. Again, Bob has got a lot of experience in this; in fact, at one point, he was asked to go to Washington, meet with the President and 59 other national health care experts to talk about the state of the health care; and today a lot of things that's going to be shown with you is a lot of the research that he has accumulated over those years, and he's going to be showing a lot of facts and figures tonight. This is the second part of a three-part workshop that we're doing with Bob. So, if you enjoy what you hear tonight, I want to encourage you to come back in November, which by the way, you have a flyer on your chairs that detail when those dates are, it's on the pack, and that would be the final of our three-part series with Bob. So with that, I want to turn you over to Mr. Bob Smoldt. Thank you, Bob.

Bob:

Thanks a lot [to all]. [Audio gap] Health care is a topic that impacts us all, and we frequently hear about things; you hear people say, "Before we can do this, health care would be approved and our problems would go away," and since I've had over 35 years in health care, I had that mentioned to me a lot with people I know with some that work in health care and some who don't, and so

some of you - some of them you agree with, some of them you just don't quite agree with. So, I want to talk tonight about some of the ones that I personally don't agree with and we could have differences in opinion here and I hope we do. We can have a little discussion about some of them and I'll mention right now, you can find people who will take position opposite of the ones that I'm going to take tonight. Anyway, three general aims for health systems anywhere; this is generally what people want regardless of what country. You want high quality care; you want access, and access has a lot of components to it, and I think especially in the United States, what we tend to want is access to the latest things that are available in medicine and there are new discoveries coming up all the time, and then we want that and we want low cost. So, those are the three things that we want. You can find some people who say that these are the aims of any health system. You can have two out of three, take a pick; and you [can base] the logic in that. I'm personally not sure that I agree with that completely. I think we can certainly make a [unintelligible], but some of the things that are said don't - the claims for meeting these things, to me, just don't agree with what I call my common sense test, and since I've been in Arizona, I have really come to like the cowboy's guide and so I get these cowboy guides to life, and there's a cowboy guide to life that I really liked, and it goes something like, "Just because you're following a well marked trail don't mean that who made it knew where they were going." [Laughter] So - and anyway, that's a little bit of solace. Okay. First fallacy, from my respect - yes, I'm going to tell you, you can find other people and I'll show you people who disagree with this - if physicians didn't make so much money, the health care cost problem would go away. Now, we all get frustrated because we think physicians make a lot of money. They do make a lot of money and they may make too much money, but let's take a look at this particular issue, physician income, because we really hear this a lot. You will see, you can find articles that will support the other position on this. This was one that appeared recently in the journal, Health Affairs - that's a health policy journal - and the New York Times picked it up, "Doctor fees, major factor in health cost." So, at any rate, let's try and take a look at some of the data that we have and then what does it mean? This is

data from that article that you just saw in the headline in the New York Times. So, they're looking at particular specialties; in orthopedics and primary care - so, family medicine, general internal medicine, pediatrics, all kind of lumped together; but this is the orthopedics for 2008, which is the most recent data that was available to these researchers. You can see what it was in the United States, \$442,000.00, that is a lot of money, and what was it in the United Kingdom and Canada? So, United Kingdom was 73% of like the US, and Canada about half - and these are obviously taking those dollars and putting them into US dollars in converting them. So, they do make more than some of the other international countries. Now, another question is it gets into how much do specialists make and how much do primary care doctors make? There's a general feeling that primary care doctors, they do make less, are they underpaid? Here's the orthopedic surgeon from that same article for US primary care, \$186,000.00, so about 42% of what the orthopedist makes. You can question whether that's really right. In the United States, there's a lot of - especially now, we're increasing - we're having chronic disease, it's increasing in the United States and I know this first-hand because I'm an insulin dependent diabetic; and the other chronic diseases and especially if you have multiple chronic diseases, which again is occurring more frequently, it's really good to have a primary care physician who's coordinating all of this stuff that's going on with you. So, it's really an important function. I personally don't think there should be that kind of disparity between these specialties, but that gets into all sorts of value, judgment, et cetera. But, here's a question for you; in these other countries, take the UK and Canada we're looking at right now, is there a discrepancy between what primary care doctors made there and the United States? You find the same sort of thing; the primary care doctors also make less in the UK and in Canada. The decrement isn't quite as great, but they do make less. So, what's an appropriate amount of money to make? Here's an interesting way that some economists took a look at this; from my perspective, they're taking a look at what specialists make. So, they're lumping every - all the specialists together: orthopedic surgeons, cardiovascular doctors, pulmonary doctors, as a group; and they're looking at what that compensation is and they did it for a number of countries. Each dot

is a country, and what we have down here is the size of the economy per capita, GDP, gross domestic product per capita; and this is just a line that kind of - it's the least squares line for those dots, and not surprising, the more the GDP you have per capita, the stronger your economy is, the higher the income, and that's what that shows. Then each dot is a country, clearly - oh, I just gave it away; I was going to ask you which one is the United States. [Laughter] I'm sorry. I punched the wrong button on this thing. These are the ones that are quite [away] from this bar and in terms of absolute numbers, there are two countries that have a much greater variation. So, this line is basically what the developed countries in the world do; that happens with their physician compensation. There are two that not only are bigger from here, but in absolute terms of higher. What two countries do you think those are?

Male 2: Germany, Japan?

Bob: No.

Female 1: China, I think, Germany?

Bob: Netherlands and Australia. I would never have guessed those two.

Male 2: Let me ask you...

Bob: So, there they - if you have [crosstalk] friends and they're frustrated, maybe they'd want to move to Australia and the Netherlands. [Laughter] Now, here's the deal; if we're making kind of more than the industrialized world does for physicians, given the size of our economy, what's the magnitude of that difference? It's about 20%. So, now here's the question; if physicians make, in the US, 20% more than you'd kind of expect in the industrialized world, what would happen if our docs made 20% less? In other words, would it help us with the health cost problem? So, let's take a look at total health spend in the United States. What percent of that pie goes to physicians? Fifty percent? Seventy-five percent? Twenty-one percent goes to physicians. Yes?

Male 2: You're talking about physicians, but the health care system employs large numbers of people of which physicians are only a small part...

Bob: Yes.

Male 2: ...and so it seems - I don't know this, but my guess is that in terms of the cost for operating a health care system, labor costs have to be the largest cost...

Bob: It is.

Male 2: ...by far.

Bob: By far.

Male 2: So, are you talking just physicians or are you talking labor cost, and those are very different...?

Bob: I'm not talking - I'm talking total health care cost in the United States. Total health care cost in the United States, the thing that we always see that's so much - the percent, our GDP is so high.

Male 2: Right.

Bob: There's a lot of things in here; it's hospitals, it's nursing homes, it's home health care, it's dentists, it's...

Male 2: It's the labor [issue].

Bob: Yes, but at any rate, so it's that whole thing, and if we're concerned about reducing total costs - this is the point I'm going to be addressing; so the part that goes to physicians and its relationship to physician income; 21% goes to physicians and if you take a look at the average, there's going to be wider issues here, about 50% of what goes into a physician's office on average would end up in physician income, the rest of it goes for rent, for buying supplies, for paying for the people that work in that office. So, about 10% goes to physician

incomes. So, a 20% reduction in physician income - for 10% of the total means you'd get a 2% reduction in total costs if physicians in the US made what you'd expect them to make based on our GDP and what other developed countries do. Now, that's still a lot of money - it's still a lot of money, but it's not a huge reduction, and here is the most important point if you're looking at this in a long-term projection, that's a one-time savings. Then the real factors that are causing health costs to go up, new discoveries in medicine, the fact that we really [order] lots of services, lots of EMRs, lots of surgery, lots of hospitalizations; that is still happening. So, it's true, physicians make a lot of money, maybe they should make less, but if we're really looking for an overall solution, from my view, this really isn't it. Now, one thing we could do, we can just have a doctor for nothing, and then we'd get a 10% savings at any time. It'd be a little bit bigger.

Female 2: Question before you [advance].

Bob: Yes, ma'am.

Female 2: In your overhead number, are you including the insurance cost as a part - as a factor in the overhead?

Bob: Well, if the insurance...

Female 2: [If we bought that], that insurance for specialist is very high.

Bob: You mean malpractice insurance?

Female 2: Insurance, in general.

Bob: Yes.

Female 2: Malpractice [crosstalk].

Bob: It absolutely would be in that number.

Female 2: [Okay].

Bob: Yes, it would be all the other costs other than what the physicians end up taking home.

Female 2: Okay.

Bob: Yes. Fallacy 2; this, to me, is the most important one. If you don't remember anything else, I hope you remember this one and I hope at the end of this, you'll actually agree with me on this, because there are plenty of people who disagree with me on this, and that is if we just put in price controls in the whole system, lower the price that we paid - lower the price that we paid for a chest x-ray, for an EMR, [unintelligible] - or excuse me, an EMG, et cetera, the health care cost problem would be solved. This was an article that's in the health policy areas we've seen a lot of attention. It's been around a long time. It was in 1989 that this economist - that Johns Hopkins published this article and it compared the US and other countries, and the title of the article - I think he gets a lot of attention because he was very [familiar] with the title - "It's the Price, Stupid," and the gist of this is that the reason that we spend more money in the United States than other places is because the price we pay [crosstalk] obviously, it is higher than it is paid in other countries. So, there are a lot of people that think that - but let's take a look at this; total cost in health care [crosstalk]. It's this price that we pay for unit of service, the price we pay for physician office visit, the price we pay for chest x-ray times the number of the use rate of these things that we use in the time [frame]. So, let's examine each of these components. We'll take a look at the price first, then we'll look at the use rate. Medicare has actually been under price controls with providers for since about - rather mid-1980s; I'm not sure exactly what year it actually went in. So, we've had over twenty years of experience with Medicare doing this, and we'll talk about was it successful [or not] [unintelligible], but I do want to point out to you that when you do this with government price controls, you tend to get things to be quite complex. You all don't necessarily see it; if you're on Medicare, you realize it's a complex program, but if you're in as administrator of the medical facility, I hope I'm

going to convince you that you realize it even more. There are formulas that are used to determine what is paid. How do we determine what is Medicare going to pay for chest x-ray in Scottsdale, Arizona? Because we're price controlled, somebody has to come up with it and this is how we do it; we use formulas, of course. What this is, the payment for service side in geographical region, chest x-ray, Scottsdale, Arizona. Each of these things is not just a number; each of these things is a formula in itself. So, let's take this one, the conversion factor. Here is the formula for the conversion factor. We have three formulas here. This is the update adjustment. These are formulas, too. Here's the formula, so this is one - the subcomponent here and this is how a subcomponent of that subcomponent is actually done. Now, how many prices do you think Medicare has to set every year?

Male 3: [More than a thousand].

Bob: Fifty thousand?

Female 2: [Hundred thousand].

Bob: Hundred thousand?

Male 3: Hundreds. [Crosstalk]

Bob: You're all really low; 1.5 million.

Male 3: Oh! [Laughter]

Bob: One-and-a-half million prices. Do you think we're spending time on the price side of this thing? This is the other frustrating thing from my standpoint, given that I think primary care docs should actually make more, what was one of the reasons we started this? The big one was to control cost, but the other one was primary care docs don't make enough compared to the specialists and this was going to solve that, because of those formulas. [Laughter] We've tweaked those formulas all the time and we still have - it still hasn't happened. Okay. [Laughter] It shouldn't be unexpected; C. Jackson Grayson, when we had price

controls in the US for the whole economy, '71 to '73, he ran that program. He's still alive. What's his life's mission right now? To talk against price control [laughter] anywhere, because he thinks they don't work. He said we started with three-and-a-half pages, we ended up with 1,534. In an effort to correct one inequity, what do you do? You end up over-correcting and you create another one somewhere else. Now, I can tell you anywhere in the Medicare program, I would love to only have 1,534 pages of regulation dealing with that. I'll show you what [our big predecessors] have to deal with. What's this? These are the cost reports for one year that Mayo Clinic, Rochester had to send in to the Medicare program for hospitals there. This person, and we got him cut off but you can kind of see the person there, is an average-sized woman and these, of course, there are two stacks there, there's a lot of information that gets sent around. Well, how much do we have to deal with? Every year, when you've got price controls, Medicare has to decide how much is going to change what they're paying physicians in hospitals. Now, when you see it in the newspaper, if you read about it, you read about it in one phrase, one sentence, "Physicians will get a 2% decrease in what Medicare pays next year," but you could do it in one sentence, but is that how it comes out? Not when you've got all those formulas that you've got to climb through and you're adjusting the factors in them, et cetera. For 2012, the proposed PPS's hospital rule was 1,032 pages. A special edition - our special little feature this year added 194 hospital, outpatient another 1,800, physicians 1,500; 4,643 pages for just the changes from 2011 to 2012. If you, as running a medical center, don't do this right, you will get called in for fraud, because you aren't doing it right. I can guarantee you with this complexity, you take an average single specialty physician or a small physician's office, I'll bet you donuts to dollars that there've been all kinds of stuff going on, and I don't blame them. There's no way they could keep up in all this. At Mayo Clinic, we have twenty people who just try and make sure we are following all Medicare regulations on how we bill. So, 4,600 in one year, but then Medicare doesn't actually pay the hospitals and physicians the dollars, they contract that out to private insurers. So, then the private insurers have to interpret because when you get a government regulation, it's hard to interpret. So, they interpret it for us - or

they try to. Last year, that was an additional 3,500 pages. Medicare program - and to give them credit, they realize this is confusing as well, so during the year, they're giving communications, that was another 11,000 pages. So, in a one-year time period, if you're running a hospital or a medical center, you had 19,000 pages you had to deal with. Now, let me ask you a question; my last year as the administrator for Mayo Clinic, the private insurer that we did the biggest business with - and this [isn't] Blue Cross of Arizona, this is Blue Cross nationally - was Blue Cross. My last year, we renegotiated the contract with Blue Cross for the next three years and in that contract, we had to specify how they were going to pay us. How many pages did it take to do that? [Laughter] For each year, we're getting about 20,000 pages here. Now, it was based on previous things that we're going on - three pages; this is complexity like you wouldn't believe. From my standpoint, complexity is not good - generally, it's not good. So, we've had a complex - I hope I convince you that it's complex from running the place, a medical center; but a legitimate question is, did it reduce the rate of cost growth with the Medicare program? Because if it did, maybe it'd be worth it. When you see this presented in the newspaper sometimes, you will - I have seen this sort of comparison; you take some time period, for this particular study, it was 1970 to 2005; non-Medicare private insurance went up 7.7% [in it] during that time, and then the Medicare went up 5.8%. So, it looks like Medicare has done a better job at controlling costs, but this has all of the costs in, the first - what you paid for a premium or your employer did, what your out-of-pocket was, what your deductibles were, and added it all together. This is only the amount that's paid by Medicare. So, what about the other amounts? During this time, the out-of-pocket payments went up by 15% per year. Now, what was one reason for that? Because the out-of-pocket payments here would include the - if you had an employer sponsored coverage, part of it is the proportion they enroll these with employer sponsored primary insurance doubled. So, what does that mean? If you're 65 and you continued to work for your employer, your employer had health insurance; by law, your insurer is primary Medicare or secondary. So, if I worked for Mayo - I didn't work for Mayo beyond 65, but if I had and I have plenty of friends who did, you have to sign up for Medicare. You sign up for

Medicare, you elect not to pay the Part B premium, and then your employer covers you; and Mayo Clinic's benefit package is a lot better than Medicare's - most private employer coverage is better than the Medicare plan. So, how much does Medicare pay when their benefit package isn't as good as the employer's? Basically, nothing, but you're counted. So, under here, they take this number, they divide it by the number of people who are enrolled in Medicare. So, they double the number of people who now have a big zero in there, but they're counted. So, that's part of it. Then there's private insurance. Many people on Medicare - most people, actually, get [Medicaid] policies, the spending under those went up 18% and here's the big one; Medicaid, because of how the regulations have been written - these are people who are what I call dual eligible, so you're eligible for coverage under Medicare and you're eligible for coverage under Medicaid. You're low income senior citizen. The way the rules have been written increasingly is shifting more that cost to Medicaid, and these tend to - and why is..? Plus, I doubt the government because - the federal government, because more of the cost - some of the cost of the Medicaid program is covered by state governance, and these tend to be the sickest patients. If you looked at the cost per person for people who are dual eligible, Medicare and Medicaid, they're some of the sickest, and those costs have been going up. So, long-winded way, if you add this all in for Medicare beneficiaries, the costs have gone up 10% compared to the private insurance of 7.7%. Now, there are other ways of looking at this and we'll do it. Oh, I forgot to mention - plus, this group in 2005 was also taking - was footing cost shifting from medical centers, from hospitals, and physicians' offices, because Medicare program on average paid less than cost, that cost - some of it - gets shifted over to private insurance, and Stanford and Belmont did a study - both of them did a study on 2005 data, they both were in this range of about 10% to 15%. So, what that means is if you're on Medicare, like I am - I got three kids, they're all employed. Thank goodness, they all have insurance from their employer. Their insurance costs - their employer's insurance cost is basically for them about 15%, and now probably 15% to 20% of that is because Medicare and Medicaid pay less than cost. Now, I'd like to show this one, it's a little bit complex, but I'd like to show it because this was

done by Peter Orszag. Peter Orszag was the head of OMB for the Obama administration, then he resigns back into private sector. Before that, he was the head of CBO, Congressional Budget Office, and he's really interested in health care. He's a smart guy, understands it really quite well. So, he looked at excess cost growth - this is his data, not mine - and what that is it's that cost growth is the number of percentage points by which the growth of spending to these various categories that he looked at here, exceeded the growth in the nominal gross domestic product per capita. So, I wish I hadn't even put this last one on, because what you've got is Medicare, Medicaid, and [no other]. So, did the Medicare program do a good thing of reducing excess cost growth from '75 to '90? No, it was the worst. From 1990 to 2005? No, it was the worst. There are people - ways to look at this; this was the time period - I may have mentioned this in our last session - this is health care expenditures per capita, this is GDP per capita, and this is kind of that managed care [HMO-er]. So, we had, once they got into place, from '94 through 2000, health cost did not grow any more rapidly in the United States than did the gross domestic product, and that's often what you'll hear people say, "We'd like to keep health costs to GDP," and we'd actually - the country - I think any country would be happy to keep health costs only 1% more than GDP, because in all countries, health costs grow more rapidly than GDP. Well, what happened then? We all revolt against the HMOs; we did in health administration, the hospitals, the physicians hated them because they had these - you had to get approval for all this utilization stuff. Patients hate them and eventually, their restrictions went away and their enrolment actually declined. I mean the managed care is still around, but we no longer have that tight look at utilization and the costs [there]. This is one of the more interesting ones, this is looking at comparisons of McAllen, Texas to El Paso, Texas; two Texas towns, and they were compared in a New Yorker article. It was written by a physician from Mass General named Dr. Atul Gawande, a really smart interesting guy. He [doesn't look] at Medicare, but the reason he used those two locations is that their populations are very similar. Their age structure is about the same, their makeup by gender is about the same, they have about the same number - percentage of minorities and types of minorities

that they have, their incomes are about the same, so it was the two groups - because a lot of times you'd compare parts in United States where populations are quite different. These are very similar, and he had Medicare data. I'll just concentrate on the bottom two, but he looked at the inpatient spend per enrollee, outpatient spend per enrollee - but let's look at this; what this means is McAllen, Texas for Medicare, Medicare spends 86% more per capita on Medicare patients in McAllen, Texas than it does in El Paso, Texas; and a big part of this is inpatient utilization per capita was 30% more, and where's the most expensive place to get care? In the hospital. That's why a 30% increase here jumps up the total costs even more, and if we had ICU utilization - and I know there are differences there as well - it does it even more, because the most expensive place in the hospital to get care is in the intensive care unit. Then somebody said, "That's interesting, but I want to know what happens to private patients." So, they went and got the data. So, these are people that are non-Medicare that are covered by private insurance in these two communities. Look at these two lines; actually, El Paso is a little bit lower - I mean McAllen is a little bit lower here. So, you took a place that was 86% higher for Medicare, and when you're dealing with the private insurance side, it actually was 7% lower; and the inpatient utilization was again quite a bit lower. One of the conclusions of these authors is it appears that private insurers do a better job of actually controlling costs than the Medicare program does. Well, why didn't price controls work? To me, it's the same reason they don't work elsewhere in the economy. Again, we go back to C. Jackson Grayson, you add price controls and you will see new services up here, your unbundled services in the medical field. So, perhaps there was something that you covered in the office visit, now you get an office visit fee plus you get a fee for use of the room. [Laughter] You add them together and your cost will go down. Do you think that actually happens? Let's take a look at this. Here is how it flows from my perspective in health administration; the costs are too high for the Medicare program, so it reduces line item payments. So, you reduce what's going to - let's take this physician, you're reducing what you're going to the physician. What do they do? They see more patients per day. There's a reason that you don't spend much time with doctors anymore,

because these rights have been jacked down, and partly because you don't spend as much time with the patient and therefore trying to figure out actually what's going on, you order up more lab tests and x-rays and images, so you don't miss something. So, what happens? Your costs go up anyway. This is a vicious circle. I have watched it for many years; and you say, "The costs are too high. What do we do?" Well, we go through this same thing. We've been doing this for over twenty years. We've got to try something different. Well, let's see if that's really true. These are two four-year time periods with the Medicare program and the amount they pay physicians, the rate that they're paying them and they're about the total cost [per] physician [service]. So, in this four-year time period, in the average, your physician fees went up 3.4% and in that year, the total cost for physician services went up 7.4%; and the difference there clearly is that there are new services that physicians can do. Well, the next four-year time period, 2001 to 2005, on average, physicians got 7/10 of 1% less than they did the year before. Now, where is the purple bar? Is it down here? Is it here? Is it part-way? This is the amazing thing today - same thing. Look at that. That really - reducing those prices really did it. Great job! The whole amount of the cost, everything - cost [of everything is] exactly the same, percentage-wise. Part of that happened - had to be happenstance. I mean it wouldn't explain it all, but it's interesting to me. Where Medicare payment rates are - people I don't think realize this, this is - take some MRI scanner, the imaging fees part of it, [if these] have all been unbundled - surprise, surprise - the US average is \$1,200.00, Canada pays \$824.00. Canada is not known as a place that pays a lot for medical services. Here's what Medicare pays, \$500.00, already quite a bit less than Canada, and as these get to where we're going, where we're trying to solve the Medicare problem is across the board reductions in what we pay in prices, this is going to get even less. This is a long quote; the key thing is that this is from the actuary, but then if you want this stuff, by the way, I'm happy to e-mail this to you - but what the way that we now have in the law of what's going to happen with how hospitals get paid is, by law, they're going to get paid less than their costs a lot. If you reduced costs in one year, the latest formula's going to work, your reward for that is that next year, you always get less than what happened to

your cost - always. So, what the actuary has done, they said, "If we do this, they're going to - providers are going to get eventually at some point" - I don't know the year; it's probably in [his other] report - "less than half of what they're getting right now," and he makes the same point I made; already these people are losing money in Medicare beneficiary. This doesn't seem to jive out very well for the future for Medicare beneficiaries. Len Nichols in testimony, an economist, "The secret is not, however, to rejigger 10,000 prices in 3,000 counties" - he doesn't have those quite right, because this would lead to 3 million prices being set and you all know it's only half that you're going to have - "until we get them right once and for all," and then he threw in this little bit, "or until medical knowledge or technology or input prices change." Guess what? Medical technology, medical knowledge, technology, input prices changed all that, and so it's basically saying is they always are. He said the secret is to pay for what we want in health and do that by bundling services together rather than separating them out, and then allow providers to find - figure out innovative ways to deliver it for less money. I think he's right. So, Medicare has committed significant effort to this, when in the end, my view, the use rate is more important. So, let's take a look at the use rate. I won't read these to you, but these are three different studies by good people who look at health care data, and what they all did, they looked at high cost areas in the United States, they looked at lower cost areas in the United States, and then the Institute of Medicine, they actually adjusted for all these top differences: race, gender, income, the percent uninsured; and made it all of these corrections and you still get this if you looked at high cost areas and low cost areas, and then you see - because it's a simple formula, price times units of service used - what is different? They all concluded it's the use rate. Of the difference between high cost areas and low cost areas, about 80% of it is the use rate, and the use rate of which services? Where are the expensive services? It's the hospital days per population, it's the ICU days per population, and it's the physician visits per population. If you looked at those figures and one of them is a lot higher than in some other place, you can pretty well bet it's going to be a high cost area. This gets complicated but it kind of makes the same point; it looks at high cost and low cost areas - and again,

Peter Orszag did this, so I'd like to show Peter Orszag here - and if you [have one], that means high cost areas and low - this one right here, this point, this is for mammograms for women 65 to 69. That means high cost areas and low cost areas do that the same. The same percent of women in that age category get mammograms in high cost areas and low cost areas. So, what he's trying to figure out is what's causing the high cost areas to be more expensive? It wasn't in these things, these little process items that CMS - Medicare measures these and every - you can go and - every hospital in the United States, if you want to see this, you can go to Medicare and compare in your computer. You can find this in every hospital, get what this number is. This was a surprise to me; preference care, there isn't much difference here. I thought there'd be a big variation; what percent of bypass you had, total hips, total knees and all that sort of thing, but clearly it isn't. What is it? Surprise, surprise! Total inpatient days, total ICU days, total physician visits, imaging and diagnostic tests, that's what I call practice style. So, physician income isn't very important, but how physicians practice is hugely important. Elliott Fisher at Dartmouth presented a lot of these studies; in order to improve quality and cost, we've been focusing on evidence-based care. That's little things like did you get an aspirin when you came into the hospital? But clinical judgment, not clinical guideline, should be the focus of policy efforts if we want to improve it, and I think he's actually right. That's because [unintelligible]. One other example; this is in cardiology - anybody from Cleveland or Elyria, by any chance? This looks at the right - this coronary intervention is done - here's Elyria, there's Cleveland, and this is the rate that it's done per thousand Medicare enrollees - beneficiaries, excuse me. Elyria is the highest in the country, by far. So, we just outlined all the metropolitan areas, each got some metropolitan area in the United States, and then we went - we [showcased] what do the best centers in heart care do - but the US news and report - world report may not think that's a good source for whether it's a good heart center or not, but it's Hopkins, Cleveland Clinic, the Texas Heart Center, Mayo Clinic, and Mass General. Hopkins is a little bit above average, Cleveland's above national average, Houston the same, and then Mayo and Mass General are in the lower parts. So, here's the question of the people who looked at this

thing, “Wait a minute, if the best heart centers in the United States aren’t doing any more than this, why do we have all of these centers way up here?” Because these things are adjusted for the factors they can adjust for as well. Now, if you were czar and you wanted to work on that issue, what would you do? These are three options. You wanted to curb the costs in Elyria while not adversely affecting the areas where the rates may be just about right. Would you cut prices for cardiology procedures everywhere, conduct an investigation, or pay for what you want? A good outcome at reasonable cost and that gets into the utilization thing. I think most of you who took a look at this would want to do this. What are we doing? This is what we’re doing. We’ve been doing this for 25 years. Right now we’re scheduled to do it from hereon [laughter] into the future. If you’re going to turn cost, remember why robbers rob banks. [Laughter] Why do robbers rob banks? Because that’s where the money is. We don’t use health services evenly in this country. A certain small percent of the population, unfortunately, has major problems - medical problems, and that’s where the costs are; 1% of the population is 20% of the cost, 10% is 64%, 20% is 80% of the cost. If we are trying to reduce costs, where are you going to concentrate? If you’re spending a lot of efforts on this whole thing - and that’s what price controls do, all of those 1.5 million prices that are being set don’t apply just to these folks, they apply to the whole thing, we’re spending a lot of effort in here and it doesn’t make any difference anyway, but if it did, it’s not going to affect the cost pretty much. You have to go into where these expensive patients are and try to put incentives to get more efficiency. So, from my standpoint, you have to focus on the sickest. If I was czar, I’d take the five most expensive conditions - to fast track the Medicare program, I’d take the five most expensive conditions, I’d look at - you would adjust for the factors for how sick these patients were, and look and see where do they do it more efficiently than other places and get good outcome, figure out how you can do that; once you complete those, go onto the next set. So, how do you actually accomplish that? I’ve got to put a pitch in here to try and get you all through another session.

Male 3:

Yes.

Bob: You come in November and we'll talk about it. I think there are ways to actually do that. Fallacy 3 - I'm sorry I took a lot of time in that. I'm going to go more quickly here - but because to me, that one on the pricing is the most important, because we've been trying this for years and that's the direction to go so far - US needs more physicians to improve the access to care. We see this a lot, especially now, because the baby boomers are getting older, the older we get, the more problems we have. Will there be enough physicians to see them? Guess who's putting out a lot of these studies and say that we actually do need more physicians?

Female 2: [Medical]...

Bob: American Association of Medical Colleges.

Female 2: [Laughter] Yes.

Bob: Now, let me tell you why - and when I talk about this, I'm talking about the number of physicians we have per population, per thousand people, and if you have a whole segment of physicians retiring and that ratio is going to go down, I would increase the size of medical schools to do it; but what was being recommended by a lot of people, actually - increase that ratio. What is it right now compared to some of the other countries? This is the physicians per thousand population, 2.4, and we're exactly the same as Canada; UK had a little bit more but we're kind of in the same ballpark, but there are differences here. We have a lot more specialists and a lot fewer primary care. These are the number of primary care docs per thousand, US, UK, Canada. Canada has a lot more primary care physicians and I think that's a major advantage they have over us, and we have a lot more specialists, but this gets into the area where in health care, from my view, about any little thing you do to tweak something, there are going to be some tradeoffs, because some of the things you do, you'll have consequences. When you look at the specialists that we have per population and you think about getting into specialty services, who do you think has the longest [rates]? Canada, because they have the fewest specialists and they also control the hospitals, so they can control how many

operating units there are; [through that] you can even [punch in] that. In the US, approximately 10% of the population waits more than a month to see a specialist; in Canada, it's 41%; and those who wait more than four months for elective surgery, 7%; in Canada, 25%. So, there are tradeoffs involved. Now, I'm not saying one's right and one's wrong; it's just that if we changed these things, there will be consequences and we should recognize that. Here is a major reason - there are two reasons I don't think we should increase the physicians per population in the United States; this is one, because are we concerned about cost in health care? We are, right? Okay. This is total physicians per thousand population, this is health cost per capita, each dot is a state. So, the direction is the more docs we have per population, what happens to the cost? It goes up. The coefficient, the correlation is 0.85; that's pretty tight correlation. Now, to me, this is common sense, because if we trained more docs per population, do we think they're going to sit around on their butts? They're going to see patients and the way we all are, we tend to want to go and see physicians, and then things get done. So, to me, it's not surprising that we see this sort of correlation; but this is the other reason, there are places that deliver care and do it with using a lot fewer physicians than we already have. This is the use of primary and special need physicians in integrated delivery systems that are HMOs. These are big HMOs, Kaiser, Group Health of Puget Sound in Seattle, and HealthPartners in Minneapolis, St. Paul. They're big centers, they've been around a long time and they integrate their care. By that, I mean the physicians are in a big multi-specialty group practice and they don't all own their own hospitals - many of them own their own hospitals. Well, what's the result of this? Those groups combined - and then one thing I need to make, this study actually did adjust for age and sex differences, because the older - if you have an older population, the older we get, the more care we need, you need more doctors - and the HMOs have the younger population. So, they did those corrections of age, sex, and income levels, I believe, was the other one; but what they find, even with primary care, this integrated practice used 26 fewer physicians - primary care physicians per population than we have in the US right now, and they used about a third fewer physicians - specialist physicians than we have in the US

right now. Now, there are two things you could say about this data. One is that these are the HMOs and they're always tight on things and I'm going to show you another study that looked at fee-for-service, multi-specialty groups practice, and reach the same conclusion. The other one is you'd never in the whole country, especially as big as the United States is, be able to get the whole country to practice as tightly as Kaiser does, or as Group Health does, or HealthPartners - and that's true; but what I don't know is I don't think we really should be 26% more. I don't think we should. I could see maybe 10%, 15% more, because it won't - it just won't be as efficient, but these are really quite high. Okay. Then this was another study, it was done by Gartner. The key thing here is that our data suggested, even in fee-for-service environments, group practices use fewer physicians per capita than is still true in the rest of the country. So, their conclusion was - and they were not very - the American Association of Medical Colleges was not every happy with this group. Their conclusion was we shouldn't finance more growth in medical schools. What we should finance is...

Female 2: Question, please, what is FSS?

Bob: Fee-for-service.

Female 2: Thank you.

Bob: So, what that is, like Kaiser gets a capitation...

Female 2: Got it.

Bob: ...and then these other groups - and the ones they've mentioned are Mayo Clinic and Intermountain in Utah - get paid predominantly on fee-for-service. There's an incentive to do more because the more you do, the more money you bring in, but even in those groups they used a lot fewer physicians. Good question. Thank you. Okay. Fallacy 4, US health care quality is not as good as other developed countries because their life expectancy [in this Earth] is less in the US. You see this all the time. I'll bet you can't go a month - if you look at the articles in the paper, they will say the US health care system has the

highest cost in the world. That's true. Then they'll say we aren't getting what we pay for, and then what do they say? Because our life expectancy is not nearly as good as many of these other countries. It's true, it isn't, but I don't think it's an indication of the health care quality of this country. This is the life expectancy. The country with the highest life expectancy of birth is Japan. The United States is four years less than that, but there's an interesting thing, if you dig deep enough, there's a subgroup in the US called Asian-Pacific Island Americans, the closest genetically to the Japanese. What do you think the life expectancy at birth is for Asian-Pacific Island Americans? These are people that live in the United States, citizens of the United States, get their health care in the US health system.

Male 2: Longer.

Bob: It's the same or longer. These are two different studies that have been done - almost exactly the same or a little bit more. Now - so genetics, your genetic makeup has a huge amount to do with this. The other thing is how we live our lives. There's another group that's been studied, hasn't received as much publicity, but it's California Adventists - and what do Adventists...? They tend to be more vegetarian, so their diets have a lot less fat, they don't smoke, they tend not - they - I shouldn't have said they don't. They tend not to smoke, don't have as high a smoking rate. They tend to exercise more than the US population. Their diet and exercise combined, what does that do? The obesity is a lot less. What's their life expectancy at birth? They get their health care from the United States health care system as well. It's higher than Japan's. Life expectancy at birth just isn't a very good measure of a health care delivery system. Why is that? This was a study done at the Institute of Medicine. On the average person, in your whole life, that your health over your lifetime, these will be the determinants on average in the United States. The health care received, 10%; it's going to be impacted by the health care you receive; 40% is our own personal behavior; 30% is genetics. Then you've got social circumstances and the others. So, some people when I show this slide, "Well, let's get rid of the whole health care delivery system. We know it doesn't make that much difference. It isn't right." The only trouble is when

you get sick - if you did a diagram of this for people when they were very sick, then this becomes a very big chunk of that pie, and what happens when we get sick or loved ones of ours get sick? We want to do something for them. Well, that's what happens. Just to show the variability again, OECD is the Organization of Economic Cooperation and Development - it's more of these developed, sort of, countries in the world. This is life expectancy at birth, this is the US, it's a little bit less, and then if we look, though, at the top ten OECD countries, and our states, do you think any of our - and you - we'll look at our state as if it was a separate country, do you think any of our states would be in the top ten? Yes. Hawaii, basically the same as Japan; again, interesting, they probably have the most Asian-Pacific Island Americans than any of our states; and then my good old state Minnesota is there. Look who is right next to Minnesota? Surprise, surprise! Sweden. If we have a few Swedes and Norwegians in the State of Minnesota, let me know, then - I wish I could do that accent. I can't do it [very well]. [Laughter] Now, then we have the bottom ten of the OECD, is it - do we have any states in the bottom ten?

Female 2: Oh, yes.

Bob: Oh, yes. Louisiana and Mississippi are right in there. Life expectancy isn't a good measure of quality. So, what would be a better measure and how does the US do in that? Here is one that I think is better, it's mortality amenable to health care and it's just for deaths before age 75. So, the researchers are trying to take out - as we get older, you're more likely to die, so they're trying to take that factor out, so it's just for people under age 70 to 75 and under. Then it's also for diseases that if they had appropriate medical care, you might be able to avoid [them more still]. Now, here are the countries and I've left off four. One of those four is the United States. Where do you think it is? Which one?

Female 1: [No].

Bob: Unfortunately, it's not. It's right here. So, even though I can expound about life expectancy at birth not being a very good measure of US quality, guess

what? We don't do very well on this one either; but now let's look at states. Do you think any states would do well here? Here are the top five states. They do as well as the best in the world and then one state is absolutely the best in the world at this statistic, which state is it? You should be able to guess this, because why would I show it?

Male 2: Hawaii.

Bob: Where did I spend my time?

Female 2: Minnesota.

Female 1: Minnesota.

Bob: Minnesota, [laughter] because again, this isn't related to your genetics, this is related to mortality amenable to health care. So, Minnesota is the best and what do you think this is? If the US is here and we've got places up there, this is the bottom five - are just atrocious, actually, on this particular statistic. If you want to know what they are, they're the ones that you'd never - if the top five were Minnesota, Utah, Vermont, Colorado, and Nebraska and the worst are Louisiana, Mississippi, Arkansas, Tennessee, and Alabama. [Laughter]

Female 2: Oh, goodness. [Unintelligible]

Male 2: It looks [awful].

Bob: Yes.

Female speaker: [I never go down there].

Bob: So, at any rate, we can really improve quality, let's not measure it by life expectancy at birth, let's do these sorts of things and let's try and get the whole country to where some of the best states are. Fallacy 5, when all US providers' general electronic medical records are [culled in], quality and class problems will be solved.

Male 3: [Laughter] Absolutely.

Bob: Yes. My answer to this - maybe, maybe not, because I think they really can be improved; but if all they do is electronify what - and by we, now I mean providers, hospitals, doctors. If we all we do is put in electronic form what we have in paper records, and we don't change anything else that we do, do you think the results are going to be any different? No way. We've got to change what we do. Now, as my health administration's begun in that time, I'd frequently get this question; banks have been on ATMs forever, why can't medical facilities get there? Well, let's take a look at this question. What's the basic data set used by ATMs? Dollars and cents, not much other than that data is in that set. What happens with health care? In health care, we have - for Mayo Clinic, we have 1,276 different blood tests we could do on. [Laughter]

Female 2: We've [unintelligible].

Bob: We have 739 imaging procedures. We have 6,000 - a little bit more than 6,000 surgical procedures we can deliver on you and for the whole country. We record our diagnostic codes according to International Classification of Disease, the ninth edition, ICD-9, and there are 14,000 different diagnostic codes that we have to be [clear with. So, there's a lot more there and I know this is going to come across like I'm offering excuses for why health care hasn't become [laughter] electronified, and I don't really want to do that. A lot of medical centers are completely electronic right now, we just don't have everybody on them, but we'd like to move in that direction and then change how we delivered care; but remember I talked about the Medicare program and all the complexity? Let me - and that coding system we were talking about? Let's take a look at this. This ICD-9 has 14,000 codes, so that means the people that work at Mayo Clinic, or any of these medical centers, has to be familiar with 14,000 codes and how you put the right code on when you go in to see the doctor, or you're in the hospital, because I'll guarantee with the Medicare program, if they think you input the wrong code on there, they're going to

accuse you of fraud. Mayo Clinic's been accused of fraud by the Medicare program because of that very thing. Well, there's a new ICD-10 now...

Female 2: Wonderful! [Laughter]

Bob: ...and...

Female 2: Could you please review what is CMS?

Bob: CM - I'm sorry. That's the medical...

Male 3: Yes.

Bob: Please do this for me, because we use these things...

Female 2: [Yes, let's have] the acronyms at this time.

Bob: Yes, it's the Center for Medicare and Medicaid Services, but it's basically the people who run the Medicare program.

Female 2: Okay.

Male 3: CMS?

Bob: Yes. This is the World Health Organization. So, this has been approved by the World Health Organization and they're basic 10 set has 68,000 codes there, but it's set up in a way where if you, as a country, want to start using this, you could either make that number less or you can increase it; and a number of countries are already on ICD-10, and the US does need to get to it and get onto it, so we're on a similar coding system. So, we're on schedule now, I think, in two years, maybe three - in two or three years to go to ICD-10 the way we have configured it in the United States and the Medicare program is the one that's doing this. How many codes do you think we're going to have?

Male 3: 186,000. [Laughter]

Bob: You are mighty close...

Male 3: Yes, right.

Bob: ...155,000. Now, that'll give us all...

Male 3: May I say one thing? [Laughter]

Bob: Yes.

Male 3: Some of those codes are crazy.

Bob: No, I'm going to get to it right now.

Male 3: Okay. Let's hear it, Bob.

Bob: You probably saw the Wall Street Journal article. Wall Street Journal had an article on this.

Male 3: [Yes, Bob].

Bob: Okay. Here is a code, V91.07XA. Now, again, if you're running a hospital, you've got to have people that are going to know what this code is, so you'd know who to put on that thing. You had 14,000, now you're going to have 155,000 - [there's got] to be a training exercise, by the way, to get your staff to do that. What's this code? I will be willing to bet anybody here \$5,000.00 that not one person in this audience will ever, in their life, have this medical problem.

Male 3: Can I guess?

Bob: Yes. I'll bet you're going to guess the other one [laughter] [that I'm going to put up].

Male 3: Injury sustainment, that sort of goes like...

Bob: [Right...]

Male 3: [Oh, yes]. [Laughter]

Bob: Not an injury, a burn sustained through water skis being on fire. That is one of the codes. Here's another one, W22.02XA, walked into a lamp post, initial encounter. Now, this one I could do, actually. I could walk into a lamp post and I feel good knowing that there's one code for the initial time that I do it and then the second time I do it, they can give me a code how many times I did it - complexity. [Laughter] Even though there are a large number of those things - but you only need one electronic medical record, right? Not really. How many clinical information technology applications, separate systems do you think a major medical center like Mayo Clinic has?

Female 2: Too many.

Bob: We do - I guarantee you, that is the truth - trying to deal with all of this. Get a number in your mind, 613 different ones. So, it's things like the cardiac cath lab has its own little technology IT system to track it. The electronic nurse assignment, getting the financial stuff, all of that has to be in there, and they all have to talk to each other, and that's what you get then when you put it into your electronic medical record. So, it's complex, but once we get them in, can we make improvements? Absolutely. I'm convinced and I'm going to show you two examples. We're concerned about cost, right? Where's the most expensive place in your care? The hospital. Where's the most expensive place in the hospital? The ICU. I'm sorry to repeat this all the time, but it's so important. So, let's look at the ICU. This is Mayo Clinic and we have all of these little data systems for patients in the hospital. This takes a look at our 15,000 sickest patients we have at the Mayo Clinic and they're pretty sick - about 15,000 a year. We get all of these data, we put it into what we call an ICU data mark, and then we have the physicians, the nurses, the pharmacists - and I'm missing people that - anybody that deals with the ICU patients, and we had computer specialists look at the data and all of the things you do to patients when they're in ICU, and we looked at when did the patient start

getting worse? When did their medical condition start getting worse? Then we looked at what happened just before that. So, you have like laboratory test X and it reached some sort of value, and all of a sudden the majority of patients really went south. We got that all done from the electronics, then we got the team together and said these are the important things where our patients are going south. They agree if that happens, this is what we do, and you got little protocols made up. So, then what happens under this system? You don't then just happen to find - have it in your electronic medical record and, hopefully, the next time the doctor comes around, will notice it and decide to do the right action. What happens now, there is a real-time alert when these things happen, that are critical elements, goes right to the ICU, there's agreement on what to do then and it's done right now with the nurses over there. Now, does it have any impact? This is the mortality, we've been implementing this gradually over time and you can see here we're getting down now. Well, pretty soon that mortality will be cut in half with this, and that's the effectiveness. What about the efficiency? The efficiency is how many ICU days do we use per patient that's in the ICU? Same sort of reduction. If we use IT systems to do things differently, we can make improvements, both in quality and in cost in these expensive areas. Is Mayo Clinic the only place to do it? No, there's a great example right here in [The Valley]. I went and visited this, it's [down]. For their ICUs, every ICU in their hospital system, they're in Colorado, Wyoming, the Dakotas, and they have a control room for their ICUs, down at their banner hospital, across the Mesa Community College. Well, this is fascinating. Every ICU patient, they have a control there and they have people that will monitor about 40 patients at a time. How can they do that? Because when something, like I've said, a result came in and it indicates a patient is going to go bad, they had a similar system, and they'd get yellow and red appear in their screen, and they then really concentrate on those patients and make sure that the ICU, in Greeley, Colorado is actually doing something. Now, what have their results been? Well, I have it up here - very similar. Their mortality went down by 31% and their ICU days went down by 30% - very similar result. These things - these electronics really can help us if we use it in a good way. Fallacy 6, with everyone insured, health reform will be accomplished.

I'd like to have everyone insured. I think we should have everyone insured, but if we don't do anything about how we deliver care, the cost and the quality issues are still low. Again, I'm sorry to repeat myself, but there's huge variability. The cost here in the hospital - this is an index of the intensity of the use of the hospital in the last two years of life for Medicare beneficiaries that die. This means that the top five states use about half as much hospital services as a country, as a whole. When you look at their outcomes, they're just as good, or better. The bottom states use hospital services at an extremely high rate. In teaching hospitals, you'd think that all teaching hospitals, they all have the latest thing, they'd all have great results? Not really. If you looked at every teaching hospital, their mortality ratio and their length of stay, how many of days they use in the hospital per patient, the best one is mortality ratio is twice as good as you'd expect and they use 34% fewer resources - or excuse me, their length of stay is 34% less. The way we were using this, the bigger the number - you had to have the higher, because we were using it in a value equation. The worst hospital - the worst teaching hospital, their mortality was 35% worse than you'd expect and they had a lot more use of the hospital in terms of days. So, there's big variability there as well. I'm going to skip this data just in the interest of time, so we'd get some discussion. Fallacy 7, the individual citizens can't do anything to improve US health care. So, here's my question for you; who can do more to improve US health care, the United States Congress or those of us in the room? [Laughter] The answer is all of us in the room can do more, and it gets back to this because of this huge thing right here. Now, I think Congress can do things to improve it, but we can really do more. You all know these things and I'll probably talk about this a little bit more in our next session on what do we need to do and how do we need to change, what do you do to improve, but this is the one that really doesn't receive enough attention, in my view. We get a lot about these things, the non-smoking and all that sort of stuff, but it's following treatments and there are some fascinating data on what happens to people who don't follow treatments, and how many complications they get, and what the cost variation is. We'll probably go over that at the next session. Now, if public education hasn't gotten us there, I mean people - I think nearly

everybody in the United States knows it's not a good thing for your health to smoke, and we don't have - compared to some countries, we don't have as high a percentage of population that smoke, but we still have a lot of people who smoke. So, at any rate, if that doesn't work, would financial incentives work? I want to talk about that at our next meeting as well, because there is some indication - and Safeway happens to be an employer who has been using this technique and has gotten some pretty impressive results, actually. We can show those to you. Well, if these fallacies do not improve US health care, how do we improve US health care? Here's how, we come November 9 and 10, [laughter] and I want to share with you, at least, what I would do if I was czar - and I'm not czar. Well, I'll tell you what I would do. So, at any rate, with that, I want to stop talking - I've talked too long here tonight - and get some of your thoughts and questions. So, let's turn it over right now. Thank you. Yes?

Male 4: I have to ask one question, to all of what we've seen, with the stats and everything else, there's been nothing that refers to malpractice insurance and when you talk to young doctors today, as I have during the course of years, the reason I dropped out of doing this is because I couldn't afford the insurance anymore. They had to shrink the offers, they had to move to a different city, blah-blah, there's all kinds of answers. So, evidently, the malpractice insurance then, in the medical field, is not that big, or the topic.

Bob: Please do not conclude from the fact that I did not have malpractice in here that I didn't think it was important.

Male 4: Well, it wasn't - you didn't mention that word once.

Female 1: Yes, [he did, sometimes].

Bob: No, I didn't, because I was talking about - well, I did mention it once. You're right.

Male 4: If you did, I'm sorry.

Bob: Yes, but at any rate, I was talking about kind of fallacies and I suppose I could have - I mean there's all kinds of others I could have put in there. Well, malpractice isn't a big deal and that, to me, would be a fallacy, because I think it is. I just didn't include it in the talk, but at the next time, I'm going to talk of what I think should happen. I actually think we should make some changes with regard to malpractice, but again, if there was only one thing I could do, it wouldn't be that. I mean that's something I think we should do, but there are other things that I think we should do before that.

Male 4: Okay.

Bob: Yes?

Male 2: I have a question with regard to the labor cost and you're saying that we don't need more medical professionals.

Bob: I said we didn't need more physicians.

Male 2: Physicians. Okay.

Bob: Yes.

Male 2: Oh, I would broaden it to medical professionals...

Bob: Okay.

Male 2: ...and I would go back to Economics 101...

Bob: Yes.

Male 2: ...supply and demand.

Bob: Yes.

Male 2: The cost would come down if we had more labor out there [providing]...

Bob: You'd think so, wouldn't you?

Female 2: No, not necessarily.

Bob: You'd think so, wouldn't you?

Male 2: Yes, I would think so.

Bob: What happens in medicine is that it's an inexact science. So, you go in and see a physician and sometimes they may be 95% sure that this is what you've got and you don't have to order any tests, but so many times, what is it? It's in that gray area and it's discretion. It's not malpractice to order these tests, but you may or may not need them, and I think what happens is the more physicians we have, you'd think that it would go down, but it doesn't. The other factor here is that since the salary of physicians is not a big deal, it's how many services they order and that determines how many allied health staff you need, because if you order twice as many MRI scans, you're going to need twice as many technicians in those areas. It's what the physicians ordered that determines the cost. So, at any rate - and the more physicians we have, the more tests they order, and that's why when you look at that thing with the physicians per population and the more you have, the more the costs go up, I think that's why. So, yes, it's kind of contrary to what you'd normally think. Yes, very good - very good point.

Female 2: A comment about that and that is available time.

Bob: Yes?

Female 2: If all of us at some point - maybe some of you still are working people; when you work, we have this time schedule that goes like this, we have to finish eating at a certain time, catch the train at a certain time; when you're not working, you have a little bit more available time to do things.

Bob: Yes.

Female 2: So, I find now that breakfast - instead of being five minutes standing up over a cup of coffee and get out the door...

Bob: [Laughter] Yes.

Female 2: ...breakfast is 30 minutes or 45 minutes with a newspaper or two newspapers. So, available time, in a way, is like available [government] doctors; the more you have, the more it's used.

Bob: Yes, and I think it's...

Female 2: So, I think that - I think there's an analogy there.

Bob: I think there is, too. I think that's true. Yes?

Male 3: Could you touch on the Elyria, Ohio, why they had such a high usage?

Bob: It's because the cardiologists are just - were doing procedures on people that I think were very questionable that they really needed them, but again, this gets into the thing that so much of medicine is kind of questionable, so what you've got to do is look at the long-term results and generally in the studies that have been done in cardiology procedures, they were doing them on patients - people that I think is very questionable and that - and I talked to Mayo cardiologists, that's kind of their conclusion as well.

Male 3: One of the problems though, if you're an emergency room physician and a patient comes in with a headache...

Bob: Yes?

Male 3: ...and you don't know the patient and don't know anything about him, you can give him an aspirin and that many times - other time it'll work, but the one time you missed a...

Bob: Yes.

Male 3: ...hemorrhage or a tumor, you're going to get nailed to the cross.

Bob: Yes, you are. Yes, that's exactly right. The annual - there's a lot of that in medicine. Like I said, it's not - there's a lot in that gray area that happens. Have I talked to this group? Did anybody hear me talk about the airline industry in medicine? Because you'll often hear when you - in our own medical fields that we talk about that our safety record really isn't nearly as good as the aircraft - as the airlines and that's really true. I think we can learn a lot from the airlines. In fact, at Mayo clinic, we hired a safety expert [laughter] from the aircraft companies to come and help us with our quality program; but that said, there is one difference and I heard in a meeting where somebody got up and they said this - and it was a physician - they said, "You know what, there's a big difference; if you have an airplane on the tarmac and you had your people look at it and they say there's a problem, you can say we can't fly that airplane. In medicine," just what you're saying, "we have a patient come into the emergency room and they're in terrible shape and we don't think they're going to make it, we can't say, 'Sorry..."

Male 3: [Laughter] You're not making it? [Laughter]

Bob: ...you're not going to make it, so we're not going,'" and that is true. So, I mean that is one difference there, but that said, I think we can learn a lot from this. I'm sorry. Have we got other questions or comments?

Male 3: Yes, just curious, when your basic physician send you onto this fellow or that fellow or that gal, and so forth, does that specialist, if you will, who's dependent upon that [big debt] physician for a certain amount of business, I would imagine...

Bob: Yes?

Male 3: ...is there a finder's fee or something like that?

Male 4: No. [Laughter]

Bob: No, there shouldn't be. If there is, there should not be a finder's fee. If there is, that basically should not happen; but you raised an interesting point. If you guys will let me digress here just a little bit, because I've talked about the integrated delivery systems, the multi-specialty physician practices, and I had an experience when I was a young health administrator at Mayo, because I was taking some classes from the University of Chicago in Health Administration at the time, and the head of that program was a fascinating guy, who's a sociologist by background, but got into health administration. He was from Sweden and he wrote a fascinating book on the United Kingdom, the United States, and Sweden, and why - from a sociological standpoint, why the health systems all evolve like they did. He said it [reflects you socially - but along the way] he said - at any rate, he called me up one day and he said, "Bob, can I get in and be seen at Mayo Clinic?" I said, "Sure." So, I set him up. When he was done, I had coffee with him. He said, "Well, let me tell you the difference between Mayo clinic..." - and this could have been Scott White, it could have been any other groups - multi-specialty group practices. "Let me tell you the difference between getting care in Chicago and getting care at the Mayo Clinic. I have three medical problems. I went to Chicago to see my general internist. He said, 'You've got three medical problems. There's a good specialist to problem A out in suburb A, there's a good specialist for problem B out in suburb B, and there's a good specialist for problem C, who's in this building,' but they have separate practices, 'tens stories above.' So, then I leave the office and I try to make appointments with all of these people, and I eventually do it; it took me six months and at the end of it, I still didn't know what I should be doing. So, I came to a multi-specialty group practice and what happened? All of these specialists all worked in the same organization. So, my general internist said, "You've got this problem." The internist ordered up the consultations and the tests that would be needed. So, each of the specialists, four days later, we got together as a team and said, 'These are what your problems are and this is how we think you ought to be treated.' It's a huge difference and when you see the reductions in hospital use and physician visits, it's because the care gets coordinated in a multi-specialty group, especially for people who have multiple problems." Multi-specialty groups cannot be as good

for some other things, but for people with multiple problems, I'd - now, [Greg] and I worked there, but I am a firm believer in it and that's why it happens. So, you just brought it up there. Sorry. Sorry for the digression there.

Male 3: Sure.

Female 2: Yes.

Bob: Yes?

Male 3: Two questions. Could you give me an idea, percentage-wise, what the overhead costs for running Medicare is versus what they actually pay the health provider?

Bob: I'm not sure I understand the question.

Male 3: Well, what is Medicare's overhead?

Bob: Oh, Medicare's?

Male 3: Yes.

Bob: Well, depending on how you count that. It probably would look like it's fairly low, because a lot of that cost is shifted onto us. I mean, by us, meaning the hospitals and the medical centers. We have to interpret all of that stuff, but otherwise, the cost of running the Medicare program, it really - it isn't in the really high percentages.

Male 3: Okay, but who makes up all those codes?

Bob: [Laughter] Oh, yes. I don't know. It's people that are involved in that program that are deciding it. I think you get into a massive - people - when you deal - with dealing people there. Yes?

Male 3: [All right. Furthermore], does Mayo Clinic take Medicare patients?

Bob: Yes, I've been asked this question, but if - it doesn't mean every Medicare patient will get an appointment, but it also doesn't mean that every patient that's in private insurance would be able to get in either, because if you get - if your calendars get filled up, then you just can't see as many people as they want to come; but that said, it would - there are certain of our primary care physicians that won't take additional Medicare patients; that is true and we have one little practice out in the west side of The Valley that won't take Medicare at all. You can go there if you're a Medicare patient, but you have to pay the bill yourself. Mayo Clinic itself isn't like that, but - and what we try to do for all of the patients is to give priority to the patients that have the most significant medical problem. So, not everybody's going to get in. Yes?

Female 2: Yes. There are several fallacies or - well, forget fallacies; correlation [is not a word I might have seen]...

Bob: Yes.

Female 2: ...[that I didn't]. Correlation of density of population to number of physicians, both the specialist and the normal proprietary [unintelligible], so the population density, education factors, academic education, income factors, these all come into play here.

Bob: Yes, they do.

Female 2: Then are we - would we then suppose to make an assumption that Alabama, Mississippi and the others with the higher mortality rates...

Bob: No.

Female 2: ...fell into [lower]...?

Bob: No. Is it some of these factors that are other than the health care that you saw on that [one tag]? Yes, that is an issue...

Female 2: [On] [crosstalk].

Bob: ...and that's - but that's why that information tries to make adjustments for that, but let me start first with the population density; when you look at physicians per thousand people, you basically are doing that. Now, you really do need to age and sex-adjust.

Female 2: Even though it's 200 miles to get to a physician, [or 150]?

Bob: Well, these - the geographic areas we're using there is the state.

Female 2: Okay.

Bob: So, it depends on what the state is, but the best work at trying to adjust for all of those factors you were talking about, the poverty level, the number of uninsured, the age, the sex, was done by the Institute of Medicine, because there was - the question you raised gets raised a lot, especially by geographic areas that don't look very good on this stuff, were different. So, the Institute of Medicine went in and I could - if any reason, I'd guess report. I won't - I can't tell you how many things they adjusted for it. They adjusted for everything and the kitchen sink, and what they found was there is still this huge variability between geographic regions and between what are called hospital referral patients. So, that's a more fine area, and there are certain areas that just use a lot more resources and they tend to be the hospital resources, and when they look at the outcomes for those patients and adjust for these same factors, they don't do any - the places that use more resources don't do any better. Yes?

Male 1: If I could, Bob - because I know there might be a couple more questions, if I could ask that you guys stick around if you have additional questions to ask Bob, but for the sake of time, I'd just like to let everybody else go. I hope you guys find your time was well spent. We do a lot of these workshops, but we don't get the questions that we get like we had today - tonight and early today. So, hopefully, you found this very thought provoking. For those of you who don't know, we provide weekly e-mails on market updates and headlines that affect the economy and your portfolio. We provide [political] commentary

from Washington through Greg Valliere, who is also a comment speaker we've brought out to you. We provide quarterly statements that hopefully are keeping you updated on what's going on around the office, but what you've just seen tonight and what we've done in the past with Mayo is truly unique. I'm not aware of any other wealth management firms around town that have this type of opportunity to bring professionals like Bob Smoldt to the table, but we want to know what you think about it. So, I'd just like to ask those of you who are here two weeks ago, you don't need to worry about this, but if you weren't here, we'd like to know if you found your time was well spent tonight and if you have any comments, and we do this with every workshop that we do in hopes of always improving our service value offering to you. So with that, I want to thank Bob for coming out tonight and if, again, you liked what you heard tonight, I want to invite you to come back in November. Turn to the back of your sheet here. Please bring anybody that you want that would benefit from this. That goes, too, for all of the other events. By the way, I mentioned the event we have coming up in two weeks on inflation and deflation, the other big event that we have this year, it's going to be at the Ritz-Carlton. It's on the back of the sheet. It's with the head of GPEC, the Greater Phoenix Economic Council. Barry Broome is a very prominent leader here in the business community and we've asked him to come out and give our clients an update on what's going on here locally, politically, real estate, et cetera. So, we invite you to come out. We will have a lot of heavy appetizers and some good alcohol being served that night. [Laughter] So, I hope you guys can join us. So with that, thank you all and have a great evening.

Male 3: Thank you.

Female 2: Yes, thank you.

Bob: Thank you.

- End of Recording -