Helping 125 Million Americans:
Improving Care for Chronic Conditions
Alliance for Health Reform
March 28, 2008

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

ED HOWARD, J.D.: Good afternoon. My name is Ed Howard. I am with the Alliance for Health Reform. I want to welcome you on behalf of the Alliance's congressional leadership, Senator Rockefeller and Senator Collins along with our Board of Directors, to this briefing on the policy implications of the growth in treatable chronic disease; diabetes, heart disease, cancer and the like. We are very pleased to have as co-sponsors today Novartis, one of the leading pharmaceutical firms in the country and the National Institute for Health Care Management, NIHCM, the non-partisan, non-profit organization doing research and policy analysis and educational activities on a range of issues. Crystal Koontz [misspelled?] of Novartis is here, I think. Nancy Chockley from NIHCM, and I am sure that they would be delighted to provide you with more information about their respective organizations if you would like to obtain it. Crystal, you want to raise your hand and let people know? Nancy? Thank you for your support and really encouragement of our putting together this forum and we are looking forward to a great discussion.

If you need to be convinced that you should be concerned about how well we cope with chronic conditions, how about this that I stole from my colleague who will be our first speaker, "96 cents out of every Medicare dollar is spent on

current treatment for chronic conditions." If you are going to something about unbridled entitlements, you better do something about chronic care. And, we hope to take a look today at how individuals and public and private sector actors cope with chronic conditions and how we might improve that response. In other words, how can we provide the best care we know how to and do it in the most efficient way possible.

Let me just make a few logistical notes. There will be a webcast available of this session on Monday at kaisernetworks.org. Thank you to the folks at Kaiser. In a few days, you can also view a transcript of today's discussion on that same website and on the Alliance website at allhealth.org. Both of them will also have electronic copies of the materials that you have in your packets. And, there is even a podcast that you can download once we get the transcript and the webcast up as well. Green question cards in your packets for appropriate use at the time when the presentations are done, along with the microphones that you can use to ask your questions. And, of course the dreaded blue evaluation forms that we would ask each of you to fill out so that we can make these programs even better for you in the future. We have really three terrific speakers today to help us grapple with the tough issues involved in chronic disease and its treatment. So, if you would please turn your pagers and cell phones off or on to vibrate, let us get on with this discussion.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

We are going to lead off this afternoon with Ken Thorpe, who is both the Executive Director of the Partnership to Fight Chronic Disease and head of the Health Policy Department at Emory University's Rollins School of Public Health. Ken has held a whole series of major academic positions. Over the last few years, he was the Deputy Assistant Secretary for Health Policy in the Clinton administration's Department of Health and Human Services a while back. And, I think it is fair to say that as much as anybody in this country, Ken Thorpe is responsible for raising the profile of chronic disease as a serious national policy concern. And Ken, we are glad you did that we are even gladder you are here to share some of your observations with us today.

KENNETH THORPE: Well, thank you Ed and it is great to be in a panel, too, with Bob and David. I had an entertainment-filled speech ready to give, but since Ed limited me to 10 minutes, all the entertainment and funny stuff unfortunately has to be cut out and so I am just going to have to just cut to the chase here. I – my role is sort of start with the big picture to basically set the stage for the other two pictures and to talk about chronic disease as an issue in the health care reform debate. We have been at this issue at trying to reform health care for at least 60 years in one way or another. And, other than the SCHIP and some other things are the margin have really been largely unsuccessful as a

nation coming to grips with issues around the uninsured and health care costs. My notion was, or at least what I would like to see happen coming into 2009, is a – to do something different, a different approach to dealing with health care reform. So, I think we need a new message, a different strategy and as we well know in this town, we have got to find a way to pull together a bi-partisan support for reforming health care.

One way to do this, we thought, was the flip-side of the uninsured. Yes, 40 million or so do not have coverage. The flip of that is that 250 million have some type of coverage, public or private. If you look at the voting patterns in 2006, 96-percent of people who voted had health insurance and their number one issue is that it costs too much. They like their coverage, but they want to find ways to make it less expensive.

We thought then to make any traction in crafting effective solutions to the affordability issue that you had to have a clear understanding of where we spend our health care dollar and what is driving the growth in spending up. So, we at the Partnership had put together a pack called the *Six Unhealthy Truths* that document the role of chronic disease and accounting for where we spend the dollars and why spending is rising over time. So, I will just go through the basic big picture statistics.

The first point is that if you look at this nationally out of the $2.2 trillion or so we spend in health care, approximately 75-percent of it is linked to patients that have one or more chronic conditions. So, just to set the profile here, sort of a typical patient here is a hypertensive diabetic with elevated cholesterol. They are overweight, or obese, so they have got some back problems, some pulmonary issues, perhaps some bouts of asthma and they are depressed about it. That is sort of a clinical picture of who is driving money in the system and you can imagine the clinical challenge associated with managing that patient in any coherent way. Unfortunately, we do not do a very good job of that for a variety of reasons.

The second issue – if I can get this. If you look at the growth in spending, it is pretty simple to decompose this. Spending rises because we are either treating more people or it is costing more to treat those people. And, obviously, the rise in spending over time is a combination of both of those. We have looked at the top 20 or 30 medical conditions over now about a 30 year period and what we found is that about two-thirds of the growth in spending is linked to a rise in the prevalence of treated disease. And, I will not go through the reasons why the prevalence of treated disease goes up. There is a whole host of reasons that could drive it up that I will talk about in a minute, but two-thirds of it is due to the fact

that the treated prevalence of disease is rising. Just to give you a quick chart here. If you look at the share of adults that are being treated for 10 of the most expensive medical conditions, 1987 versus 2005, you can see a substantial explosion in the share of the adult population that is under medical management for one or more of these conditions. And, if you look at a treatment of mental disorders, that is largely depression and anxiety disorders, diabetes prevalence is doubled over that time period. Pulmonary conditions have doubled. You go down the list and see that the share of the adult population under medical management for any one of these chronic health care conditions has increased substantially over time. Well, why does this happen? And, it is important to try to decompose why this happens, because there is parts of that rise in the prevalence of treated disease that we as a policy community can address and there is parts of them that we may not want to address, that is that the rising prevalence may actually be a good thing. And, I know David will probably talk some about that in the work that he has done.

But, the one I am most interested in is that, and this is one where it is ironic that we have two economists on the panel, because I spent the last three or four years now trying to introduce economists to epidemiologists. They do not really know each other very well and have not spent a lot of time working in each other's domains, but one of the reasons why

prevalence increases over time is because we have a true increase in the clinical incidence of disease. Economists generally do not deal with that, they deal with technology and they look at demographic changes, and essentially assume that the underlying distribution of morbidity age adjusted does not change over time. In fact, it has changed dramatically over the last 20 or 30 years. So, one of the important things that we need to figure out is how much of the increase in treated prevalences link to an increase in the true incidence of disease. There is obviously other reasons why it goes up. We have changed clinical thresholds for treating patients. We are more aggressive now to treating asymptomatic patients than we were a decade ago. While we are better at detecting and screening disease, we are picking more up. People live longer. And, there is obviously other reasons as well.

Fourth truth gets into the obesity issue directly. We know that today about 34-percent of adults are clinically categorized as obese. That is double from what it was in the mid-1980s. If you look at that increase in obesity prevalence over time, that alone accounts for about 20 to 30-percent of the growth in spending. Well, how does that happen? Well, I will give you an example here of diabetes, which I think is kind of an interesting case study. Diabetes diagnosed and treated prevalence between 1980 and 2004 has increased from 5 to about 8.8-percent. Just parenthetically, our detection

rates of diagnosing and treating diabetes has not changed over that time period. We are only still getting about 62-percent of total diabetics under medical management. What has changed, if you look at the top three bars, all of the growth in diabetes prevalence that we see and as a result in spending linked to diabetes is largely linked to rising rates of obesity. In this chart, about 80, 85-percent of the increase in diabetes prevalence is due to rising rates of obesity, and the remainder is due to rising rates of over-weight. And, you can see at the bottom one, diabetes prevalence amount normal-weight individuals has actually gone down a little bit. So, in essence, the entire increase in the treated prevalence of diabetes is linked exclusively to rising rates of obesity and over-weight.

The fifth truth, this is the good news and this is where we, I think, need to focus our attention, a lot of this is preventable. Data from the CDC and Centers for Disease Control and Prevention have shown that about 80-percent of incident cases of heart disease and stroke are potentially preventable, the same with diabetes. And, up to 40-percent of certain forms of cancer are preventable. We have now seen the link this week come out between obesity and dementia. So, the list of chronic conditions linked to this continues to expand. And, now it gets to the tough part. What do we have to do to get those changes? Stop smoking, get in shape, and eat

healthy. So, those are three challenges for today. So, we actually have cameras monitoring on every table to see what you are eating and how much you have eaten with a little calorie meter.

If you are going to focus policy makers on this issue of affordability, you can sort of see what has come out of this so far. You got to go to where the money is, which is where chronic disease comes in. Seventy-five percent of spending embedded in health care is linked to chronic disease, and a good chunk of the increase is linked to the rising rates of obesity. So, that means in terms of our policy orientation, we should really need to focus on how best to clinically manage patients with chronic illness, including doing a better job of having them self-manage their disease. And, what can we do to target the rise of obesity in this country? And, we as a coalition, the Partnership has 110 members now, have come together to try to focus policy attention on this issue, because if you think about those as ways of dealing with the affordability of health care, they are not partisan issues. They are not democratic issues, or republican issues, or conservative issues, or liberal issues. We call them the commonsense initiatives. They are just the right thing to do in terms of health reform. And, health reform here is really a broad collection of not only health interventions, but it is behavioral interventions, and environmental interventions, and

so on. So, we are trying to go back to the basics of what health care reform means as opposed to just focusing exclusively on health financing reform.

Our challenge is nobody knows these numbers. So, when you poll policy makers and the public on what role does chronic disease play in mortality, 75-percent was the right number. What role does it play in terms of spending, 75-percent is the right number. You can see that about 85-percent of the public gets that number wrong. So, I got a quit pretty quickly, because I am in overtime now. I only have a couple more slides.

Let me just end with this last slide then. I think I have made the case that on health reform, we need to find a major issue that the public can feel its heart about and the policy makers can actually come together in a bi-partisan way to do something about. And, we think the issues around cost and quality are a way to start the discussion, not end it. And, I am not saying that we do not continue to focus on the uninsured, but we have got to someplace to get some traction on a very important issue. We think health reform is the way to really do this, because if you lay the case out in a dispassionate, numerical fashion to policy makers and to interest groups, they can see that the two places I think we need to focus attention is on the better management and prevention of chronic disease and what can we do in the

schools, workplace and communities to prevent the rise in childhood and adult obesity in this country. Those are not the traditional health care cost containment discussions that we have had for the last 20 years. That discussion is focused more on incentives, benefit design, co-pays, deductibles, and information, all still important in the debate. We want to broaden the focus and broaden the debate more widely to focus on the key drivers and where the dollars are embedded in the system. So, I appreciate the invite and the next two panelists, I know, are going to give us more detail on how this could happen and does it actually work. So, thanks for coming and everybody have a good weekend.

ED HOWARD, J.D.: Thank you Ken. Thanks very much Ken. Next we are going to hear from David Cutler. He is a Professor of Economics at Harvard and the Associate Dean for Social Sciences at the faculty there. He has been a member of the President's Council of Economic Advisors. He has been an advisor to several presidential campaigns, past and present. He is also the author of *Your Money or Your Life*, which is not a joke about Jack Benny. It is a very important book, and if you have not read it, I would commend it to you. It takes a hard-headed look at the return on investment for a number of various health interventions. David has some insights for us today about opportunities for getting greater value out of our

treatment of chronic conditions. And, David thanks for joining us.

DAVID CUTLER: Thank you and I will be sure to send you the royalty check. Ken mentioned bringing economists to talk about health care issues and epidemiological issues. And, I want to try and combine the two in a way that Ken noted was so important. And, in particular, I want to ask how well do we do at improving chronic care management, what have been the gains, and how much left is there to do? And, I want to – just start off. Ken spoke both about prevention and about management. I want to be focused primarily on the management and not to denigrate the prevention end, but just in the interest of time.

So, let me start off with the bad news, because as an economist you have to talk about bad news or you get thrown out of the society. So, the bad news is that we do not do a very good job in controlling chronic disease. Hypertension is one example I will give you and high cholesterol is another one. This chart shows you which of people with hypertension now are successfully treated. The answer is about 31-percent of people with high blood pressure have their blood pressure controlled. Actually, if you look at people's responses about why their blood pressure is not controlled, about a quarter of people with high blood pressure will tell you they are not aware of it. A small number will tell you they are aware of, but no treatment had been recommended to them. And, then a lot of

people will tell you they are being treated, but the treatment is not bringing them to levels of control. Whether that is because they are not taking it enough, whether that is because it is the wrong dosage, whether that is because the problem is so big that no amount of effective treatment could really control it, that group is getting some benefit, which I will tell you about in a little bit, but not as much as we would like them to have. Big problems both in getting people into the system, I think when one looks at the unaware, one thinks a lot about how do you provide insurance coverage and get people into the system. And, then a lot about using what we know and that is particularly down at the bottom, the how do you get people to do better at what they do. And, that is going to be a theme that comes up.

You all know there has been a revolution in how we treat people with high cholesterol. So, if you want to see what the impact of lipitor has been, here it is. In the late 1980s, early 1990s, about 4-percent of people with high cholesterol were successfully managed and today it is about a quarter. So, that is actually a very big improvement. On the other hand, it is still no where near where we would like it to be. You would think with all those people taking lipitor, surely there would be nobody left in the country with cholesterol levels that were above prehistoric man. But, that is actually – that actually turns out – it turns out not to be

the case. There is still about a third of people who tell you they are unaware they have high cholesterol. The test is a little bit more involved than for high blood pressure. A fair number, 22-percent, say they are not being recommended therapy. And, then another 16-percent or so are treated, but not so successfully controlled. So, there is still a lot of work to be done. Just imagine how many more prescriptions for various things one needs to have.

Let me – I think the important questions are what difference does the treatment make and what would be the impact of doing better still? And, so that is what I want to talk about, but a little bit in terms of medically, which I just showed you, and then much more in terms of economically.

One way you can gauge the impact is you look at what has happened over time and there has been an enormous reduction in coronary heart disease mortality. It has declined by about two-thirds in the past four decades. At least a part of this is because of better treatment, not all of it. Some of it is because fewer people are smoking, and a little bit other on the risk dimension. But, a good part would be because we treat people for these conditions. And, this is actually a big deal. If you look at why it is that American's are living longer than we used to, at least in the past few decades, the single most important reason is that we are not dying from cardiovascular disease, heart disease and strokes, in particular. Infant

mortality is contributing a little. Very few other things are having much material impact. So, in total about two-thirds to three-quarters of improved longevity as a result of doing more for people with cardiovascular disease.

I will not tell you very much about the details of what I have done other than to say what I have tried to do is look at how much has all this treatment done for us relative to all the other things that are going on. So, I try and simulate what levels of blood pressure people would have in the absence of therapy and then say what different has treatment made. As Ken showed you, in the absence of therapy, things would be getting a lot worse, because people are more obese than they used to be. And, so that is going to lead you to say that, in fact, we should have had a growing problem. The fact that we have had improvements relative to that means that therapy has done some good.

This just sort of quantifies it a little bit. Basically things in red are bad and things in blue and green are good. So, the – what you see on the left is for men who are 60 to 69, how many of them have – would be predicted to have various stages of hypertension. The red is Stage 2, which is very severe hypertension. The sort of peach color is Stage 1, which is moderate hypertension. It would have been about two-thirds of men in that age group, about three-quarters of woman in that age group. It turns out it is about one-third to

40-percent. So, there are still the people who are being not successfully treated, but you can see sort of enormous improvements. That is, what treatment has done is it has compressed the share of people who are not controlled in half and many people are at fairly good levels.

We then simulated what would be the impact of all of this. I will not go through the gory detail, but just give you the highlights. If you look at the rates of say cardiovascular disease deaths or strokes or heart attacks that people would have had, we would predict them to have gone up, because more people are obese and more people would have uncontrolled blood pressure. Relative to that, they have actually declined. So, we have had 86,000 excess deaths avoided, 500,000 plus excess stroked avoided, and then over a quarter million hospital discharges for heart attacks that have not occurred. That is the good news. So, the good news side of this is that we have, by treating people better, we have made enormous improvements. The bad news is the last set of ours, which is gee if we had done what we wanted to do which is to get everyone to the levels of control that we wanted, we would have had even more improvement. So, the number of deaths would have declined by roughly an equivalent amount and the number of admissions for stroke and for heart attack would have declined as well. I will show you about that. So, I will show you about the good and the bad.

The good is that the estimated mortality reductions are actually very big, relative to other stuff. I have just given you here a way of thinking about it, but it turns out to be a very big number. The bad is that we have not reached – we have not really reached the goals. And, Ken spoke about the goals and this is sort of a way of quantifying them. We could have had close to 100,000 fewer deaths a year, a quarter million fewer discharges for stroke, and 140,000 fewer discharges for heart attacks than we actually realized if we can figure out how to get those people who are not aware, and particularly those people who are treated, but not treated to guidelines levels to be better treated.

On med, it is actually phenomenal. Even though these drugs can be fairly expensive as you know, a drug like lipitor or other high cholesterol drugs, cholesterol reducing drugs can cost about $2 or $4 dollars a day. But, the benefits to people in terms of being in better health are actually quite substantial. Using various valuations about what good health is worth to people, that is how much do people enjoy being in better health, we estimate that roughly for every dollar spent, the returns have been about $6 to $10. I do not want to focus on any specific number. It is clearly a somewhat squishy number. The point I want to make is that by any metric this has been a very good thing. People get to live longer, healthier lives by essential any valuation that you put on

that. It has been a great thing for people and if you added in savings from fewer hospitalizations and impacts on quality of life and work loss, you would get an even bigger number. There is no sense inflating it too much. At some point you just conclude, it is a great idea. And, I think for any rational calculation, it would be a fantastic idea to put in place measures that we could – that could bring us to greater levels of compliance. Not because it would save us money. I do not know whether on med, it would save us money. But, because it would be good for us in the way we like to live our lives.

The real question I am just going to leave with this, because I am sure it is going to come up. The real question is how to do it. And, in particular, have we done the sort of easy part, that is invent the drugs, make people roughly aware of them through public health and through physicians and get those who are willing to take it, to take it. And, at least one idea that comes through my mind is maybe what we are going to need to do is to think about more intensive interventions that say to people look we are going to work with you very closely to make sure that you take these drugs. We know that price is a barrier to some people and we will have to deal with the price, but beyond just dealing with the price, have to work with people to structure their lives so that they make the preventive changes and the chronic care management changes that are really needed to bring effective treatment. And, I

suspect, at least part of me suspects that the next phase of this is going to be much more intensive than what we traditionally think about in the medical system and in health care reform. And, so I just want to kind of end up with that thought about we ought to be prepared to do something beyond what we have traditionally done.

ED HOWARD, J.D.: Terrific. Thank you David. By the way, you have heard from our two economists and I did not do either one of them justice in their introductions. You will find information supplementary to my very brief words in your materials, as you will also for our last speaker, whom I am about to give an inadequate introduction to. That would be Bob Greczyn. He is somebody who is responsible for managing and paying for chronic care treatment in a big chunk of our population. He is the President and CEO of Blue Cross and Blue Shield of North Carolina, posts that he has held for the better part of a decade. He is also a leader in a number of community health initiatives in North Carolina. Bob's task today is to give us a sense of how you take an enormous task like improving our treatment of chronic conditions and operationalize it. Bob, thanks for being with us.

ROBERT GRECZYN: Thanks Ed. It is great to be here. The first thing I want to point out to people is something that Ken said which is that 96-percent of voters just want to be sure that they keep their coverage and it costs less. And, the

truth of the matter is that all 96-percent of them have no idea how much it actually costs. So, I think if I were going to rename this conference, what I might say is Helping 125 Million Americans: Improving Care for Chronic Conditions and Oh By the Way, Why Don't We Solve the Problem Instead of Treating It. And, that to me is sort of the crux of the fact that often times in these kinds of discussions, we spend so much time lost in sort of a medical model of care that we forget about the fact, and I know David hit on it, but chose not to go there for time reasons, but I think we give short shrift to prevention in all of this. And, I think it is one of the areas where we really need to focus going forward. And, as I talk about this, I want you to understand that I am not sitting up here trying to present my organization or any health insurer as having the answers to these problems. We are still lost in the medical model as much as anybody else is and trying to fight our way out of it.

I am also not surprised by some of the studies that I read in your packet that indicate that treating more people does not actually reduce costs as much as improves quality, which again is a wonderful, wonderful outcome to improve quality. And, I think over a longer term, it actually will reduce costs and I think I will be able to show that in some ways when I talk about some of the things that we are doing in North Carolina to think about these issues. But, I think

everybody needs to understand, and you saw it here, that we did not get here over night. It took us 35 years to get here and all this tends to be sort of circular. We talk about obesity and high blood pressure and heart disease and cholesterol. And, by the way zocor works just as well as lipitor, and it is generic. So, it costs a lot less. I just – sorry, I am a health insurance guy. What can I say? But, all these things kind of revolve back a lot of this being driven by obesity and all of the conditions related to obesity. And, as we think about this, I think there is a – there really is this good news story here, and if I may, it is sort of the pony in the pile of whatever. The good news is that we can prevent this. The good news is that we not only can treat it, but we really can do a much better job of preventing these problems from growing and if we prevent it, then the people who are unaware that they have high blood pressure will not need to worry about the fact that they are unaware. They can stay unaware, because the will not have high blood pressure if they are doing some basic things that they need to do.

So, I want to talk just a little bit about some of the things that we are doing in North Carolina. But, I think one point I want to make as I go through this is we all talk about how we are going to structure things into a more of a team based environment, how we are going to create incentives and in the process of talking about incentives, we end up talking

about incentives for everyone, we end up paying everyone, but the patient for engaging in the process. So, often times the incentive is to the physician. We spend too much time still doing things to people and for them, instead of really fully engaging them in their responsibility to take care of themselves and improve their own health, because I do not think anybody can make somebody improve their health. That is going to take actual engagement on the part of the person. So, from North Carolina's perspective, there are a couple things.

One is I think North Carolina is pretty well nationally recognized in terms of some of our obesity efforts. One of the things we did a couple of years ago is we put in place really the first center of excellence in the U.S. for bariatric surgery. We made a very conscious decision that we were going to take an unsafe procedure and see if we can make it safe. Because for some people, it is their last resort after they have tried everything else. I wish I had time to go into all the details, but I think it is a huge example of the fact that when you actually sit down with doctors that they actually do not always understand. They all think they are doing quality, they do not necessarily understand what quality really is and they also do not necessarily do the same things that they say they would do for a particular patient. And, I think we have found that and we also found that once we agreed on a set of criteria for what represented quality for that procedure that

the folks who were not doing it that way, all of a sudden started to do it that way. So, I think there is huge opportunity here for us to make progress. We are really the first plan in the country to recognize obesity as a primary diagnosis. And, that is pretty esoteric, but it used to be that doctors had to tell us that the patient had high blood pressure and by the way, they were obese, too. And, you could not see the patient just to treat obesity. You had to see them to treat the high blood pressure. We do not do that anymore. We let doctors actually treat patients for obesity. We are the first plan in the country to credential registered dieticians and we actually pay for visits to registered dieticians for our members for a diagnosis of obesity. And, so it is a different way of thinking about it.

But, beyond that, there is a lot more kind of basic things that I think we are doing that are very important here. First of all, we build our own programs. And, one of the things that that allows us to do is it allows us to change on a dime. If something is not working, we can modify it, change it, rethink what is going on there. So, we build our own programs. Where it is appropriate, we separate our programs between children and adults, because child asthmatics are very different than adult asthmatics, and so on.

One of the things we did a couple of years ago, because we had this amazing epiphany, we used to have an asthma program

and a diabetes program and a high blood pressure program. And, if you happened to have asthma, diabetes and high blood pressure, then you were talking to three of our case management nurses, which makes absolutely no sense and I have no idea why it took us so long to figure this out. But, what we did a couple of years ago was we integrated our disease management and our case managements programs, and now, people come in to an integrated program and if they have asthma, diabetes, two of the three, four out of five, whatever it is, they still talk to the same person and they get information that is customized to them for their issues. And, actually I think it has made a huge difference and we call it our Member Health Partnerships. And, we identify candidates through a variety of ways, heath risk assessments that we are increasingly involved in, claims analysis, surveys, and so on.

And, we are also doing a lot more work with employers and I really think employers are kind of the – we are starting to wake up giant asset that we have in all of this. I think by and large, they have been fairly fearful of getting involved for fear of doing the wrong things, and I think what we see now is that with the right help from us and from others that they are really starting to engage very actively with their members, and we are doing it for our 5,000 employees as well. We just took all the sweets out of vending machines. We made the stuff in the cafeterias more healthy. We banned smoking in North

Carolina. We built a walking trail around our building. We have weight loss challenges for large groups of people. And, I have not gotten a single death threat. And, I am actually starting to get emails from people that say thank you for giving me the initiative to get involved in my own health, which I think is pretty exciting.

We have now created an employer dashboard that really gives employers an opportunity to look at their own aggregate risks, not individual patients, but they get to look at their own aggregate risks and it helps them better define what areas that they want to focus on in terms – what is going to have the biggest impact in their employee population in terms of prevention, in terms of addressing these sorts of issues with their employees.

And, then we aggressively measure our results. You can not do these things without measuring your results and understanding whether these things are working now. We are pretty consistently showing a 3 for 1 return on our investment in disease management and case managements. I think it is a – it is really pretty fantastic return. We are showing a 12-percent increase in hemoglobin A1c, microalbumin, and cholesterol testing for folks with diabetes who are engaged in the program. A 13-percent decrease in diabetes hospital admissions. A 16-percent decrease in asthma related admissions. And, we just got done with a two year study of

obesity efforts that showed that for 1,200 people who were engaged in the program that they reduced their costs, and I say they reduced their costs by $200 per person and they have one-third the medical trend that you would expect going forward. So, it is a huge opportunity.

We just rolled out a new program called Medication Dedication that addresses another concern. People need to take their medications here. So, what we have done is generics are free and we have reduced the co-pays on the brand name drugs if they are engaged in the program. It is a huge opportunity for them to begin to get an incentive. But, we have done a lot more than that. We have really worked with our communities across the state. Next week, we start a Million Step March that is very highly publicized with a guy named Gary Marino across our state. We have fought to get physical education back in the schools in North Carolina. And – because, health care is a lot more a reflection of all the other things we do in our society than I think we give it credit for sometimes. But, it is not as hard as it sounds. Wellness Councils of America says that if each and everyone of us will eat 100 calories less per day, that is one of those little teeny cans of coke, and walk 30 to 45 minutes, three to four days a week, that we will lose weight and we will get healthier. That sounds easy enough that I think most of us can do it. Thank you.

ED HOWARD, J.D.: Thanks very much Bob. Let me just ask a quick follow up question. You noted a two year time period for one of those –

ROBERT GRECZYN: Yes.

ED HOWARD, J.D.: – studies. Are the results that you were citing for the hemoglobin precedence and some of the other results over comparable periods or not?

ROBERT GRECZYN: Yes. Pretty much they are over comparable period since we integrated our disease management programs.

ED HOWARD, J.D.: So, you are confident that these are trends that are actually trends and not just one time –

ROBERT GRECZYN: These are not –

ED HOWARD, J.D: – behavioral modifications?

ROBERT GRECZYN: These are not one month trends.

ED HOWARD, J.D.: Okay. Very good. Now you get a chance to ask your questions. I remind you there are green question cards you can write your question on. There are microphones here and in the back where you can come forward, which if you do, I would appreciate if you would identify yourself and address the question to a particular panelist if you wish. Let me just start by – oh, let me just start by recognizing the gentlemen who has just approached the microphone to the rear.

BILL EMMETT: Oh, well thank you. My name is Bill Emmett and I am with the Campaign for Mental Health Reform. I noticed in the chart that Ken presented earlier in his presentation that showed the rise in prevalence in conditions. The mental disorders probably experienced the greatest rise of all the disorders listed. And, arguably mental disorders are linked in many ways to many of the other conditions. Yet, in the presentations today, there has been very little attention to mental disorders. So, I am wondering what you see as the challenges that keep us from addressing mental disorders as a chronic condition basically and what actions we can take to do that.

KENNETH THORPE: Alright. I will give it a shot. I think there is a couple challenges. You just heard Bob describe and I think it would be important to really understand and decompose sort of the structure of how these programs work to see if we can not replicate them and duplicate them to get that 3 to 1 return that really does show that appropriately structured, well-designed interventions can actually not only improve quality, but save money. On the mental health side, I think that our challenge is really two-fold. One is to make sure that we really understand the intervention model in an appropriate way about how to treat and how to prevent depression and other types of mental disorders. I mean, we have a good model certainly for the cardiovascular risk factors

about how to intervene and intercede to try to prevent those and manage them, and that is a well-established set of clinical protocols that the ADA and the American Heart Association and others have put together every year. And, I think we need to have a similar – and I know that people are working on this – attention paid to the treatment and prevention of mental disease. Obviously, issues around payment and the structure of benefits matters is a second issue that obviously has received a lot of attention up here in the Hill in the last month or so. And, third I think, too, is to recognize that a lot of what we see in terms of rising rates of mental disorders are co-morbid to a lot of these cardiovascular risk factors which you have just heard about. Certainly mental disease is a risk factor linked to diabetes and cardiovascular disease. And, that as we treat those, we need to also make sure that we are also addressing the treatment of depression and other types of mental disorders at the same time.

So, some of it is that we were picking the low hanging fruit in a sense where we got established clinical models in place. There is clinical agreement about how to proceed. There is clinical agreement about the periodicity of checking hemoglobin and annual eye exams and extremity exams, and so on. And, everybody had bought into that. It is just a matter of how can we produce that result in a health system that kind of discourages us from doing it. I think it is a harder task on

the treatment of mental disease, but I think that to the extent that we can continue to put together the same types of guidelines and the same types of structure that we have done for some of these cardiovascular risk profiles, that would be a terrific start.

ROBERT GRECZYN: Yes. I guess I could not agree more Ken. I think one of the things we have found and it is very variable. When I talked about the bariatric program, the bariatric surgeons knew that if they did not do something that the procedure was just not going to be covered anymore. So, they were very willing to engage in the process with some other specialties who I will not name and mental health is not one of them. I would say that the message that came back was we do quality, we do not track our outcomes, go away. And, as long as that is prevalent out there, then that is going to be a problem that we have to deal with and I would love to see more engagement on those issues. Mental health is particularly difficult, because a lot of basic mental health, depression treatment actually is happening in primary care physicians' offices, rather than in a psychologist or a psychiatrist's office.

ED HOWARD, J.D.: David?

DAVID CUTLER: Just one comment on a particular form of mental issues, which is clinical depression. The latest studies I have seen suggest that about 25-percent of people

with clinical depression are treated to guideline levels, which is roughly comparable to the share of people with high blood pressure or high cholesterol. And, it sort of strikes me that there is about a speed limit in the current medical care system that rough – no more than 25 or 30-percent of people with any chronic condition are going to be well-treated the way that we arrange things now.

ED THORPE, J.D.: Yes. Go ahead.

NORA SUPER: Hi. I am Nora Super with the Kaiser –with Kaiser Permanente. My question is for David. I am little troubled by your last statement about under utilization. Do not want to leave people with that under utilization of effective, cost-efficient therapies continues to be the major public health challenge. So, I would hope you would agree that many patients are also being poked and prodded and receiving unnecessary services and procedures and treatments. And, so I am going to offer a way out and ask that if you also believe that more robust comparative effectiveness research could teach us more about which therapies have been over utilized and under utilized, and would ask the whole panel what your thoughts are about, as you know at the federal level we are having this big debate about comparative effectiveness research and what you all may think what that might look like and your thoughts about as we debate this as that moves forward. Thanks.

DAVID CUTLER: Thanks for the question. Actually the great irony of American health care is that some people get too much and some people get too little and it is actually the same people who get too much and too little, and depending on the circumstance. So, when they have chronic disease and it is not particular acute, they get too little. And, then all of sudden something kicks in and it becomes acute and they will get way too much. And actually all the studies that I am aware of show that if you waved your magic wand and got people better chronic disease care and better prevent care and at the same time eliminated stuff they do not need, that on net you would save a lot of money. People would be a lot better off and they would live a lot longer.

So, it is sort of dealing with that challenge and that is why it is very difficult and that is why you have sort of policy debates about should we raise cost sharing, because people are using too much, and therefore we ought to discourage them from using it or should we lower cost sharing, because then people would use more of their preventive services. And, the answer is with only one tool, you are going to make mistakes one way or the other. So, I think the kind of things that you were talking about going beyond just gee, should we make people pay more or pay less, but get into okay, what do we really know about what works and how do we give the doctors the incentives to do the right things, the sort of knowledge and

the incentives are going to be absolutely key on both the getting people to do the things that we think they should do and getting people not to get the things that are just not doing much good for them.

ROBERT GRECZYN: Yes. From my perspective, I would say bravo on the comparative effectiveness institute that has been proposed at the national level. It is about time. Love to see that. And, I think that the Blue Cross Association has been a very big supporter of that as a part of the pathway to covering America, which I would encourage each of you to take a look at. I think David is right that part of the problem here is we say it is our payment systems. So, we have a fee for service payment system that encourages over utilization. So, some would militate going back to say a capitation system, which tends to under utilize services more than what we do now. So, I think knowledge is the first piece. If we can get a buy in that there is not enough information about what qualify really is out there and get people bought in to standards to care and evidence-based care, then we have a basis on which to incentivize that and pay for it, which I think is critical to making it happen.

KENNETH THORPE: I am going to add to this real quickly. I agree with the previous two comments. I would hope, though, as we discuss this issue of comparative effectiveness though that we do not have such a narrow focus on just the existing

medical interventions for treating disease, that we really do have a broader view of this that looks at what types of interventions are most effective in preventing the rise in obesity. What types of interventions are effective at the work site for improving individuals health, or at the – in the community or in the schools, and so on. So, I think we have got to go back to sort of this basic models of the underlying determinants of health. Certainly medical interventions are a piece of this, but if we are really going to do comparative effectiveness analysis, I think, in its totality, I think we need to make sure that we do not so narrowly define that we lose the broader picture and the broader focus on what is really important here.

ED THORPE, J.D.: And, if I can take a 30 second detour for a commercial. Great minds running in the same channels, we will be conducting in this room, I believe, a week from today, a briefing on comparative effectiveness. And, we would invite you to sign up. You will be getting the notice for that within either the rest of the afternoon or Monday for sure. Yes. I believe there was somebody waiting to ask a question.

BRENDA SOLICK: I am Brenda Solick [misspelled?] with the Alzheimer's Association, and we just had a report come out about a week ago that shows that 10 million baby boomers are going to get Alzheimer's disease. And, having dementia will have a huge impact on chronic care management of any disease.

So, I wondered, I guess the question is for you Dr. Thorpe. Has the Partnership taken into the consideration the impact of dementia? I noticed it was not on your list. But, we do know that some of the things that are good for a healthy heart are also good for a healthy brain.

KENNETH THORPE: We have and actually we do have the Alzheimer's community in our – just one of our 110 members in the Partnership. The – when I put down mental disorders, that was a collection of a wide variety of mental disorders, bi-polar, anxiety, dementia gets coded into that as well. Yes. I think what we are focused on in terms of the chronic care piece, we are starting with the existing acute care components, but we, I think, all recognize that if we are going to do this right, we have got to find better linkages between the management of patients in the traditional acute care system, mental health system, and long-term care system. That these things are truncated, they are separated. Our delivery models do not do well in moving across those barriers.

I really think that is the next challenge that we are going to raise as a policy issue about one, how can we start by redesigning the current acute care delivery model which needs a lot of help. But, then more broadly, how can we really rethink the broader delivery model that really segments, I think, and appropriate care in different sectors and probably does not do as good a job as we could in this issue of Alzheimer's,

dementia, cutting across long-term care, acute care, the mental health system is a perfect case study to figure out more appropriate, not only prevention models with the obesity piece, but more appropriate clinical management models. So, thanks for raising that.

ROBERT GRECZYN: And, thank you for raising that to a baby boomer. But, I believe, didn't a report just come out that linked obesity –

MALE SPEAKER: Yes.

ROBERT GRECZYN: – and Alzheimer's. And, so you have to go back to some extent to all of this stuff goes around in a little tight circle and it could really give you a pretty good focus.

ED HOWARD, J.D.: I do not want to lose the thread of what Ken was saying. We also had a specific question on this. Trying to deal with an integrated approach to very fragmented delivery and payment systems has to present some real challenges. How do you deal – and, in the case of dual elligibles, you have folks who are accounting for 40 or 45-percent of the spending in Medicare and Medicaid, respectively. How do you align those incentives and the structures and the payment systems to get at the kind of relationships between the programs so the people actually get decent care, whichever hand is paying the provider and in whatever setting?

KENNETH THORPE: Well, I mean, there is three pieces to that. The first one in Medicaid is sort of a classic case study of what is wrong in the management of this. The first thing you got to do is have people that are continuously eligible for a program. So, in a lot of the programs that I have seen, if you do quarterly re-certifications, or twice a year certifications of eligibility, you just start to manage a patient, get to know him or her, get him involved in coordinating his or her care and then they go away. So, that is a challenge. That just – to the basic structure of eligibility in the Medicaid program is how can you get people would retain and be continuously enrolled in programs so you can actually work with them to clinical manage the disease.

But, we have touched on the other two pieces is that, in – I will go ahead and take my shot at my favorite program, Medicare, but if you look at the traditional Medicare program, we were talking about this earlier, it has a terrific program for treating patients that we treated in the 1950s, episodically treated acutely ill patients, but that as you have heard, not the type of patient that is in the system today. And, that payment model in traditional Medicare does not allow the types of innovative structures that Bob was discussing to widely diffuse. So, it is not a big surprise that we do not have these types of integrated delivery models that are more attuned and more adept at preventing and dealing with chronic

disease, because we are running cross currents on the payment system that economically makes those models essentially not profitable to do.

So, we have got some basic challenges, I think in health policy to focus attention on what in traditional Medicare, because that is the leader, could we do to move us down the path to allow more integration of care? How can we more rapidly diffuse information technology to give primary care physicians the tools to manage that patient that I started out describing that has seven or eight chronic health care conditions is probably seeing 10 or 12 physicians during the year, 30 or 40 medications, and bring that together in a coherent way. So, we have got a lot of basic health structural things to do in health reform that I am hoping moving into 2009 that we can start to build some momentum here in a bi-partisan way to actually do something substantive on health reform, perhaps using Medicare and the FEHB as models for the more faster and more accelerated diffusion of the types of that Bob was describing.

ROBERT GERCZYN: I would just expand on that just a little bit and say one of the real issues right now is that unless Medicare is at least willing to take a step toward de-emphasizing procedure lists and emphasizing primary care, then we are not going to have primary care physicians to particularly worry about. It is getting to be – it is getting

to the point where it is getting harder and harder to get folks to go into a primary care residency program, and I think that is something to be pretty concerned about.

ED HOWARD, J.D.: Yes. We have some folks at the microphone.

LORI FEINBERG: Yes. You have taken care of a lot of my question. I am Lori Feinberg from Department of HHS. And, it seems to me that Medicare has tried several demonstrations, most of which have not been so successful in integrating care. And, you have talked about these ones in the employer setting where there are case managers, but it is not clear they are coordinated with the physicians. What kind of suggestions do you have should be Medicare's next step in trying to get to where all you see us wanting to take the health care system?

ED HOWARD, J.D.: And, let me just say we have a couple of questions submitted on cards about some of the demonstration programs and your – soliciting your advice on why they failed and how they might be better structured, so.

KENNETH THORPE: Yes. I guess on those demonstrations, I just go back to the sort of the basics on what a demonstration program is trying to do. I mean, by design, you are looking at a whole lot of different approaches for managing disease and evaluating how well they do. Some are going to work, some are not, almost by design. And, what I would do is to take away, is to say look let us look at the ones that seem

to be effective in at least improving quality or reducing hospitalizations. So, for example I would love to look at what Bob has done and there is other in the packet that have shown results in terms of reduction and cost share – spending. And, look at the design of them. What – and break it down into the essential features. What is it about the design and elements of the types of programs that Bob looked at or the types of programs and some of the Medicare demonstrations that generated savings? What are the essential features of those? How could we fund those features in a more broadly replicated model? How could we pay for them and just really pay for them in as minimal as way as possible in order to generate a positive return on investment?

So, my take away from the demonstrations is not that they are negative or they are failed. I think what we need to do is to say let us look at what worked and why and how we can take those essential moving parts and replicate them more broadly and what type of financial incentives would we have to put into place in order to allow that type of a structure to more quickly diffuse.

ROBERT GRECZYN: And, I would say, I am not really that aware of the demonstration projects, but we are involved in Medicare Advantage. I think it is an area where – and not private fee for service. It is an area where I think we do do a lot of effort around patient management, things like we

monitor our folks who are in heart failure every morning by computer, so that we monitor their weight. And, if they have gained a certain amount of weight, we send them to the doctor. So, those kinds of things, I think can show some promise.

ED HOWARD, J.D.: David?

DAVID CUTLER: There is an issue around Medicare that is important, I think. To first approximation, about half of physicians' revenue will come from public payers and about half will come from private payers. That means that if this solution is to get physicians to change fundamentally the way they practice, which is a lot of what we are talking about, it is very hard to do that when only half of your payment is moving one way or the other. Currently Medicare does not do very much and so you are trying to deal with the private sector and you are trying to convince physicians as we are trying to do in Boston, trying to convince them to fundamentally change the way they practice medicine, acknowledging that half of the money is not going to follow that.

Some of what happens, I think, I suspect in some of these demonstrations is that even Medicare is not a big enough share of what the physicians practice is to have a big impact by itself. So, one of the areas that I wondered about and I have not done anything more than that is what if one thought about this not as a particular payer changing things, Medicare, Blue Cross Blue Shield of North Carolina or wherever else, but

what if one thought of about this as a sort of regional or local model that you said gee, look if all the physicians in Boston, or all the physicians in Charlotte, or all the physicians in Atlanta decide they want to get together and the insurers and the doctors and the hospitals and so on, get together and say look we want a new model of chronic care treatment and prevention and chronic care financing, can we come to you who run Medicare and you who run the private insurance companies and put this forward and say look, we all join in with this and maybe it will involve buying IT or maybe it will involve doing other kinds of payment changes, would you be open to that? And, I think currently the –

ROBERT GRECZYN: Bring it on.

DAVID CUTLER: Currently the answer is no, there is not an ability to do that. I think it may be as much legislative as in operation. But, that kind of thing might be a way to make progress, and really say we are going to have some model communities out there.

ROBERT GRECZYN: I actually challenged the medical community in the Eastern part of North Carolina to do exactly that and I am waiting for them to do.

KENNETH THORPE: Just a –

ROBERT GRECZYN: I can not wait.

KENNETH THORPE: Just a quick follow on that, in terms of a state that has taken this on, and I think that is exactly

the right model, is that you sort of identify what are the key ingredients to really doing this right, you get some consensus around it, is Vermont who passed three years ago now their I think landmark legislation that did more delivery system innovation probably one state and one piece of legislation that we have seen in any place else in the country. So that is a wonderful experiment to watch how that unfolds in a state where they have come together across all payers and come together community by community to really rebuild a delivery model populated with information technology in a very different way that has all the payers participating.

ED HOWARD, J.D.: That is very good. Yes. We have another person back here.

CLAUDIA WILLIAMS: Hi. Claudia Williams from the Markle Foundation. I applaud this group for saying that the road ahead will be focused on more intensive interventions and really getting our arms around reducing individual risk behaviors. But, too often we just put that out into the future. We say let us focus now on the folks who are sick. Let us focus on the medical model. I guess what I am calling for is really concrete paths forward for building behavior change into people's care. I do not hear a lot of concrete payment structures or organization delivery models for doing that. I think a lot of our prevention occurs in very distributed, sort of these community coalitions. Those can be

helpful, but I think we really need to start in the same way were doing with comparative effectiveness, putting our heads around – we can not put this off 20 more years and focus only on the folks who are already sick. So, I would love any of your thoughts on what is our next step. I mean, we need to know what interventions work, but to some extent, we have never tested truly integrating that behavior change process into care. And, so I am not sure we have exactly the right models yet to know how to do that.

ED HOWARD, J.D.: Bob?

ROBERT GRECZYN: I am not at all sure that we have the correct models to do that either. But, I will tell you that I really do not think we are waiting to do that. And, it is both on the acute and the chronic side. I mean, we in North Carolina fully funded the hospital associations efforts around patient quality and safety. We are going to do the same thing for the medical society. We are trying to get them together, and I think we will, to talk about some of these issues and how we change – how we look at changing the reimbursement models to do this. And, in the mean time, we are actively engaged through employers, through individuals, through our case managements programs, trying to change the outcome and a lot of the public outreach, things like this Million Step March that is really changing – we want it change the discussion going

forward. But, in terms of do we have the answer, it is just plain hard.

ED HOWARD, J.D.: David, then Ken.

DAVID CUTLER: We actually have some things we can learn from other areas where we have tried change behavior. So, the one I consider most salient is getting people to save for retirement, which is – has a lot of the hallmark features of getting people to control their weight and so on. So, let me describe the finding to you. If you – what most employers do when you are hired, is they say okay, we have a 401K plan. Here is this form. Just fill out this form and you will be in the plan, or call this 800 number, go on the web and just fill it out and you will be a member of the plan. And, about 40-percent of people do it right away. If you reverse it and say, okay you have just been hired, we just put you in the 401K plan, but if you do not want to be, just fill out this form and we will disenroll you or call this number or go on the web. Ninety percent of people remain enrolled. So, just that very simple act of having to make a telephone call discourages 50-percent of people from signing up for the 401K plan. What that suggests to me is that the model that we are going to have to work with for a lot of people who have difficulty has got to be something so easy and where the default is to do what the right thing is and it can not be that we require an active step on the part of the individual. And, that is – at least initially,

as we start off, and that is what I meant by it is going to have to be more intensive. That is, just saying – just laying it all out to people and saying, okay here is all the information, you just call this number and you can be involved, is not going to get all that many people. Those programs may be great, but we are going to have to do something that is closer to default. I am not actually sure what that is, but I think whoever can figure out what that model is will really have a wonderful way to work with most people. Those 90-percent of people in the 401ks are not unhappy. They do not feel like they were pressured into it. They – in fact, they are saving much more for retirement and they are much better off and they are quite happy with that experience.

ED HOWARD, J.D.: Ken?

KENNETH THORPE: Two – just two quick observations on that. One is it is sort of silly and maybe simple as it sounds, up until the point where you make the link between rising rates of obesity and rising rates of health care spending, your ability to really develop action and consensus and agenda around this has been pretty limited. Really the prevailing view among economists up until I think pretty recently is that we can explain about 30-percent of the rise in health care spending by the usual demand side factors that economists like to look at. Then, there is this massive residual that has just always been technology. Well, it is not

all just technology. I mean, technology is a big chunk of that, no question. But, the fact that a substantial amount of the rise is really linked to rising rates of the incidents of disease linked to obesity is an important part of changing the nature of the dialogue and building a case to spend the resources to focus on that. So, I think that is one observation.

Two, is that in terms of just incentives, the Medicare program going back to them has a huge incentive to deal with this issue early on for people in their 40s and 50s, because we now have at least three studies out from Rand, the University of Florida, and one from RTI, that when you look at adults 60, 65 and above who are healthy, normal weight, no chronic disease, no disabilities that they will spend 15 to 35-percent less over the course of their lifetime on health care than somebody who is obese that has one or more disabilities, and one or more chronic health care conditions. So, the lifetime costs are lower and there is a big stake that Medicare faces in finding interventions in ways to improve the health of seniors coming into the program rather than just sort of waiting for them to show up and dealing with medical complications as they present.

ED HOWARD, J.D.: Yes sir.

MATTHEW GABER: Do you have any comments or reactions to the recent study from the Netherlands that show that some

prevention efforts can actually cost more long-term than treatment outcomes? And, along those lines, some comments I think I have, and clarify me if I am wrong, but some of the comments I heard from you over the speech was that some of the prevention efforts you are suggesting might not lead to cost-savings but they will lead to improved quality. For a lot of people if there is no visible reduction in costs, it is not enough of an incentive for them to change their lifestyles. So, how might you be willing to realistically sell that to people with that kind of attitude?

ED HOWARD, J.D.: Before you answer, I just want to ask if you would like to identify yourself.

MATTHEW GABER: Sure, Matthew Gaber [misspelled?] with the National Conference of State Legislatures.

ED HOWARD, J.D.: Yes. Go ahead. Bob? Ken?

ROBERT GRECZYN: Yes. I raised that issue, but it was not around prevention. It was actually around treatment. That treating more people did not necessarily save money, but it – according to the studies in the book, but it appeared to increase the quality. I am not familiar with the prevention study from the Netherlands. Perhaps some of my policy wonk friends are.

KENNETH THORPE: Yes. I mean, I saw that and it sort of led me to go back and look at what I thought were real studies that were well designed, well executed. If you go – I

will be happy to give you the sites for the work that Rand has done. There is a – it is online now and health services research are very good well-designed study from University of Florida researcher looking at the lifetime costs of obese versus normal weight adults. And, they do show over the course of the lifetime that it is about 15-percent less than somebody who is obese and has one or more chronic health care conditions. And, RTI has a study coming out as well. So, I think that the bulk of the evidence runs exactly opposite way.

On the prevention side, I think we just have to be careful about what – about how broadly we are talking about it. I do not think anybody up here is advocating that we provide and have a huge public campaign for 100-percent of woman 90 and above to get a mammogram. I mean, that is not the type of – yes, I mean you can look at some of these preventive services and to the extreme, they probably do not make a lot of sense in terms of detecting disease and appropriately intervening. The types of things, however, we are talking about are very targeted interventions that deal with lifestyle, that deal with weight, that deal with the ability of – to come in and intervene to make sure that somebody who is pre-diabetic does not transfer over to becoming a clinical diabetic, that somebody who is overweight does not move into somebody who becomes obese. And, we do have effective interventions that can do that.

So, I think the types of preventions that we are talking about are really focused on that type of intervention as opposed to, again I think it is part of your packet, that piece in the *New England Journal of Medicine* that I think ironically was talking about what the presidential candidates were saying about prevention. The irony is they are not really talking about much of those things that is in the *New England Journal of Medicine* article at all. What they are talking about is what I just mentioned, and the irony is that that type of intervention was not talked at all in that *New England Journal* article. So, I think we just have to be very careful about, in terms of the terminology what we mean by prevention, because it means a lot of different things to a lot of different people.

ED HOWARD, J.D.: If I could just ask a follow up question. There is something, some official body that has a name something like the Preventive Services Task Force, is there not? And, those interventions are evaluated for purposes of being covered or not covered, and being pronounced efficacious or not. How does that fit in? Presumably some things do not get certified, because they are not cost-effective. Is that the way it works or is that the way it should work?

KENNETH THORPE: Yes. I mean, again. Those are very broad definitions that are trying to bring together

recommendations about screening, cancer screening, immunizations, other types of preventive interventions that the bulk of the medical literature says is what seems to be clinically the most appropriate. They may or may not generate reductions in expenditures, but they are viewed as good medicine. The stuff that we are talking, or at least what I am talking about, on the obesity side, I think does two things. One is that it can save money if it is appropriately designed and appropriately structured, and if it is narrowly viewed as a specific intervention that is trying to deal with changes in lifestyle.

LISA SUMMERS: My name is Lisa Summers. I am with the National Partnership for Women and Families. And, my question has to do with the kind of work force we need that is best suited to the kinds of changed that you are talking about, which are very wonderful to hear. I spent many years in the trenches as a primary care provider, primarily in academic health centers and I think you are absolutely right that there just has not been enough focus on primary care and prevention. Most of what you have talked about when you have talked providers, you have talked about physicians and medical care. There was the reference to registered dieticians. So, I would be interested in your comments about what we need to do if we need to make changes in our workforce, and specifically what you see as the role of folks like nurse practitioners, physical

therapists, folks who typically have faced very significant barriers to practice, but there is certainly good data that they are very effective in the kind of care that you are talking about.

ROBERT GRECZYN: I will say that the way I look at it, and I said earlier that I think we need to be careful that we do not lose all the primary care physicians here. Having said that, I think that is half the issue. And, I think one of the things that we need to really take a hard look at is making sure that highly trained physicians are actually doing the things that physicians need to be doing. And, that highly trained nurse practitioners and others are doing the things that they can do more effectively so that we are actually multiplying the capability of our system rather than doing what we intend do right now, which is focus everything on the physician.

ED HOWARD, J.D.: David?

DAVID CUTLER: I just want to second that and add in that a big barrier at the moment is the payment system. So for example, if you have a nurse practitioner reach out to a Medicare beneficiary, even most private insured people, and call them up and say, "Hey, how come you have not come in for your HbA1c screen or your mammogram or anything?" The reason why they do not do that is because there is no reimbursement

for it at all. And, so it – the practice is sort of – is tied up with the financing issue that we spoke about.

ROBERT GERCZYN: Well, there is reimbursement. However, it has to be – currently it has to be billed generally under the physician's code, which really needs to change. Guilty as charge.

AYANA NUZUM: Hi. My name is Ayana Nuzum. I am with GMC Media. I have three questions and they are in three separate areas. First I would like to have some discussion around cost and health care disparities. The second question, I would like you to discuss is around transplants and what is happening in that area and what your thoughts are on that. And, the third thing is around alternative medicine and how does that fit into the whole cost discussion. Thank you.

ED HOWARD, J.D.: Three broad questions succinctly stated. Thank you. Any takers on any parts?

KENNETH THORPE: On the disparities piece, I think that one of the ways to get at differences in rates in infant mortality, differences in rates of treatment, differences in rates of cardiovascular disease, is a lot of the focus we have been talking about. A lot of this is both due to the system and getting people into the system early, early diagnoses, early detection, appropriate treatment. And, we do that in a very uneven manner, and so people are not accessing that type of system in even waves, and so one would hope that some of the

disparities you see in some of the outcomes could be eliminated. On the – one of the big areas and big challenges that we face is that, like all countries, there has been a dramatic reduction in infant mortality over the last 40, 50 years. And, that has been a worldwide phenomenon. But, in this country, there is remaining huge differences in infant mortality rates between African American women and white women. And, getting to the structure and the roots of that is a major public challenge that we face.

Then again, I think by refocusing some of our time, attention, and efforts on rethinking the health delivery model, the primary care delivery system. There are great models internationally on how this is done. The French actually have a very good model for doing and delivering prenatal care in a very effective way and believe it or not, there is a lot of lessons to run from some of these delivery systems and public health interventions from the way that some of the European countries do this, whether it is Denmark or France or the Netherlands and so on.

So, I think to your point is that to me, the debate about disparities has been too narrowly focused on just the insurance piece. That is an important part of it. There is no question that if you do not have insurance that you use less and you are seen later in the course of your disease. But, it goes at – to a broader set of issues in terms of the delivery

model and primary care and just some structural public health interventions that at least in this country, we have not done a very good job of delivering.

AYANA NUZUM: The only reason I asked that question is because Robert, when you talked about the work you are doing in North Carolina and the partnerships that you are developing, it seems to be as though the health care communities almost have to insist in some regard that business step up. You can have all the walking trails in the world, but if you have got high fat in hamburgers or in other food products, then it becomes almost like a moot issue. We are walking the track, but then we are going to get the food that we know is not necessarily healthy for us. So, that was the reason I wanted to ask that question, because I wanted it for you specifically, wanted to know were there business partnerships that you all are starting to become more vocal about developing that may make all your work worth it.

ROBERT GERCZYN: Well, to address the issue of the hamburgers. First of all, yes, it is a very interesting balance that you have to strike, having just taken all the fun stuff out of the vending machines, and made water 50 cents and diet sodas a dollar and we also have to make sure that – and we have also made the selections in our cafeteria better. And, we are talking to employer groups across the state about doing these things. One of the reasons we did it with our employees

is because we made the guinea pigs, and what we are trying to do is we are trying to create models that can be replicated by other employers, whether we have nurse practitioner clinics. We have on site day care. We — all the way down the line. But, if you get too crazy with it too quick, what happens is everybody stops eating at your cafeteria. Your cafeteria goes broke and they all go out for lunch, and that kills your productivity because they do not get back in time. So, that is why we are trying to learn about some of these things and then be able to go authoritatively to a major bank and say, "We did this in this way using this process and it worked," or, "Do not waste your time."

AYANA NUZUM: [Inaudible]

ED HOWARD, J.D.: She had a question about transplants that she would like — transplants and alternative medicine.

AYANA NUZUM: In terms of transplants, I attended a session over at the Kato Institute a couple of weeks ago around transplants and the costs of transplants and what that is going — the impact that is having now on not only cities but organizations like yours, how expensive it is. And, I just wanted to know how do we see that in terms of the — it is a chronic condition. I mean, kidney disease on the rise as a result of a lot of other things and how does that play out, or how do you see that happening in terms of not just kidney transplants but other transplants that are needed.

ROBERT GERCZYN: Yes. That is a – it is a big issue, and maybe I can answer it a little differently. One way is to say the more our kids are impacted by obesity and things like that, the longer they have the disease and the much more likely it seems to me that they are going to be the ones that are getting in line for the transplants later on. But, it is a very ticklish issue from the societal standpoint, because we are not ready to deal with hard questions around that. I will give you a great example. We fought like heck not to cover bone marrow transplantation for breast cancer years ago. Got the crap beat out of us in the news paper, ended up folding like a house of cards. Turns out today, no doctor in his right – in his or her right mind would go anywhere near that procedure, because it does not work. We knew that. The science did not support it. So, I mean, these are very ticklish social issues where being right is often not a very good place to be.

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health. I really like this panel, because when we are focusing on chronic conditions, it is clear that there are a lot of social determinants of health that Ken has put in the perspective of where all the costs are, and we also have a health care delivery system that is highly fragmented, all different silos and within the silos a doctor has a limited set of resources and responsibilities and the

patient of course, has a limited set of choices. So, we usually talk past each other and sort of blame somebody for the fact that as population, we are getting – having poorer health and our health care spending continues to increase. And, so then the policy issue is well, how do you create incentives that work within the fragmented system. And, what I am hearing from all of you, including the insurer representative here, is that maybe the structure, the fragmented structure needs to be transcended in order to really address the underlying causes of health problems and the way we are approaching them. That is music to my ears, because people with chronic conditions often have disabilities and disabilities are a protected group. And, we have a very strong civil rights tradition for protecting people with disabilities and the courts have even told us what non-discrimination means.

So, my question is those principles of non-discrimination, which are usually not institutionalized in the way the silos function. Is there a way of linking them to the health care delivery system as a system at the geographical level, instead of at the plan level or the provider level, which is how civil rights often gets addressed. Is it possible to start thinking about health care within a community, for example, or a state? You mentioned Vermont as a state that is trying to integrate its delivery system. It seems to me if we do that, we can bridge both the delivery system of health care

with the public health policies that do influence the social determinants of health, which incidentally are featured in a very good PBS series right now tonight at 10:30 on PBS here in Washington, D.C., the *Unnatural Causes* series.

ED HOWARD, J.D.: Okay. You want to take a crack at that David.

DAVID CUTLER: It is a great issue and I think it picks up on some of the themes in our discussion. I will just say, to my mind, many of the most interesting things that are going on in health care nowadays are at the local level. They are actually not just – they are not at the practice level. There are some interesting things at the insurer level, but there are a lot at the local level, ranging from provider payment changes in Northern California, to guidelines, setting guidelines in Minnesota, to measurement of individual physicians or groups of physicians in Wisconsin, to –

FEMALE SPEAKER: Can't hear you.

DAVID CUTLER: – to increasing use of generic drugs, to chronic disease management systems. And, so there is a lot of – there has been – there is a lot of interest in moving, but it is kind of – folks are doing it, but it is really pushing up hill, because you are battling against the financial incentives. You are battling against the public programs frequently, so you sort of see these kind of outstanding cases happen in Vermont and so on. But, it is very difficult and

probably – certainly, we have to make it much easier to do those sorts of things. There are also kind of minor issues like it is not clear if you are violating antitrust laws when you go ahead and do these things that have to be overcome.

ED HOWARD, J.D.: Ken?

KENNETH THORPE: Yes. To just add to that is that I – in order to do a lot of what we have been talking about, I think you need to start really talking about a different conceptual model of how to do this, and I really view this as an integrated model that starts with patients that are healthy, asymptomatic, all the way to people that are chronically ill and have established long-standing diseases and if you think about this as a continuum where you have got interventions across this whole spectrum. They range from primary prevention, secondary prevention, population-based initiatives in the community schools, work place, all the way through to the actually appropriate clinical treatment of established chronic disease. I mean, that is a different conceptual model. So, one place to start is that you got to have a model. And, I think our ability to sort of move to that model is in part, comes from the data that I started with. I mean, we are only going to get people's attention in the Medicare program purchasers if we can show the links between chronic disease, rising rates of chronic disease and what they pay in premiums. And, if they want to deal with the issue of affordability, they

got to pay attention to this. So, I think that that was step one in trying to draw that link, at least from the partnership that I had up, which again is a non-partisan group ranging from the unions to the employers to everybody in between, to draw that link to say this is a place where we can come together and really focus attention. What do we do? How do we approach this?

And, that is where you sort of got to build and give people an idea of what the conceptual model looks like which is as fully integrated population based to case management system and a completely, I think redesigned delivery model. We have got to do it. I do not think we have any choice, because again, if you look at the clinical characteristics of patients in the system today and the patients that we are going to be treating 10 years from now, they are very different than what the Medicare program in terms of payment philosophy was designed and structured to do. They bear no resemblance to in the 1950s and 60s for most part. It is a completely different clinical profile that we are years behind in putting in place an appropriate prevention, primary care, and case management delivery model that is really more attune, more effective in dealing with today's problems.

So, we just need the leadership. Vermont showed great leadership to do this at a state level. It is going to expand hopefully into a regional level. We are going to need

leadership from Medicare, and I think to David's point, leveraging this into the private sector, perhaps using the power that we have through the FEHB. But, we are going to have to have that type of sort of leadership on moving ahead, laying the model out, making the business case that this is important, and hopefully at the state level as well, through efforts like Bob's and other's, their Medicaid program has done some really exciting things with developing community care networks in that state. So, I think that the leadership has got to happen, but it is going to be both at the state and if we are going to do this nationally, we are going to have this run in part through the Medicare program as well.

ED HOWARD, J.D. Go ahead Bob.

ROBERT GERCZYN: And, I would agree with much of what Ken said. I will say that you can play with the processes and the models and all of that all you want to and if we continue to have a system that is flawed, that is delivery flawed quality of care, then we still have huge problem out there, and I think today we have that.

ED HOWARD, J.D.: As we go to the questioner in the back, let me just take this opportunity, we only have about 10 minutes left, to urge you to pull out those blue evaluation forms and fill them out as we have these last couple of questions. Yes?

MARY GILIBERTI: I am Mary Giliberti, and I am with the National Alliance on Mental Illness. And, you talked a lot about how we might incorporate this into national health care reform and I have looked recently at some of the state programs like Vermont, there is little pieces of it here and there, but having done policy work for a lot of years, I know that most people have the attention to look at two or three policy changes. Could you talk about in national health care reform, what are like to two or three top things that you would like to see in that to address chronic disease.

KENNETH THORPE: Yes. And, I think you are right. I mean, I think the problem is that we run into this definitional road block that when people talk about health care reform, they talk about health care financing reform, the politics of moving money around the system. Who pays, who does not pay, how we are going to cover people, and so on. And, obviously as a political movement, we have not resolved the politics of health care financing reform in 60 or 70 years. So, I think our notion is to flip it over as I started out the conversation this afternoon by focusing on A, affordability, so let us get to the pocket book issue, B, lay out the case empirically about where the money is spent and what is driving the growth in spending, and direct our political and our design and our medical and our economic attention to solving these problems. So, what I would like to see, whether it is at the state level,

and a lot of states are starting to look at this, in Vermont it is the Blueprint for Health, in Illinois it is the Roadmap for Health. West Virginia is going to be looking at these tops of chronic care delivery models as well.

Coming into 2009, no matter who wins, what I would like to see is basically three things, leadership and thinking through how we can transform the Medicare program to more effectively manage and prevent chronic disease. They own the chronic disease issue. That is where all the spending in the Medicare program is. Unless we do something on managing chronic disease in Medicare, we have very few options for controlling the growth in Medicare. We either have to increase co-pays, reduce payments, increase the age of eligibility, all those wonderful political things, where we are just shifting things around the system, but not solving anything in particular. So, I would like to see leadership in the Medicare program on looking at existing programs like Bob talked about and others around the country about what has had a demonstrated positive impact on outcomes and costs, and how can we take those essential elements and find ways, either regionally or statewide to start diffusing those into the traditional Medicare program, first point.

Second part I would like to see is that we are going to lead more leadership and more funding to actually do this health information technology initiative. Unless we provide

the basic infrastructure to allow physicians to more effectively manage their patients and have the information portals to do so, no wonder none of these disease management programs work. I mean we are doing with this with one hand tied behind our back. We do not have the essential tools in place to really effectively do it. So, I would like to see leadership there to say that look that we are really going to have by date certain all primary care physicians in this country have an electronic health record. That is what Vermont has done. Part of their legislature was to set out a goal that within two to three years, all physicians would have it. They have got General Electric building a state wide health information technology portal. And, they had the leadership and the vision to go ahead and do that. So, that is the second thing we need to do.

And, I think that the third thing we need to do is to figure out how we can actually look more broadly outside the Medicare program in terms of prevention primary care so that for patients coming into the Medicare program, they come in healthier. They come in without the disabilities, without the chronic disease. They come in closer to normal weight. I think what that means is that we look at prevention efforts for people 45 and 50 and try to find leadership there to think through about what kind of programs at the work site are effective. What do we know about work site health promotion

programs that are good? What are the key design features of those, and lets incent employers to put those in place. What do we know about community based interventions that seem to be effective? And, how can we take some of those good examples of community bases interventions and challenge our communities through incentive grants or others to replicate those in communities. And, let us go back to the schools. Why we have done the No Child Left Behind, and it has been an interesting and controversial set of legislation. Over the intervening years, we have created a massive health gap in our schools. The kids are bigger. They are coming out slower. They cost more money. And, it is not a productive work force coming into the latter part of the 21st century. So, I think we need to get serious again. We are looking at what goes on in the schools in terms of just activity level and it is not sort of the old days where I used to sit around and shoot baskets once every two to three minutes and wait for somebody else's turn to come up. I mean, there is new innovated exciting programs that are out there in some of the schools that are really engaging the kids in physical activity and engaging them in physical education about diet exercise and nutrition that they can bring home and work with their parents.

So, some of it is again, having the leadership, having the right model, and I think having the right focus to deal with these issues of the delivery system innovations, the

technology platform, and really do a more effective job on primary prevention in those three domains.

ED HOWARD, J.D.: David and then Bob.

DAVID CUTLER: Sorry. I have been involved in advising one the presidential candidates, Senator Obama. So, some of what I will say is specific about that, which is in putting together that health plan, there was a lot of attention given to this. And, if you read many of the proposals there is a lot of interest in it. The debate has not focused in this area yet. It has focused on other things. It is also the case that it is in a lot of what Senator Clinton talks about as well and somewhat interestingly actually, Senator McCain has a lot of discussion about these sorts of issues as well. So, rather than sort of think about the differences, which we are often prone to do, just one of the comments I want to make is that I think on this issue, on the issue of encouraging better – more prevention and better chronic disease management and a healthier lifestyle and all of that. I think there is actually quite a lot of consensus that something has to be done, that we have to do something really big. And, you see it across the political spectrum and that gives me some hope that even if the specifics are now different across the candidates and so on that at the appropriate time, there will be a way that people can come together and say, "Look, let us pull together a package of this that makes a lot of sense." Because, it is not

an issue on which there is enormous controversy about the need to do something.

ED HOWARD, J.D.: Bob?

ROBERT GERCZYN: I just want to address the children's issue primarily. But, first of all there is another difference. Not a single presidential candidate has asked me my opinion.

FEMALE SPEAKER: Yet.

ROBERT GERCZYN: Hillary is in North Carolina today. Maybe I should hurry back and sit by the phone. But, at any rate the – some of the things we have tried to do, first of all we have provided every day care facility in North Carolina with a curriculum set around physical activity and nutrition that was developed based on national standards and we have pushed very hard to get physical – at least physical activity, they do not – they refuse to call it education, back into the school system. There is a lot of people that think that because it took us 35 years to get into the shape that we are in that it may actually be a generational change to get us out of it. But, if we do not get focused on that generation – I am not suggesting we give up on the rest of us, but if we do not get focused on that generation, then we are going to lose that generation, too.

KENNETH THORPE: I was just going to –

ED HOWARD, J.D.: Go ahead Ken.

KENNETH THORPE: I had a quick accent to David's comments. I have been over the years fortunate enough to work with most of the remaining candidates in the raise on this issue and our Partnership more broadly working with Doug Holtek [misspelled?], who is McCain's economic advisor, former CBO Director, really an insightful, smart person himself on the issue as well. And, we got them all to in their health care plans to spend a lot time. And, I invite you to go look at Senator Obama's plans, Senator Clinton's plan, McCain's plan is less well-developed on this area, but the three things they have in common is that, particularly on the democratic side, there is an incredible amount of detail and focus about all these issues we have been talking about.

And, I knew we were making progress and traction sort of working with these candidates as part of the Partnership over the last year, when on the Stephanopoulos show about a month ago, I actually heard John McCain say two things, health reform and chronic disease. So, that is enormous progress. I think we go their attention on this. I think that David is right. The problem is is that you are running in a primary race. You do not spend a lot of time with me toos, and saying that we agree on this. In the democratic primary in particular, you are going to talk about coverage, pure and simple. And, they are going to highlight their differences on coverage, which obviously they have. On these issues, these

structural issues that we are talking about and this is why I am more optimistic coming into 2009, then I have been in a while, they all recognize, whether it is McCain, or Hillary, or Barack that we go to do something bi-partisan. We need a win. We got to have a different message, a different strategy. We need to deal with the cost problem, no matter how the financing issue resolves itself. We have got to deal with these structural issues. They agree in that and I think that that is sort of the exciting part of this debate that does not get, unfortunately picked up anywhere. That there is actually, on the real issues of health reform, a lot of consensus, I think moving forward.

ED HOWARD, J.D.: That would be a great note to end on. But, I have a plaintive cry for help from a congressional staffer before we go, and I wonder if, I guess it is addressed primarily to our two economists if you could offer some advice. Ken, just mentioned CBO, the Congressional Budget Office has historically not scored chronic care coordination legislation dynamically. So, we have difficulties in getting our bill costs scores to reflect the savings we think can be achieved. How would you recommend that we address this challenge? What kind of data? What kind of features do you think would be most helpful to CBO?

KENNETH THORPE: Let me take a first shot at this, because this has been an area that I have focused on for the

last couple of years. Some of this comes back – from a report that they did several years ago doing an evaluation of care management, disease management programs, really as they existed sort of in the mid-1990s and late 90s. And, to no one's surprise given the fact that the payment model is wrong, the delivery systems are wrong and there is no technology to do this, a lot of the stuff does not work. So, was not to me a big surprise. And, so the conclusion was well this stuff does not work. Again, I go back to the point I made earlier. I think that is the wrong take away.

In order to get CBO to look at this and this is my perspective. You can ask the CBO folks directly. They are an evidence based crowd. So, they want published data. They want to understand the machinations of how the programs have worked. They want to know cross studies that you look at, whether there are – if you can get randomized trials, great, but certainly well designed observational studies and case control studies. They want to look at the published data. They want to see the similarities across the published data in terms of interventions that work. They want to see the common threads and common elements to those approaches with respect to how they work.

So, my suggestion would be to take what we know about published programs or even in Bob's cased, the unpublished data, look at the common features. What is it about these

programs that work, that we have seen and have demonstrated empirical results from, one. Two, as you are writing legislation, you got to be specific. You just can not say disease management or care management. They will score that as zippo, because they do not know what that means. That means sort of sending somebody a flyer saying do not eat too much to some of these more structured approaches that we are talking about. So, I think you have got to link the legislative language, the key design features in the legislative language directly to evidence that it is big enough, it can not be a case date or too, but it has got to be a sufficient body of research and data, that they buy into the fact that says if you do A, B, and C, we believe these studies. They are solid and they are strong. And, they are – they have had a big enough breadth in terms of their impact that we think these can work, and they will probably take the studies results and discount them by 80-percent of whatever, but that is the starting point.

The problem is is that all too often, and I do not blame them at all for doing this, is that to get scorable savings in the CBO world, you really led to enforceable mechanisms, whether the regulatory camps or different types of enforcement procedures that generate and guaranty the savings as part of the legislative language. So, I think we need to do a better job of pulling together what works, why it works, what are the moving parts to it, work with the folks at CBO on these

to see whether or not they believe it and just start the dialogue with them on this issue in a much more structured way. Again, they are data driven using actual empirical observations on these studies and studies like – experiences like Bob's would be a terrific starting point to start that type of discussion.

ED HOWARD, J.D.: David, you want to add to that? Good answer.

DAVID CUTLER: I think Ken's right. I also think that because big programs have different effects than small programs, we will never know for sure the impact of what a big program would be by just looking at the little program. So, I think fundamentally, we are going to go into the debate about health reform next year, flying a little bit blind. That is, we will not have the data. Just in the sort of way of anecdote. I mentioned that I advised in the putting together of Senator Obama's health plan. In that we assumed zero savings from chronic disease management. But, obviously it has some costs. We went ahead with it anyways, because we see it as the right thing to do. And, that is the sense in which the previous question was – and the previous discussion was really right.

In the current environment, you can not do anything unless it saves money, whether or not it is the right thing to do. And, hopefully in a little bit of time, there will be an

environment where you can do things because it is the right thing to do, not just because you are absolutely certain you are going to spend less money. Although everyone hopes and believes and trusts that you will. But, if that is going to be the rationale, we are just never going to get – we are just never going to be there. And, so it has got to be a situation where we are convinced because the economics are right, because the medicine is right, because it is right for people that were willing to gamble and go ahead with it. And, I think there is a lot of kind of edging up to that and I think people are – my impression is that people are ready to go ahead and do that.

ED HOWARD, J.D.: And, that echoes some comments that Kate Baker made on this platform a few weeks ago. Kate being a member of the Council of Economic Advisors under President Bush, to the effect that the price tag is not always the most important thing compared to the value that you are creating in whatever changes you are advocating.

Well, this has been a terrific discussion. I want to thank, once again, Novartis and National Institute of Heath Care Management for their encouragement and support in this enterprise. I want to thank you for ignoring the cherry blossoms and the beautiful Spring day to sit through a tough discussion on a very complicated subject. And, I want to ask you to join me in thanking the panel for their incredible contribution.

[END RECORDING]