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A PLAN FOR COST CONTAINMENT FOR GROUP MEDICAL EXPENSE COVERAGES

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An interdisciplinary examination into various methods to control costs under Group Medical Expense coverages.

Discussion covers the roles of insurers, employers, health care providers, and the government - and the manner in which they interrelate.

MR. ALAN M. THALER: The need for cost containment has been with us for a long time. I have only to look at the geometric progression of the cost of medical care in the nation to comprehend that we have a system which will collapse of its own unless a plan for cost containment of Group Medical Expense coverage is developed without delay and implemented within the next few years.

In the discussion this morning, I have assigned to myself the role of the insurers. I shall make my remarks brief so that we can benefit from the advice of our panel who will deal with the aspects of this topic over which insurers have the least control.

The insurer's role has been a topic of intensive study and discussion in the Health Insurance Association this past year. Only recently, the Health Insurance Institute has published a booklet entitled "A Program to Contain the Cost and Assure the Quality of Health Care." A copy may be obtained by writing the Health Insurance Institute, 277 Park Avenue, New York.

The booklet addresses the topic by breaking the problem down into two categories: 1) action which can be undertaken without additional review; 2) action which requires additional legislation.

It is a good program. When you have read this pamphlet, you will see how clearly its implementation requires the involvement of health care providers, employers and government. The program in no way excuses insurers from an active role in the project. Its fulfillment requires a high level of energy, vision and commitment on the part of all concerned.

DR. JOSEPH M. RULE:* I personally question very greatly whether the national health care cost is out of control to the extent people perceive it to be. If you take the booklet which is published by the Social Security Administration each year on expenditures for health care in this nation and plot on semi-log paper total health care costs from 1940 forward, the points will lie on a straight line within the width of the dot you plot. The means that for 36 years the inertial growth in the health

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care system has been at a constant rate. The change in dollars appears to be out of control, but the percent changes are no different than they were through the 40's, 50's and 60's.

There is no question that the percent of the Gross National Product that is going to health care is increasing and taking money away from other areas, but I must question whether spending roughly 8.3% to 8.5% of the Gross National Product for the health of the nation is particularly out of balance.

So you have to ask yourself, what are your priorities, what are your goals and what is it you are trying to accomplish? People have problems when what they observe is different from what they expect to see. In many cases the correct solution to a problem is to change the expectation, not the performance.

The other aspect of the problem is: Who's cost are we trying to control? Are we trying to control the national costs, the insurance industry costs, the employers' costs, or the employees' costs?

I will present to you some very sobering facts from testimony I gave to the House Ways and Means Committee about two years ago. DuPont first made medical insurance available to its employees in 1951 on a 100% payroll deduction plan. Through the ensuing ten years, the Company increased the scope of benefits. The Company now pays 100% of all family hospital and diagnostic costs, and about 80% of the surgical physician's fees. The Company also offers, at the employee's expense, a program for primary care in drugs and appliances up to $100 per employee or $200 per family, while the Company pays 80% of costs over that. The net cost of that program to the DuPont Company today is over $100-million. In addition, the Company has a very elaborate in-house medical program which was primarily designed to make certain that we were not damaging employee health in the work environment.

During the evolution of this medical insurance program we have not been able to measure any change in days off due to sickness. Our current rate is within 2/10ths of 1% of where it was in 1950. We cannot document in any way, shape, or form that our employee health has gone up with the expenditure of the $100-million. The medical insurance program, although believed to be beneficial, must be looked upon as an operating expense of the corporation which returns no measurable benefit to the employer, except to be competitive in the labor market in the hiring and maintaining of a work force. The major benefits of a company-paid medical insurance program are enjoyed by the employees and providers of health care. The employees have one of their family needs paid for with tax-free dollars, while health care providers have the credit risk removed from major medical bills.

I am not aware of anyone who has shown that change in obesity and hypertension particularly late in life, causes a dramatic effect on the final outcome. People who have not been obese during most of their histories have substantially less expectation for a coronary than people who have been highly obese most of their lives, but I am not aware that a person who has been obese for 30 years, who reduces at age 45, substantially shifts his medical risk.

However, the corporation has the wherewithal, if it elects to do it, to substantially impact its Blue Cross/Blue Shield premiums through corporate medical programs. But to do it, the corporate world must perceive itself differently than it has. Corporations historically have taken the position that medical insurance is a benefit just like vacations and pension plans. There are some things they will administer, but there are also things in which they do not want to get very seriously involved.

I hear the corporate world shouting very loudly about their concern for medical insurance costs and yet, when I watch their behavior and their willingness to come to grips with the issue, very few corporations are prepared to get involved. In the last five years there has been some corporate intervention in Health Maintenance Organization formation and at least a few have elected to operate their own Health Maintenance Organizations, but I am not positive whether the motivation of that move has been cost containment or whether it has been to make certain that a quality medical program is available to employees in the specific geographic areas in which the corporation elects to operate. The DuPont Company has been able to train its employees to work safely for over three-million work hours for every lost time accident by insisting that all people attend monthly safety meetings and develop an attitude and a behavior which says, "We will not put up with unsafe actions, knowingly, on a DuPont location". That issue really is not open to much debate.

You either put on your hard hat, you put on your safety glasses, you put on your steel toe shoes, or you do not work for the DuPont Company at this location. We will not allow an employee knowingly to endanger the health of his coworkers in that work environment. There is a very strict, formal program to make sure that the work environment is not known to have hazards in it. As a result of that program, we find that our employees off the job have less than half the number of expected accidents - the effect of this program does carry over into home life and off-the-job activities.

To make this program work, corporate management must take a strong posture in it. When I was a young manager, I was in one of our General Manager's offices one day when the Chairman of the Board called up and said these words, "Mr. ________, I consider bad safety performance the same as bad management," and hung up. Now that department for about six months had been at the bottom of the monthly report on accidents. Thirty days later they were up in the middle of the pack. Within ten minutes of hearing those words, the General Manager had his Division Managers for manufacturing, research and sales in his office, and within 24 hours there was an intense, formal safety program underway in that department. It is possible to impact people's behavior, but you have to get their attention, and you have to let it be known that management is concerned.

On the other hand, there have probably been millions of dollars wasted on health education, on the assumption that the reason people do not do what you want them to do is lack of information. As a trained marketing man, I disagree with that. What you have to do is make health care relevant to people, and then you have to get the proper information to them. The way you make it relevant is through your corporate annual physical program.

There exist excellent statistical data on what people die of, and what the disease patterns are at different age brackets. If you are communicating with a group of 18- or 19-year olds, I do not think there is much use in talking to them about coronaries and strokes, because that is not their problem. Similarly, if you are talking to a young family man in the 20- to 30-year age bracket, there is not any sense in trying to talk to him the same way you do a retiree at age 65 or 70.

An extensive study performed at the Methodist Hospital in Indianapolis, Indiana, has tabulated the major causes of death, by age bracket, for both males and females. Of white male deaths, at high school ages, 43% are automobile accidents, 6% suicides, 4.7% drownings, and 3.5% homicides. These people really are not very receptive to most of the health education material which is published. They do not perceive that they are going to get cancer, they do not perceive that they are going to die of a coronary, stroke, and so on. At age 40-44, heart disease accounts for 34% of the white male deaths, motor vehicles 5%, suicides 4.7%, sclerosis of the liver 4%, vascular lesions affecting the central nervous system 4%.

These statistics can be made relevant to different population groups to get their attention. There is nothing more relevant to a man than saying, at the time of his annual physical, "Look, you are 40% overweight, you are hypertensive, you are pre-diabetic, and you have a life expectancy of 5.3 years. Now are you willing to do something about it?" I think at that point you can get his attention.

Population groups have been followed in California for over a decade to examine what happened to them compared to diagnostic tests performed at the beginning of the study. Data was analyzed according to normal health practices: do you eat breakfast, do you smoke, how much do you drink, what level of physical activity do you have each week, do you snack between meals at an extensive rate, do you sleep eight hours? Some very dramatic results emerged from this study. A white male who is 45 years old who followed three or less of these good health practices, has a life expectancy of 21.6 years. If he follows four or five, he gains seven years of expectancy. If he follows six or seven, he gains 12 years of expectancy. Data on women do not show as dramatic a shift in life expectancy, but there is still a high correlation.

However, merely because there is correlation, there may be no cause and effect. I happen to believe, in this case, that there is a cause and effect relationship.

There is one other key piece of information. Contrary to popular belief, the higher you are in the corporate structure, the better your health. We observe that our production line people have roughly twice the number of work days off due to sickness as the salaried technical staff. The higher the salary level, the less hospital days per population group we observe.

In conclusion, the technology is in hand, the wherewithal is in hand, and the management systems are in hand, but I am not sure that the perception of the corporate role in the health of its employees is in hand to deal with the problem.

MR. DAVID M. KINZER: Massachusetts is No. 2 in this country in terms of physician-population ratio, and No. 1 in the country with respect to nurses. There are enough hospitals - a lot of people are now saying, more than enough - and 4.5 beds per thousand inhabitants. Massachusetts has gone further than any state I know in developing less expensive alternatives to hospitalization. There are, for example, 60 Neighborhood Health Centers that were built to meet the needs of poor people around the City of Boston, and elsewhere - to keep them out of hospitals by maintaining preventive care. There are 170 Home Health Agencies, 900 Human Service Providers (agencies that are in the twilight zone between the social and medical services - halfway houses, alcoholism detoxification centers and the like). We have done better than any place I know in getting the specialists out of the city and into the country. All across the State of Massachusetts, behind every hill, is a hospital with a specialist-dominated staff.

We have done remarkably well as a hospital system in responding to the pressure which has come from government, the insurance industry, and everybody else to stress the out-patient alternative vs. the in-patient. Our hospitals are handling 9.5 out-patient visits for each in-patient admission compared to a national average of about 6.7 to 1. As a result of this, we have contained the admissions to hospitals and leveled them.

And out of all of this, we have had a cost crisis.

We have a tradition of generosity. Not only have Medicaid and Medicare been generous in their benefits, but so also have Blue Cross and Blue Shield insurance. You really cannot compete in the insurance business here without being comprehensive and this has been aided and abetted by our legislature which, as an example, passed a law two years ago mandating that every insurance policy sold has to cover psychiatry - in-patient and out-patient.

Coincidentally, we have more controls than anybody else. We invented rate controls. We have had utilization control on a statewide basis since 1973. We were one of the pioneer states in the area of facilities control, and we have, of course, the planning control certificate of need.

In this environment, up until just a year ago, our costs have gone up on a curve steeper than any state in the rest of the country.

Part of the problem of cost is abundance of availability of services. Another part of the problem is abundance of generosity of benefits.

The field is just beginning to realize, after 25 years of talking about the doctor shortage, that suddenly we might have too many of them. Now there is talk of how we can keep doctors from staying in Massachusetts after 25 years of trying to keep them here. In Washington, there is still a tremendous surge to "relieve the shortage of physicians." Our medical schools are beefing up their enrollments and turning out more and more physicians. We are still turning out more nurses each year than the year before. We are still providing more new services each year.

In this environment, where the country's appetite for medical care is being whetted continuously by the promise of National Health Insurance, the problem of cost control, and this is an understatement, becomes quite difficult.

The Massachusetts Hospital Association has the most extensive and elaborate program of shared services of any state in the country. I have 30 industrial engineers working for me who go out into the hospitals and study their laundries, their kitchens, their nursing services, their power plants and report to the Board and the Administrator how the hospital can become more efficient. We have joint purchasing extensively developed. We have a shared computer system. It is much cheaper for a hospital to share our centralized computer than to buy their own and try to staff it.

This activity is saving money, but what happens to these savings? Let me relate a conversation I had just recently with the Director of one of our teaching hospitals. He came up to me and said, "Dave, I want you to know that I think your industrial engineers are terrific. Their reports saved me $100,000 last year." In the next breath, he said, "I have on my table $400,000 worth of requests from my medical staff for new services, new equipment and new initiatives and these savings will make it possible to do more for them." He said further that all of these services are not only desirable and justified, but the public is demanding them.

There is not much we can do institution by institution to squeeze out much more money and have it show in the premiums that employers pay for their health insurance. The counterbalancing force is so overwhelming that the costs still go up and we still have a crisis. Our main gains in the future must be achieved by systems efficiencies, consolidating the number of hospitals and beds and specialized services in a given service area. Unfortunately, there are four things that go against this trend: the doctors, the Board of the hospital, the Administrator and the public.

Some small towns are so ferociously competitive that they simply will not hear of even sharing an ambulance between the two towns. In Boston, we have competition between three large medical schools and their teaching hospitals. Each medical school has to offer all the things the other medical schools offer.

The definition of "comprehensive" broadens each year. President Carter and Senator Kennedy are not talking about cutting benefits, they are both talking about more benefits. To broaden continually the benefit pattern and then, in the next breath, talk about controlling costs is absurd. A year ago, Ford Motor Company decided to ask their union employees to accept co-payments and a deductible. They went on strike. The final agreement was for even more comprehensive benefits than what they had before. The United Mine Workers attempted co-payments as a cost saving device and they had wildcat strikes all over Appalachia. The Senate, a couple of months ago, voted overwhelmingly that pregnancy was not only a health benefit but a disability, and required employers to cover this. If we are really going to have cost control, we have to pull out what the people can budget for, and keep in what is catastrophic. But, the public is not ready to accept reduced benefits.

The country cannot expect hospitals, by controls put on at the point where services are provided, to control demand. This is what President Carter wants to do with his 9% cap. He is saying that we are going to give you so many dollars and then we are going to control your costs. He is talking about controlling government costs. He is not talking about controlling hospital costs. There are serious limits to the long range impact of this. Government can squeeze hospitals, and when they squeeze too hard the hospitals cannot afford to pay physicians to provide this or that service fulltime. The physicians then go into private practice and move out of the hospital. This is happening in Radiology now, because the radiologists are getting nervous that too many bureaucrats are looking at their income. The radiologists are changing to a fee-for-service reimbursement. They are going into business for themselves and making money at it. The service moves out of the hospital but overall costs go up.

One of the fallacies of President Carter's bill is that it addresses just hospitals. It might work for a little while and save a little money, but something has to be done to control demand. The main thing we must have learned from Medicare is that when you tell all the people in America over age 65 that they can have their hips replaced if they have an arthritic situation and they cannot walk very well, it is surprising how many of them get their hips replaced. In a place like this where we have outstanding surgeous, who should be surprised that we have a demand for open heart surgery that exceeds the supply? In order to get at this problem, somebody is going to have to make some tough decisions about the relative payoff of services like this for older people. I happen to believe that we need to give a higher priority to our young people in providing adequate health maintenance services, but the money is being eaten up by pacemakers, etc., for the older population. The payoff on heart surgery for somebody over 65 is perhaps a few more years of life, and these operations cost $10,000 to $20,000.

This is the area where decisions have to be made by employers as well as by government. You cannot expect us, the hospitals and the physicians, to make them all. The good hospitals of Boston are deciding, for example, how much open heart surgery they are going to do each year, and saying to the people who come in last, "We cannot do anymore this year". A hospital like Massachusetts General, for example, would go broke if it did all the open heart procedures that it is capable of doing and that the public wants.

The demand issue is very important, somebody has to bite the bullet, and I have not seen it yet.

MR. THALER: I live in Flagstaff, Arizona, which is at the border of the Navajo nation. The Indians in that reservation are practicing medicine through their medicine men still in a very effective way. A spiritually inspired way, I might add. Maybe we have to think about behavioral changes in a serious manner here.

We have an energy crisis. People were not concerned about it until they had to start queuing up in their automobiles and then they were terribly concerned. We do observe a little change in behavior. Now we do have smaller cars. Maybe it is possible over time to affect behavior, but quick dramatic changes are hard to achieve.

MR. WILLIAM C. L. HSIAO: I would like to share just a few thoughts with you on what I perceive as the concerns in Washington today. Frequently, Washington seems to be a faceless monster who implements legislation in a mindless way. I am sure there is some truth to that, but also the government uses these programs as an instrument for social change, which interferes directly with the prevailing business practices.

While it does appear so, Washington is not an entity unto itself. Rather, it is a place where the conflicting interest of all groups are brought together and fought through the political process. It is a place where the interests of many groups are synthesized. When it comes to health care, these groups include the employers, employees, other consumers, hospitals, doctors, Blue Cross / Blue Shield and commercial insurance companies, cities and states. In the end, when these conflicts are resolved, they seldom completely satisfy any one particular group. Therefore, these policies can seem to be irrational when they are viewed from just one perspective. Equally threatening is that the government programs are likely to require some change in the way in which business is conducted.

Health insurance is a public concern today. How Washington deals with this concern will affect private health insurance. However, the insurance industry can influence Washington's actions by its attitude and the actions it takes to mitigate the public concerns. There are two reasons for the importance of insurance in health care. First, the availability of health insurance affects people's ability to obtain health services. Second, health insurance enlarges the share of our society's total resources which are being spent on health care. Consequently, changes in the organization and the design of health insurance could increase or decrease the pressure for National Health Insurance.

The Federal Government has three major concerns which are directly related to health insurance. First of all, the government wants to ensure that all Americans have adequate financial access to medical care. Second, it wants to reduce or eliminate the financial hardship of large medical bills. And third, it wants to limit the rise in health care cost.

Good health is a prerequisite in the pursuit of happiness and liberty. People increasingly believe that the United States is wealthy enough to assure that everyone has access to good quality medical care as a basic right, thus ensuring that everyone has an equal opportunity to fully participate as a citizen.

Most Americans today have some form of health insurance. Most persons in the middle and upper middle classes have adequate health insurance coverage. The Medicare and Medicaid programs have helped many poor people obtain adequate medical services. However, there remains a large gap among the low income people who are not eligible for Medicaid and continue not being covered by health insurance; or, their coverage is very inadequate. No one knows for sure how many people fall into this gap, but reasonable guesses range from 20- to 50-million persons who do not have adequate basic coverage for medical expenses. Those who have been excluded from Medicaid and private plans are lagging well behind the others in their use of medical services. One probable effect is diminished health, reduced productivity, and needless suffering.

With the rapid rise in medical care costs, the ability to afford adequate medical care is no longer a problem only for the poor. Public programs and private health insurance have provided financial protection for many, yet some Americans continually face the difficulty of meeting the high cost of catastrophic illness. For families with large medical bills, private insurance fails to provide major medical coverage to a large segment of the population. The estimates vary from different sources, but the reasonable guesses range from 50- to 80-million people that still do not have insurance coverage for major medical bills. In a day when the average cost of health care for terminal cancer exceeds $20,000, even those with some insurance can face bankruptcy when they suffer from a major illness.

The growth of private insurance and the implementation of Medicare and Medicaid have heightened awareness of insurance - whether public or private - and is partially responsible for the rise in medical costs. Historically, insurance policies have emphasized complete coverage for short hospital stays. Therefore, patients may prefer to be hospitalized even when out-patient or Nursing Home care is cheaper. Furthermore, insurance reduces the amount that the patient has to pay directly out of his pocket. Therefore, it reduces the patient's concern about the cost of medical services. This weakens the market discipline, and consequently, the provider of services can use very sophisticated equipment, order many more lab tests, perform questionable surgery, all of which may have very little additional benefit to the patient, yet leads to ever rising higher costs.

The first problem, incomplete coverage, can be remedied by universal coverage. This is relatively easy to accomplish. There are a number of options. On one end of the spectrum the government can provide the financial means to the poor people who cannot afford it to enhance their ability to buy health insurance. On the other extreme the government might insure everyone through a government program. The critical issue here is how should the risk be pooled, whether it should be pooled on a regional or nationwide basis.

The second problem, coverage of major medical expenses, is again relatively easy to resolve. The government can mandate these coverages through private health insurance. On the other extreme the government can provide directly the major medical coverages through a social insurance scheme.

The thorniest problem of the three is how to control the rise in medical cost. The proposed solutions can be classified into two broad groups: centralized control, and decentralized market discipline. The debate is still raging on the optimal solution. But there is more heat than light. Most suggested remedies have not been tried long enough nor carried out on a wide enough scope to demonstrate whether or not they are effective. These remedies include certificate of need legislation, prospective budgeting for hospitals, rate setting, fee schedules for doctors, Professional Standards Review Organizations, and competition promoted through the establishment of Health Maintenance Organizations. All of them are logical and rational, yet they seldom take into account the political environment in which we operate. Also they tend to ignore the likely responses by the institutions and doctors to these measures.

A good illustration is a recent development in Massachusetts. When the certificate of need process began to impinge on the desire of certain hospitals to expand, these institutions were able to lobby very effectively in the state legislature to make exceptions to controls by certificate of need. Since hospitals in Massachusetts are dominated by teaching hospitals, this group was able to push through legislation to exempt research facilities from the certificate of need law. I believe there is a justifiable question as to how effective the certificate of need law can be in our political environment. Every community takes tremendous pride in its availability of beds right in their community. There can be beds and CAT scanner equipment available in the next town, but that is not the same as having them as part of your own community resources. Hence these desires are translated into political pressures. Legislators can easily override the decisions made by the certificate of need process. Free spending can only be curbed if the same government entity has to pay the bill later, but now private insurance and the Federal Government are paying the largest share of the medical bills.

Another example is the experience from prospective budgeting adopted by states to control rising hospital costs. The State of Connecticut has had prospective budgeting for voluntary, acute care hospitals for the past three years. Through this process, Connecticut limits the increase in hospital charges to 8% - 10%. However, the total revenue to the hospitals continue to increase at the national trend level. In fiscal year 1975, the patient revenue increased by 15.8%. The charges are held down by the prospective budgeting method, but the hospitals made it up by increasing special services such as x-rays, lab tests and drugs. The annual report by the Connecticut Commission on Hospitals and Health Care concluded at the beginning of 1977 that its prospective budgeting system has not reduced the total hospital cost in the State.

The point is clear. Before we embrace any cost containment program as the savior of rising costs, we need to conduct a critical evaluation of these schemes. This responsibility is particularly relevant to actuaries because our motto is, in part, 'Substitute Facts for Appearances'.

A broad approach which is gaining some momentum is to restore market discipline by passing more of the risk back to consumers and providers. The financial risks can be passed back to consumers by redesigning the benefits. This can be done by reintroducing cost sharing provisions - larger deductibles and coinsurance. Consumers would become more price conscious because they would have to pay more out of their own pockets. Some individuals may shop around for the lowest price service with good quality. This would increase market discipline and may restore some competition. This idea has some logic, but it would only work if hospitals are competing with each other, and doctors are also competing with each other. Also, it is not clear that consumers are willing to accept this.

Another idea is restoration of competition by pooling risk differently. For example, instead of pooling risk only by age and sex, the premium would be based also on geographic location. Employers or the government would only pay a premium based on the national average. If people want to live in or want to obtain health services from a high cost area, then they must pay the extra cost out of their pocket. This idea has not been tried on a wide scope.

The people and the government must decide whether it is more effective to contain health care cost by centralized regulation or by decentralized market discipline. The decentralized approach requires new and innovative methods in designing benefits and pooling risk. This is the challenge facing the insurance industry.

DR. RULE: People do not want to buy low cost, low quality medical care when you are dealing with their personal health. Through the years the connotation of high cost has been high quality and this is a very difficult problem. I have tried to champion in the corporation and in the national forum well-managed indemnity policies. They provide the wherewithal to communicate to the employee what he should expect. When you are dealing with a usual and customary benefit, you are inviting exploitation of the system.

MR. BRUCE W. BUTLER: Would Mr. Kinzer please comment on the long-run and short-run advantages of the Massachusetts cost control legislation.

MR. KINZER: Massachusetts passed a bill a year ago which is still in the course of implementation. Right now the basis for judging what is a legitimate cost and what is not by department does not exist. We are working on the development of the parameters. We have only a price control mechanism now which prevents hospitals from going beyond a certain point above their costs on their charge schedule. Over the last year this has had a deterrent effect. Our data indicates that our expenditure increase has been 10% in Massachusetts compared to 15% nationally. The main explanation is that over the last year our hospitals have done a pretty good job of holding the line on labor costs. In fact, we did such a good job that we dropped a little below, not only the state pattern of increases, but the national.

In order to make President Carter's bill palatable to labor, the administration wrote in a pass-through for non-supervisory employees. From our perspective, this will destroy or nearly destroy any cost control impact that such legislation will have.

MR. ROY R. ANDERSON: Mr. Kinzer's observations should lead to a recognition that there can be no meaningful plan for cost containment so long as the patient is amply covered by insurance.

This is a fatal flaw in the present system of medical care insurance - both private and government. Efforts to construct controls on the environment in which the physician is making his own decisions cannot correct that flaw. Artificial limits on hospital incomes will not work. Nor will any other scheme that evades the critical problem: physicians are practicing high technology medical care under ground rules over which they have almost complete control.

MR. ALAN N. FERGUSON: One of the things we can all do is get more involved in Health Service Agencies. There are 200 of them around the country - the Health Insurance Association recently sent around a questionnaire to people in the industry who are involved in them, about 250 people. Now each agency has upwards to 100 people involved, so there are 20,000 people that are involved in one way or another in Health Service

Agencies. Two-hundred and fifty people from the industry is about 1% of the total number of people involved - and really that is pathetic.

It is unfortunate that we are classified as providers rather than consumers, because there certainly needs to be a better balance on the consumer side. The consumers are generally unsophisticated and unable to deal with the hospitals and the doctors' requests for sophisticated equipment. But, we are knowledgeable, sophisticated, have fiscal responsibility and it is a pity that only relatively few people in our business are involved in these things.