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Summary: Health care, managed care, and Medicare in particular remain in the political spotlight. Managed care, once almost universally seen as the answer to the nation's health-care woes, is now being viewed, at least by some, in a very different light. What opportunities does this provide to different political forces this election year? What longer term, perhaps more basic, health-care issues may become political fodder in the future?

The panel presents the status of recent legislative proposals and current election debates, and then focuses more attention on the potential longer-term directions for the health-care system.

Mr. James J. Murphy: I currently serve as the vice-president for health at the AAA. I work as vice president and manager of Merrill Lynch/Howard Johnson's H&W Actuarial Services. Dwight Bartlett is going to give us an update on Washington health-care issues. Dwight is Senior Health Fellow at the AAA. His career includes recent service as the Maryland Insurance Commissioner. He's been the chief actuary of the Social Security Administration and successful in consulting, as well as an insurance executive. Dwight's a Past-President of the SOA, and he received the Academy's R.J. Myers Public Service Award in 1998.

After Dwight gives us a quick look at the current issues in Washington D.C., Gerry Smedinghoff is going to take a critical look at the overall health-care system. "Should the U.S. employers get out of health care?" is the title of his address. Gerry has been a frequent speaker on technology and health-care issues. He has appeared on PBS television, had articles published in the *Washington Post* and *Contingencies*. Prior to joining Universal CIO, as director of marketing, he was a consulting actuary for Watson Wyatt Worldwide. His current health-care activities

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are volunteer efforts working through the Cato Institute and the National Center for Policy Analysis, both in Washington, D.C.

After Gerry tears down the current system and Dwight has said what the politicians are thinking, Terry Ward's going to give us an idea of what might be done about all this. Terry is president and CEO of the Ward Group. He has a varied and eclectic career in sales, marketing, business, and real-estate development. His background includes once being a top-40 disc jockey, working with the Houston Astros baseball team, and now he's becoming an expert in health-care delivery.

Mr. Dwight K. Bartlett III: My part of this program is intended to be rather brief. I'm going to have to rattle through a fair amount of material quite quickly. First, I want to just go through a laundry list of what has been talked about primarily by the Clinton Administration, the Bush campaign, and in Congress. We haven't heard a whole lot recently by the presidential candidates about general Medicare reform, although they do have positions on general Medicare reform.

The Bush plan basically is what was proposed by the co-chairs of the Medicare Reform Commission that was appointed several years ago and met until about a year ago and then disbanded without being able to get a sufficient number of votes to make a specific proposal. But a plan was developed by the co-chairs, Congressman William Thomas (R-CA) and Senator John Breaux, (D-LA). That plan basically relies on competition in the private sector. It would, in effect, expand the Medicare+Choice plan. It had enrolled many more Medicare people in those kinds of HMOs, Medicare HMOs, and so on, and the plan would be essentially a defined-contribution plan, although I know that Senator Breaux and Congressman Thomas feel that's an inappropriate appellation, but that's a fair description of the plan.

The Gore proposal is simply to rely more heavily on general revenues to finance the existing program. He proposes putting something like $75 billion of additional general revenues into the Medicare program over the next 10 years, and, of course, we can argue what the economic implications of doing that are. Are those $75 billion real money or are they just IOUs from the government? But those are the basic elements of the two presidential candidates' proposals that aren't getting a lot of conversation right now.

The next item is patient's protection. The House and Senate in 1999 passed separate bills providing a laundry list of types of patient's protection for people enrolled in HMO plans. A conference committee was appointed to try to reconcile the two bills. That conference committee has met on and off for a year, and, of course, Congress is coming near to the end of its time. It's clear that nothing is going to pass in 2000 in patient's protection. The two bills differed in two important areas that make the two bills essentially irreconcilable.

The House bill would have the patient's protection reforms apply to all plans, insured and self-insured, and also would have greatly expanded the right of plan participants to sue the plan for denial of coverage. The Senate bill would have restricted the application of the provisions of the bill to self-insured plans so that insured plans that are regulated by state government would not be affected. It had

nothing in it that would expand the right of participants to sue the plan. Those have been the two big sticking points over the last year. I assume that this will be revisited with the new Congress after January 1, 2001, and I suspect those will remain a couple of important sticking points.

Long-Term Care (LTC) insurance premium deductibility. It's intriguing to me that five years ago or so when people talked about the future of the Medicare program, all anybody could talk about was the fact that the baby-boom generation is aging and that there's going to be an enormous expansion demand for LTC services and so on, and all of the sudden that's disappeared off the radar screen. It's been replaced by conversation about prescription-drug coverage and patient's protection, but there have been proposals. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided that if you purchase a qualified LTC policy that the premium that you pay for it could be included in your medical expenses and deductible as a medical expense. But you probably recall that if you list your deductions, you don't get the deduction of your medical expenses until they exceed 7.5% of your adjusted gross income. Well, very few people have medical expenses that exceed 7.5% of their adjusted gross income. Therefore, practically nobody has been able to deduct their LTC premiums. The proposal is to remove the LTC insurance premiums for qualified policies from that 7.5% test so that one could immediately deduct his or her LTC premiums without having to go through that 7.5%. I think that probably stands a pretty good chance of passing in the new Congress.

What are we going to do about the uninsured in this country? We've got 44 million, allegedly. I think that figure is somewhat controversial, and that there may be an equivalent number of people who are underinsured. They have some kind of health insurance but totally inadequate to really meet their needs. We might be talking about 80-90 million who have inadequate health insurance. It is a big problem. The item that received the most conversation in Congress and by the presidential candidates is a refundable tax credit in tax returns to help people pay for their health insurance premiums.

Bush has proposed $1,000 a year for individuals and $2,000 for families. Refundable means that if credit exceeds your tax liability, the government will write you a check instead of you deducting it from your tax liability. Gore has also proposed a refundable tax credit of 25% of health insurance premiums, and, again, I think that one is going to be revisited when the new Congress comes into session in 2001.

The fifth item is increased reimbursement to providers. You've been reading a lot about how Medicare HMOs and the Medicare+Choice program have been bailing out. In Maryland, for example, in1999 we had, I believe, four Medicare+Choice HMO plans that the citizens of Maryland could elect. Three have dropped out, and one has remained for their existing participants but has petitioned the government for the right to decline any new entrants. They've also tripled the premium that participants have to pay. So they all argue that they're getting inadequate

reimbursement from the government to break even on their coverage for Medicare enrollees in their HMOs.

Also, providers and particularly hospitals, are claiming that the reimbursement they get from the government, the Medicare program, is totally inadequate to meet the cost of providing care to Medicare plan participants and that many hospitals are financially strained. I believe the HIPAA put limits on the level of increase in reimbursement to health-care providers, and it turned out that those limits have cut Medicare cost more substantially than was originally predicted. There is a proposal to substantially increase the level of reimbursement and restore to a major extent the cuts that were made by HIPAA. I think this proposal has a fair chance of passing before Congress adjourns.

The last item, drug-benefit coverage, got most of the conversation. Table 1 gives some of the details of the Administration and Republican plans. Both candidates are saying that they're anxious to provide prescription-drug coverage, that everybody recognizes that prescription drug costs are a much more important part of the total medical-care costs of the elderly than they were 10-20 years ago. There seems to be a consensus, politically speaking, that we need to provide prescription-drug coverage of a sort.

TABLE 1
Drug Benefit Proposals for Elderly/Disabled

	Administration Plan	Republican Plan
Basic Approach	Add PDB to Medicare on voluntary basis	Private insurers and Medicare offer competing Plans
Administration	PBM's selected by gov't, one per region	Insurers
Use of Formularies	Yes, covering all "medically necessary" drugs	Yes, on actuarially Equivalent basis
Deductible	$0	$250
Co-payment	50%	50%
Max. Benefits	$1250/$2500	$2100
Catastrophic	Over $4000 out of pocket	Over $600 out of pocket
Low Income Subsidies	Phased for those below 150% of poverty	Same
Premium	$26 month/$52 month	$35-40 month
Premium Subsidies	50%	30%
Estimated Cost	$40-80B/5 years	$40B/5 years
Immediate Remedies	None prior to 2002	Block grants to states

Again, like the general Medicare reform proposals, the Bush proposal would rely to a much greater extent on the use of private insurers to provide the prescription-drug coverage and that people would have an opportunity to enroll in a variety of plans, assuming plans were willing to offer the coverage. The Health Insurance Association of America, for one, has said that it doesn't think that many of its

members are going to be willing to offer the coverage because of the antiselection effects that they would anticipate in this. Both the administration plan, by the way, and the Bush plan would be voluntary plans.

In other words, somewhere between 60-70% of people over age 65 in the U.S. have drug coverage of one sort or another. I have drug coverage as a retired employee of a company I worked for in the 1980s, and many Americans have coverage that way. Many have bought the Medicare Supplement or Medigap plans that provide drug coverage, and, of course, if you're enrolled in Medicaid, the state programs for the poor or the near poor, you get prescription drug coverage under the Medicaid program. Sixty to 70% of the elderly do have prescription-drug coverage of some sort. That is why both the administration and Republican proposals are voluntary.

What would happen if the proposals were passed? Would employers drop their prescription-drug coverage for their retired employees? The administration plan, for example, proposes a subsidy to employer prescription-drug coverage to encourage employers to keep their prescription-drug coverage in place and not to drop it. Both proposals provide more generous coverage for the poor and near poor and subsidies for the premium cost of the prescription drug coverage. Clearly, this is something that's not going to get passed in 2000, but this is obviously going to be revisited in a major way when the new Congress comes back into session.

Mr. Gerard G. Smedinghoff: What I'm going to do is explain why trying to provide health care while ignoring or violating the laws of economics is like trying to run an airline while ignoring or violating the laws of gravity. The three words you need to remember from my talk are information, risk, and choice. They represent the three economic disciplines of information theory, game theory, and public choice theory. They explain why the rest of the economy is booming while the health-care industry is failing.

The causes of our health-care crisis are the same as the causes of our energy crisis back in the 1970s: government regulation and price fixing. The main problems on the federal side are the Internal Revenue Code (IRC), specifically the Section 105 exemption for employer-sponsored health care, ERISA, and the HMO Act of 1973. On the state side, the biggest offenders are rate regulation, price fixing, underwriting restrictions, and benefit mandates.

What separates health care from the rest of our economy? First of all, you'll notice that health-care prices are increasing. Over the last 50 years health care has exceeded the overall CPI by over 120%, while the rest of our economy is benefiting from what is known as Moore's Law, which says that the cost of digital technology decreases by 50% every 18 months.

Quantity and quality in health care have been decreasing. Take a simple standard measure like a length of stay. Twenty-five years ago, when a woman gave birth in a hospital, the average length of stay was five days. Today the average length of stay is down to two days, and there are some people who would like to push it down to one. Now, it might make sense if health care was getting more expensive

because lengths of stays were increasing. But it's just the opposite; we're paying a lot more, and we're getting a lot less.

Customer participation is discouraged in the health-care transaction. With any other product or service, there's a lot more customer participation and interaction. Take a very complex product like a personal computer. The more you know about PCs, the more a company like Dell or Gateway wants to do business with you. Ideally, they want you to log onto their Web site, configure your own computer, and buy it without any interaction with them. But with health care it's just the opposite. The more that you know about the health-care products and services that you want, the more barriers are put in the way through things like gatekeepers and pre-certification to keep you from getting it.

Customer options in health care have been decreasing. It's a throwback to the 1970s when AT&T was your only choice for a long-distance phone company. Pretty much by law now all health plans look alike, and as all the HMOs are merging HMOs there's very little choice out there in the health-care market.

The evolution of the health-care market is that we've decided that we can't trust anybody. Apparently we can't trust the physicians. They're too incompetent. We can't trust patients. They're too irresponsible. We can't trust hospitals because they're too greedy. And, of course, we can't trust HMOs because they're too cheap.

Finally, there are a lot of externalities in the health-care transaction. An externality is an economic term for an extra factor that you have to deal with which has nothing to do with the transaction. For example, with health care, where you work pretty much determines when, how, and where you buy health care. Where you live can determine your health-care purchases. In some cases, even where you're spouse works can be a determining factor.

The main reason for the decline in our health-care economy is that the primary vehicle for delivering health care, the HMO managed-care plan, does not exist anywhere else in our economy. The concept of the HMO is that we're going to take a category, health care, and this HMO is going to be able to provide all products to all people at all places at all times at the highest quality and at the best price.

This model has been tried only twice in the last 20 years by two other companies outside of the health-care arena. The first was United Airlines' attempt to do this with travel. You might call it a travel maintenance organization. United Airlines had this great idea. They even formed a company called Allegis to do it. Allegis was going to cover the traveler's every need from door to door: the flight, the hotel, the rental car, all the way on down. Well, nobody remembers the name of Allegis today because it lasted about 18 months, and the CEO who started the idea was fired. Sears, as you all know, tried the same thing with financial services. Remember Sears Financial Network, with the Discover credit card, the Dean Witter brokerage, Allstate insurance, and all that?

The only place today where you will find even a remote resemblance to the HMO model in the rest of our economy is the new car dealership. When you buy a new

car, the salesman will try to convince you to bring that car back for all of your maintenance and service. But, fortunately, since there's no legislation coercing or requiring you to do that, what do we do? We get our batteries from Sears. We get our tires from Goodyear. We get our mufflers from Midas. We get our oil changed at Jiffy Lube. The good news is we don't need to get a referral from Mr. GoodWrench, our primary-care mechanic, to go there.

Well, how many people remember the energy crisis back in the 1970s, the long lines, the gas shortages, and the chaos? Back in the 1970s, buying a simple tank of gas was a negative-sum game. You had to ask yourself a lot of questions. There were a lot of externalities involved in that purchase. You had to ask yourself:

- Is the gas station going to even be open? Many stations cut their hours on evenings and weekends.
- How long do I have to wait in line? Maybe I should come back later when the line might be shorter.
- Are they going to run out of gas before I get to the front of the line?
- Should I top off my tank now even though it's still three-quarters full?
- Finally, probably the ultimate absurdity in economic externalities, in California you had to ask yourself if your license plate was even or odd.

Well, nothing could be simpler and easier than buying gasoline today. With the credit-card activated pumps, you simply swipe your card, pump your gas, and go. There's only one variable, and that's the amount of the total sale, which is within total control of the customer. There are no interactions. You don't have to talk to anybody. There are no externalities.

Buying health care today is like a nostalgic throwback to buying gasoline back in the 1970s. You've got to got to work through a long list of economic externalities such as:

- Is the physician in my network?
- What's the additional cost of going out of network?
- Is the treatment I want covered?
- Do I need a pre-certification or a referral?
- Then, of course, what are the myriad of deductibles, coinsurance, and co-payments?

Well, some of you may remember back in the 1970s President Carter went on national television and declared that our energy crisis was the moral equivalent of a war. Today, with such cheap and abundant energy, you could almost say our energy situation is the moral equivalent of a bachelor party. Since we've solved the energy crisis of the 1970s, it makes sense to ask the following three questions:

- Why was buying gasoline so difficult 25 years ago?
- Why is buying gasoline so simple today?
- Why is buying health care everyone's worst nightmare and only guaranteed to get worse?

Remember I said the three words were: information, risk, and choice. Let's start with information theory. The key principle of information theory is that wealth is created as more data is transmitted with fewer errors over the same unit of time.

This is the corollary to what you might call the production principle, which says wealth is created as more goods are manufactured and shipped with fewer defects over the same unit of time. There are three aspects to the information principle.

- Speed. Obviously, the faster, the better. We all want a faster Internet connection.
- Compression. If you remember the early-model VCRs from the late 1970s or early 1980s, you can appreciate this. Those early-model VCRs required about 12 steps just to set the clock or to record a program. Since very few of us had the patience to go through the manual and walk through all those steps, our VCRs just blinked at 12:00 all the time. The modern-day VCRs have what's called on-screen programming or one-touch programming. You don't need to force yourself to walk through 12 steps to record a program. All you need is that one six-digit number that's listed in the *TV Guide*. What we've done is compressed the task of recording a program from 12 steps down to one.
- Errors and externalities. This is like static on a phone line or a background noise and, obviously, the less, the better.

How do the laws of information apply to health care? First of all, with speed, the rule is delay and movement do not add value. Delay is making you wait longer for something that you want right now. You're actuaries. You all know about the time value of money. I don't have to explain that. Movement also does not add value. If I take a glass of water, and I move it over there, I haven't added any value to that glass of water.

What are we doing in health care? We seem to be trying to delay the health-care interaction as long as possible through things like gatekeepers and pre-certifications. We're bouncing the patient around from the gatekeeper to other doctors. It takes a long time to get to see the doctor you really wanted to in the first place. The way to think about this is that products and patients do not get any credit for frequent-flyer miles. It doesn't matter how far they travel. All that matters is how quickly did they get the health-care service that they wanted?

Compression. Prices are the most valuable form of economic information. Why? They're just like that VCR code. A price reduces all the information about a product or service down to one number. Unfortunately, in health care, we deem prices as something to be so obscene as to almost be pornographic, something never to be shown or experienced by the customer.

Instead of communicating prices, what do we communicate? We give people, the health plan members, these provider directories that are about the size of the Yellow Pages. By the time the patients actually get it into their hands they're virtually worthless because half the doctors are no longer in that network anyway.

Third is externality. What we do by segregating our money through the tax code by arbitrarily labeling our income as things such as health care, pension, housing, and education, is creating an externality that's pure waste and does not create wealth. We don't become a wealthier society or we don't create any more resources through segregation.

Some of you might remember back in the 1970s, when Congress had this great idea that they would solve the energy crisis by segregating oil into categories of old oil and new oil. Segregating oil did not solve the energy crisis. Segregation did not and does not work with people. Remember the great post-war experiment in Germany segregating Germans between east and west? Of course we tried that in the U.S., segregating people between white and colored.

It doesn't work with dollar bills either. Let me illustrate this. If you don't remember anything else from my talk, I'd at least like you to remember this: economics is not about money. It is about the allocation of resources.

Take a borderless economy, or what I would call a desegregated economy. Let's say you had four goods in that economy: food, clothing, housing, and health care. If you allocated your resources equally among those four items, this is roughly what you have, 25% of your resources allocated to food, clothing, housing, and health care. This could either be your own personal spending or it could be the entire economy as a whole.

If you decided you wanted more health care, what would you have to do? You'd have to allocate some of your resources away from food, clothing, and housing toward health care. You don't create more resources or more wealth by segregating the economy as we do with the tax code. We end up with less food, clothing, housing, and health care, and we create this huge overhead category of what I call the A-4 border guards of the monetary economy. We've got the IRS agents, actuaries, accountants, and attorneys. They don't create any more resources. They don't add any wealth to our economy.

Trust. The key principle of trust is that wealth is directly related to your time horizon and your confidence about the future. Would you rather invest in the 1970s when we had high inflation, high unemployment, an energy crisis, and a threat of war? Or would you rather invest in the 1990s when you had low inflation, full employment, cheap and abundant energy, and no threat of war? The opposite of trust is risk. Your wealth is inversely related to your risk and uncertainty. Would you rather buy gasoline today, when you can just pull in the next station, fill up your car, and go? Or would you rather play musical chairs at the gas pump like we did in the 1970s?

Let's look at how the laws of game theory apply to health care. First of all, trust. Oversight and inspection do not add value. Oversight is simply watching someone else do his or her job. Inspection is simply having a second worker inspect the work of a first worker.

What is utilization review in managed care? It is nothing but oversight and inspection. The rest of our economy, especially in the manufacturing sector, has made great strides over the past 20 years by adopting what is known as the artisan concept, popularized by Dr. Joseph M. Juran, the quality guru, back in the 1950s in Japan. The artisan concept has three principles:

- The worker knows the job. If he doesn't know the job, he shouldn't be there.
- The worker knows when the result of his work is unacceptable.

- The worker has the knowledge and authority to bring unacceptable performance in line with acceptable performance.

If those three conditions do not hold, you don't hire an overseer or inspector. You either retrain the person or you redesign the task. Back in the 1970s Bain & Company did a study of manufacturing in Japan and the U.S. They found that in the U.S. the supervisor-to-worker ratio was 10:1. In Japan it was 100:1. That meant that the U.S. had 10 times more supervisors than the Japanese. Over time, guess what's going to happen? Guess who's going to be able to build the higher quality car at the lower price with much less useless waste on their payroll?

Another aspect of oversight and inspection, or the lack of trust, is the Stark Amendment, a law passed by Representative Pete Stark of California, which makes it illegal for a doctor to refer a service (it might be a lab test or an x-ray) to another business in which that doctor might have a financial interest. If you apply the Stark Amendment to other products and services, you could virtually shut down our economy. The rest of our economy operates on what's called supply chain management (SCM). The Japanese call these relationships a keiretsus, where the manufacturer and the supplier do a stock swap to unite their financial interest.

Think about this in your personal life. If you buy a new car from General Motors, such as a Buick dealership, the salesman will try and convince you to finance that car through GMAC. But GMAC is nothing but a wholly-owned subsidiary of General Motors. If you bring that car back to the dealer for service, they're going to install AC Delco parts in that car. What is AC Delco? It's nothing but a wholly owned subsidiary of General Motors. We've got a situation in our economy where we are allowed to trust used-car salesmen, but we can't trust doctors.

The level of trust in our economy is so high today that many manufacturers will pay their suppliers before they even get the goods. What happens is a supplier will send what's called an advance ship notice (ASN) to the manufacturer, that says, We are going to ship you a 1,000 parts today, and they're going to arrive at your dock at two o'clock tomorrow afternoon. For a company like Ford, that's good enough; they will release payment immediately.

For 20-30 years Ford would try and hold onto their money by delaying payment as long as possible to earn interest on the funds. In that scenario you've got the supplier calling up Ford, hassling Ford, and trying to get paid. Then you've got somebody on Ford's payroll answering those calls, trying to sweet-talk the supplier into continuing to send shipments without getting paid. You've got an additional person on the payroll at the supplier, and an additional person on the payroll at Ford. Neither of them is adding value to the car that you and I are buying, but they're both adding cost. Again, along come the Japanese. They don't have these inefficiencies built into their supply chain. Guess who's able to build the better car at the lower price?

Information creates wealth and reduces risk. You could say information creates wealth by reducing risk. You're never better off with less information. You may not like the information you get, but you're never better off with less information.

What is information in our health-care economy but underwriting and advertising? Advertising of physicians, letting the public know what services they have to offer. Underwriting is the exchange of information from the buyer to the seller.

In the rest of our economy, for example, when you rent a car through Hertz, what you do is you exchange information in advance such that they know who you are. They know when you're coming. They know what car you want. You're able to just walk into the Hertz rental agency, get into your car and drive off with maybe a 15- or a 30-second wait.

Third issue is choice. Your wealth is directly related to satisfaction of your individual preferences, your ability to control the outcome, and your marginal return on your incremental investment.

Economists divide goods into two general categories of public goods and private goods. Public goods are goods such that everybody gets the same thing in the same way. Private goods are goods that we all get on a personalized basis. The differentiator between what is a public good and what is a private good is the answer in this question, Can different people satisfy personal preferences simultaneously without any negative consequences? With food and clothing the answer is obviously yes. We all wore different clothes today. We ate different things for breakfast. Nobody else suffered because of that. With traffic laws the answer is obviously no. I can't drive home tonight and ignore all the traffic lights.

The logic of public choice theory holds that:

- If everybody gets the same thing, like when AT&T was the only long distance phone company back in the 1970s,
- If your input's going to be ignored, for example, if you were in the army, you probably remember you weren't asked what you wanted for dinner every night,
- And if it doesn't pay to fight city hall, meaning that if you're Ross Perot or Steve Forbes, spending $50-100 million can't get you elected,

If all those three things are true, then what you should do to maximize your wealth is adopt a stance that's called rational ignorance. Rational ignorance simply says, I don't know and I don't care. Well, ignorance might be bliss, but it can be very costly. With health care it can be very deadly.

Take a simple category like motor oil. When you drive into a Jiffy Lube, the first question a person that works there is going to ask you is, Do you want Pennzoil 10W30? Well, most of us are rationally ignorant about motor oil. We don't know; and we don't care. Even though we're rationally ignorant, we get a choice.

Unfortunately, when you move into more important categories like the education of your children, education is a public good. Everybody gets the same thing in the same way. They all get the same public schools in their neighborhood. Go to an even more important category, such as your life savings. A lot of our life savings is a public good. We all get the same social security and Medicare by law, and all the people that work for the same employer are stuck with the same pension plan whether they like it or not.

Your health is probably the most important thing in your life. They say, When you've got your health, you've got everything. It's probably our highest category item. Unfortunately, health care is generally a public good. All your coworkers get the same health plan in the same way. When they retire, we're all members of the Medicare plan. Notice we've got our priorities upside down. The low-priority items that we really don't care about, we have the most choice with respect to. But with the highest category items like our health, we have the least choice.

If you own a business, what are the consequences of rational ignorance? Essentially what you're doing is you're giving your employees the company credit card, which has no spending limit. They're going into a shopping mall where the items have no price tags, and they're not held accountable for what they buy. I would assume that most people couldn't run their businesses based on these principles. You can't run your household on these principles. But these are the principles that we're running our health-care system on.

Let me go back to segregation. In my article from the April 2000 *Health Section Newsletter*, I explain the destructive effects of the tax code. We essentially have a two-tiered economy. We've got a privileged class of people who get access to the employer-sponsored tax exemption. We've got a disenfranchised class that does not. There are also the A-4 border guards, the accountants, the IRS agents, the actuaries, and the attorneys. They're just adding delay, movement, inspection, and oversight into the health-care economy, and they're sucking up a lot of resources.

Ultimately you've got to ask yourself, Do you want the laws of economics working for you or against you? What we're doing through the IRC and ERISA is segregating our monetary system, and we're actually segregating it to the second power. Not only are we segregating our money into arbitrary categories like health care, pension, education, and take-home pay, but also through ERISA we're segregating the fiduciary responsibility for that money. It may be your money, but your employer tells you how, when, and where you can spend it.

We've got all these additional externalities in our health-care economy, like we did with gasoline back in the 1970s. We've added all this delay, movement, inspection, and oversight, which we have to get rid of. We have a complete absence of trust in our health-care economy. We can't trust the doctors or the patients. Most of the actors in our health-care economy are walking around in a state of rational ignorance. They're saying, I don't know and I don't care.

We've got to turn this around. We've got to turn health care from a public good into a private good. Finally, health care is essentially a vendor-oriented market. It's geared towards the employer and not the customer. The reason it's geared toward the employer is obviously the employer's paying the bill, and it's also geared toward the revenue stream of the hospital networks and the HMOs.

I'll close with the plea, Mr. President, tear down this wall. Assign ERISA and the IRC to the dustbin of history. Georges Clemenceau once said that war is too important to be left to the generals. Well, just as war is too important to be left to the generals, and just as the education of your children is too important to be left

to the government, your health and your health care are way too important to be left to your employer.

Mr. Terry S. Ward: My presentation focuses on the possibilities for a new delivery model of health care. It's interesting to note that a lot of the discussion in the presidential debates is on the financing side, which is hugely important, of course. I do not have a health-care background, but discovered health care from an experience I had seven years ago. From a patient-consumer experience, it changed my life. Not because of an illness, but rather how I was treated as a patient when I needed to see a doctor. It has been an interesting seven years, and a wonderful group of people have come together to help create this model that you're about to see. I ask folks working on the financing of health care if we as consumers get to chose our health insurance plans, what might we choose?

Seven years ago I woke up one morning and had a forest fire in my lower abdomen. I left my house at 12 noon after begging for an appointment, and returned at 6:30 that evening. Yes, I did have my prescription. But what I went through that day as a consumer of health-care products and services was unacceptable. Fortunately, I was in a position in my business where I could spend the next two years studying the system. I literally went back from when the pilgrims landed and studied the evolution of health care and medicine, where it came from, how it got to where it is, what are diagnostic-related groups, certificate needs, Medicare, managed care, and Kaiser in California, where they started hiring physicians in the 1940s.

We went to consumers, physicians, hospitals, and the different components of health care through focus groups in three or four different states. We hired a wonderful company to do this. We evaluated the market, and what you're going to hear is some of what we learned. What we learned from consumers and employers is the access and the convenience is, in some degree, unacceptable. On one day, we go six miles in one direction to see the doctor. On another day we go four miles in another direction to get an MRI, then another place to give blood, and then maybe two or three weeks later we get the results of our tests, while during that time we're wondering if we have a serious illness. It's not personalized.

American people are confused. In one of our focus groups a lady said, "I don't care what they do with Medicare. Just keep the government out of it." A lady in California said, "I'm not part of an HMO. My insurance company is Kaiser." The lack of choice: they want to be better informed. This whole relationship with physicians and providers to most consumers is nonexistent. In our focus groups, 89% of the people said that at one time or another they needed to see a physician, but they avoided the system because of the hassle getting in and out of it. And, of course, cost.

Physicians' issues are:

- The loss of empowerment. This notion that if you need an MRI, they've got to put it off for two or three days while they call an 800 number to get permission from somebody who's a non-clinic or a medical person.

- Personal efficiency and legal: a couple of physicians said, "Every day when I walk into my office I'm sure I'm breaking some law."
- Increased overhead, decreased reimbursement, and, of course, income pressures.

For hospitals, of course, the big blow was the 1997 Budget Act. Some think it was a good thing; some think it was a bad thing. We've gone too far from one side, too far to the other. Where's the balance? Right now the estimates are 75-80% of hospitals in this country are losing money. Their credit ratings are being downgraded. Issues with legal, regulatory, increased overhead, decreased reimbursement, income pressure, and physician relationships with hospitals are at an all-time low.

Health care certainly is in chaos, and it's really not because of quality, money, managed care, or lack of physicians and hospitals. The reason, as we all know, is cost and distribution. Competition has created some of it, the rising number of uninsured along with public ignorance. This is where I was seven years ago. Basically I thought, "Well, an employer takes $250 a month out of an employee's paycheck. That's what it costs." That's what 98% of the American people think. Part of this problem, as Gerry just mentioned, is the lack of the American consumers' involvement in health care. As he pointed out, we're so involved and demanding in other areas, but we aren't in health care. People want million-dollar health care for $10 co-payments. They moan and groan a little bit about gas going up a quarter, but they go nuts because they have to pay $50 for a prescription. This is interesting in that, as Gerry said, this is our health.

Duplication, operational inefficiency, and the payment system, the government's created some of this chaos. Here are some of our attempts to fix it. Of course, we tried to do universal health care. We brought in managed care. A lot of people forgot that managed care was brought in several years ago to try to fix it. And, of course, it's made it worse. We have the 1997 Budget Act. We've redesigned health plans. We've had takeovers, mergers and acquisitions, distribution networks, and now the patient bill of rights.

Our group came to the conclusion that the three components that absolutely depend on each other in health care do not work with each other. In fact, again, as Gerry pointed out, there's incentive to not work together through the gatekeeper model. Hospitals, physicians, and payers do not work together. We felt like the old solution of continuing to throw money at it would not work. It's like running a car into a brick wall at 100 miles an hour. Can you ever fix it?

A new model needed to be created that promoted cooperation, choice, and consumerism, and only a revolution will bring order to the chaos. When I'm in front of hospital folks they really frown at that and say, "Well, maybe it's an evolution." I say, "Well, possibly you're right, but from a consumer's perspective we feel like it might be time for a revolution."

What's driving it? Cost. We spent $1.1 trillion in 1998 on health care and went to the physician 1.6 billion times. The projections for 2020 are there'll be 70 million

people over the age of 65 with costs projected to be $3.5 trillion or 38% of the gross domestic product.

There are five generations living in the country right now with different health-care demands and requirements. I will say that this was one of the most significant things that we learned as we were creating what we feel like might be a new model.

We focus-grouped all five generations, and the difference in these generation's values and morals is staggering. It's like asking, "Did that World War II generation really raise the boomer generation? Are they really their parents?" To give you a quick example of the World War II generation, my father, who is 80, fairly healthy, and plays golf two or three times a week will drive for a half a day looking for a store because he has a 50-cent-off coupon. But the whole time he'll be griping about paying $1.25 for a gallon of gas. Now, the baby boomers, on the other hand, will pay $10 to have it delivered to their door, and we are going in the convenience stores paying $6.55 for a gallon of water. My dad says, "Can you believe they're paying $6 a gallon for water?"

What we learned was very significant. We asked questions of all these different groups. How do you like the current system? What would you change? And so on. We focused on, as Mr. Bartlett mentioned, the 80 million baby boomers who are the wealthiest generation in the history of the U.S. and are going to inherit $10 trillion over the next 12 years, the largest shift of money in the history of our country. It's interesting to note that the vast majority of that money right now is sitting in Treasuries and CDs because of that very conservative World War II generation. Where will it go when the boomers get their hands on it? Well, it's what's driving the stock market and our belief is it will continue to. But they're also spending the money on leisure, health, and wellness.

Now, the baby boomers' values and attitudes are educated and able to force change. They're health-conscious, demanding, and time-conscious. They want control and choice. They're the most selfish, self-centered generation to ever live. They're going to want to be 72-years old running three miles a day looking like they're 40. They're going to want immediate access and convenience. They're the generation that came up with drive-thru dry cleanings, pharmacies, restaurants, and who knows if drive-thru brain surgery will ever happen, but I wouldn't dismiss it.

Consumerism will lead the change wave in health care. Here's the second most significant thing we learned. We spent in this country a quarter of a trillion dollars out of pocket in 1998 on health and wellness, and $65 billion of it was spent on acupuncture, herbs, and vitamins. This was not part of the $1.1 trillion. When we saw this we said there is a market in consumer-driven health-care industry right now. When I'm in front of a group of doctors, which is quite frequently, I get beat up real bad by them. These figures create waves of moans and groans of "Voodoo medicine," and "It's all in their head."

I say, "Doctor, most likely you're right, but the question you should ask yourself is why are Americans doing this? Furthermore, when we get up every morning, isn't

it 80% in our heads how we feel, how we're getting along with our spouse or our kids or at our job or boss? If I go to an herb store and take an herb, and it's in my head, and I feel better, who cares?" Then what's interesting is when it's over, someone will come up, and will say, "You know, my mother-in-law started getting acupuncture treatments." Then another doctor walks up and says, "My wife takes herbs." It's amazing.

What's the solution for this revolution? We believe that the right partners are critical. We have an organizational chart with six of them: physicians, hospitals, information systems, real estate, operations, and wellness. We do have those partners. We believe this model might obsolete the current health-care system as we know in the same way the computer has done to the typewriter.

What is HealthCare Village? It's a market-oriented, consumer-driven, health and wellness community medical center that will provide primary and secondary care with a strong emphasis on education, prevention, wellness, and disease management. We hope—and it's going to take the consumer to do this, not the government, not physicians, not hospitals, but us as health-care consumers—to empower the patient and the physician again.

We buy four insurances in our lives as consumers. We buy home, auto, life, and health. It's interesting to note that the first three, if we have to use them, we're somewhat devastated. How many times have you heard, "Well, I'm not going to turn that fender bender into the insurance company; I'll just write a check?" We use our car insurance if we've had an accident or a theft, our homeowner's insurance if we've had a fire or a theft, and our life insurance if somebody has died. But with health insurance, we feel like we're getting taken advantage of if we're not using it. The reason is, we as consumers don't pay for it; somebody else does. We believe that the system has already started to change and has to change.

I believe that both presidential candidates are not telling the truth. Eighty-five percent of health-care needs can and should be delivered outside of that more expensive tertiary hospital. Eighty percent of the people in this country, as you well know, spend less than $500 a year on health care. It's the 80/20 Pareto's Principle: 20% of the people are spending 80% of the health-care dollars. Of that 80%, of course, it's in the last three to six months of their life.

What else is the HealthCare Village? It's a master plan health-care delivery model. We're looking at it as a health-care product that we can take directly to employers with the Aetnas of the world providing some catastrophic health insurance. Let the consumer and the physician manage those primary and secondary dollars. It's community-based and consumer-focused. It promotes wellness and education. It's a vehicle for successful hospital and physician partnerships. It assists employers with the management and cost of family care.

What does it look like? What we had to do was to put numbers to this thing. To be able to get the financing for it, we had to develop a prototype. We made a prototype of a major metropolitan HealthCare Village. The other two models we have are a Health Care Plaza and a Health Care Villa. I might mention to you the

first one, after seven years of this, is starting construction in Houston, Texas in January 2000. It appears that probably in April 2001 we'll have one going in St. Louis and possibly one in Lexington, Kentucky. It's been the biggest, most challenging thing I've ever taken on. There have been two or three times that I've come close to throwing in the towel.

The model for the metropolitan HealthCare Village could house 100-120 physicians. It sits on Main Street in the community. We like to say—and I don't mean from a financial perspective—that it belongs to the men, women, and children of that community, not my company or doctors or hospitals. In Houston where we're building it we've brought the businesses, the Chamber of Commerce, and the churches in. They're all involved in this, which is very powerful.

One important issue is parking, parking, parking. I come out of retail. It's interesting. I've gone to health-care facilities all over this country looking at how it's being delivered, from Mayo Clinic to Celebration in Florida, and Scripps and Sharps in San Diego, and I've seen people, sick people, sitting in parking lots waiting for somebody else to leave in order to park.

Another important issue is community. Town center. Sidewalks. Bring back that town center thing here. We want people coming here before they're sick. People say, "Well, it looks like a resort or a country club." They are referring to the main entrance of the HealthCare Village. We say, "Good, we don't want it to look scary and traditional." There will be high-quality health care delivered in here, so we want it to look high quality, but at the same time friendly, warm, and pleasing to the eye. There is a Harvest Grill, and the ambulatory short-stay hospital. We will never do open heart surgery or brain tumors in here. This is not a tertiary facility.

When you step in you will see what we call the Great Hall, or the heart of the village, because it connects all of it. It's like stepping into a giant living room. It's interesting to note, coming from retail, what we did. We wanted to know who the health-care consumer really was. It's amazing that 75% of the largest industry in the world is controlled and directed by women. They're the ones that take the kids to the doctor. They use the system three times more than men. Quite frankly, they're the one that says to the men in their life, whether sons, husband, or fathers, "You know, you've had that knot on your shoulder for six months, and you're not doing anything about it. I'm calling and getting your appointment." Sadly, that's the way it is. We wanted to appeal to our direct consumer.

One of our centers of excellence, the women's center, looks upon the wellness gardener or what we call the soul of the village. I'll tell you as somebody who has not experienced a serious illness, with both parents fairly healthy and still alive, I was amazed at how the spiritual part of health care adds to healing and how important it is. It's very big in our model. A lady in our focus group said, "If I'm sick all night and throwing up and don't want to put my makeup on, I don't want to go through your Great Hall and take a chance on running into a neighbor." Again, this is the purpose of focus groups.

There are 17 different places to enter the facility. There is an entrance into the women's center with its own parking. We got rid of the separation, those sliding glass windows that you can't see through, the doorbell, and the clipboard. That is how we're currently greeted into a physician's office when the greeter slides the windows open and throw that clipboard at you with the six pages of stuff to fill out and say, "The doctor will be with you when he or she can." It's all gone.

A lot of people look at this and say, "This looks expensive." Part of what I've done in my past careers in retail was build for Walgreen's and Blockbuster. They certainly taught me how to put up a building that can last 25-30 years with a door that opens 300 times an hour, and how to do it all. Quality is inexpensive. Quite frankly, we're building these things for 25% less than what most hospitals are doing their ambulatory clinics for.

What's inside the HealthCare Village? We want this to be the hospital of the future. About a year ago I had rotator cuff surgery, and I had to stay all night. The doctor asked me if I wanted to stay. I wasn't waking up. My wife was there, and she slept on this vinyl something or other over in the corner. It is just amazing how hospitals feel when you're staying there all night. I didn't have to stay. I wanted to get out of there about 2:00 a.m. Then, of course, when it was time for me to go at 7:30 a.m., I had to wait two hours for the doctor to be found to release me. I felt like a prisoner.

Again, this is the hospital of the future. Why did my wife have to sleep on that vinyl thing? Why couldn't there have been a queen-size bed so she could have snuggled up against me? Who says you can't have that type of environment and family-type relationships within a hospital? We found two hospitals in the country that are using queen-size beds.

The core of the village and what makes it work are our 10 physician-based centers of excellence. Have any of you read Harvard Professor Regina E. Herzlinger's book, *Market-Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry*? You should get it. It's a very interesting book. She's coming out with a new one. She talks about this model. She refers to these 10 centers of excellence as focused factories. That sounds funny in health care. It's like, "Do I want to go to a focused factory?" But what she's saying is, when it's time for open heart surgery, do you want to go to a hospital that does 200-300 a year or do you want to go to one that does 200-300 a month, such as the Texas Heart Institute in Houston?

As I studied, I found a hospital in Canada called Shouldice Hospital, in Toronto, that does only one procedure: hernias. It is the ultimate focused factory. We went up and visited. It is the most amazing thing. Its re-do factor is 0.0032. Every year at the Hyatt in Toronto, everybody who's had a hernia operation at their hospital has a hernia party.

What we have done is create these centers of excellence and recruited the top-quality physician groups or independent groups to come in. We believe physicians should stay as entrepreneurs. This whole business of hospital purchasing; it

doesn't work. We also believe physicians have to be accountable. We did learn that there's greed out there and that this whole hospital/physician relationship is next to impossible to fix. It might be two or three more generations before anything can be done. The bottom line is about control. What the hospital wants to control and what the doctor wants to control are so different. It's like the Palestinians and Israelis. They're never going to do it. They've got to have another way of coming together.

What does it mean to the community? We believe that the health of the community has to be a priority. We in this country never hit the health-care system until we're sick, but we'll spend $500 a year to change our oil on our car and tune it up to keep it from getting sick. Why is it that we look at our own health this way? We believe we need to start a actual lifestyle change of focusing on prevention instead of the intervention, the whole continuum of care and then, of course, mental health which got left out of managed care.

We're going to have daycare, arts and craft classes, and health fairs. This is as much about wellness as it is illness. Your dentist will be here. Barnes & Noble Health & Lifestyle Bookstore will be here. The baby boomers will—if a doctor says you've got to have surgery—go out, get on that Internet, and become smarter than the physician about that particular illness. All the different health-related retail allied services want to be in a HealthCare Village in your community in one area.

This is one of our bigger grocery stores in Houston who feeds the community. We feel like they owe it to that community. We're actually talking to Whole Foods about coming in and doing nutrition cooking classes. If somebody's just been told they have diabetes and have to change their diet, let's not send that person home and just hope that they do it. There is a way for that grocery store that feeds the people in that community—and we believe they owe it to that community—to step up and help change people's lifestyles.

A lady in our focus group said, "I'm 75. I'm healthy. My husband passed away, and I'm lonely." We've literally had doctors say with this $10 co-payment thing that certain people will come in two or three times a month and pay that $10 just to visit, and say, "Oh, no, I don't mind waiting two hours. Go ahead. I'll be happy." They're just lonely. We thought, let's go to Hobby Lobby and see if they'll come in and sponsor an arts and craft class on Tuesday night, and maybe do a ballroom dancing lesson on Wednesday night.

Again, you can create an atmosphere with a quarter of a trillion dollars out of pocket that we're spending in America. If you create the right atmosphere—in our opinion from our focus groups—people will begin to change a lifestyle.

Our library is sponsored by Baylor College of Medicine and the Exxon Foundation. The library has Internet stations every 50 feet in here. Instead of going to drkoop.com, go to healthcarevillage.com and talk to the physician that's in your community's HealthCare Village, instead of one up in Jump-Start, Minnesota somewhere.

Our community auditorium is available to many groups. We want the boy scouts and girl scouts of the community have their Tuesday night meetings in here. We believe that the AA can meet here, stop-smoking classes, and first-time parenting classes.

How do you bring something like this in and provide it as an amenity? Community corporate sponsors are needed. Intel's an option, but actually we're close with Pfizer. Two-and-a-half years ago in Houston, Enron wrote a $150 million check to have our new baseball stadium called Enron Stadium. We also have the Compaq Center where the Rockets play. Then I realized that Pfizer spends $1.5 million in advertising Viagra in three big Texas markets, San Antonio, Dallas, and Houston, in one night. For $1.5 million, this can become the Pfizer auditorium in that community for 15 years.

This is like a church without the religion. This room is a community room that a number of things can happen. The number-one issue with kids going to the doctor is fear. We're not suggesting that your kid's going to come up and say, "Mommy, can I go to the doctor?" But we are suggesting that you've got to start somewhere, and you can do something about that fear.

There will be a little village or the kids' center. It is daycare for the mom and dad who work at the village, but, most importantly, for that mom who has an appointment for a test that can't get a babysitter. She can drop her child off here for an hour while she's doing that.

In closing, this appears to be a little bit about sticks and bricks, but the truth is there are too many health-care sticks and bricks out there already. One thing that was interesting in the study of this process was (and I will tell you that part of the reason it's taken so long to get it off the ground is because I was looking at it for many years as a stick-and-brick deal) three years ago something happened that made me wake up and understand it's about processes and systems. Let me quickly explain that. On my six-hour doctor appointment I had a prostate infection, and due to the thing we hear about cancer I wanted to go to a urologist and just get checked out. I had asked for my records to be transferred, and I had to get the referral, and all the other things you have to do. It took two weeks to get my records transferred from that one doctor to the specialist. When I finally went to the specialist,I realized they were in the same building.

How does Federal Express get a package from California to New York in 24 hours for $12 with a 3% error rate? I went to Tennessee to find out. If any of you have never done this, you must go visit Fed-Ex. It is the most awesome processing system you'll ever see, and I'll just say quickly two things. One is if we drop-off a package in a Fed-Ex box here to go to a place across the street, it will go to Tennessee and come back tonight. Now they do it for $12 with a 3% error rate, and it's there by 10:00 a.m. or they pay for it (incidentally, out of 80% of the 3% errors, the slip's filled out wrong by the consumer).

How do they get a boat, truck, package, airplane, and a driver in one place in 10 minutes? If that airplane is not in the maintenance hangar or not in the air, it's

losing money. I wanted to get a prescription, a result from a test, an image, a doctor, and a consumer in one area in 10 minutes. We were able to take part of their system and implement it in our HealthCare Village model. Everybody out there's got their gazillion-dollar new health-care information stuff, and the fact of the matter is it's about connectivity, internal and external.

The other amazing thing that was very significant is I studied Wal-Mart's processes and systems. When you scan a tube of toothpaste at a Wal-Mart that scan goes two places. It goes to Arkansas, at their corporate office, and it goes to Procter & Gamble (P&G) in Cincinnati, Ohio. Indirectly it is P&G's job to restock that and every tube of toothpaste, every Q-Tip, and shampoo bottle they have in every Wal-Mart in this country.

Here's what happened. P&G was tired of waiting to get their money from Wal-Mart for three and four months. P&G came up with a technology, paid for it to install it in Wal-Mart, that said, "You don't even have to pay us until you've collected the money." In fact, 90% of the items on a Wal-Mart shelf are there on consignment. It's like a giant flea market. They don't have to pay until they've collected the money. But what P&G said is: "We'll cut your costs. You'll never have to call an order in. We'll know the minute it sells, and we'll ship it out, but what we want is every night at 12:01 a.m. our money wired from your accounts to our accounts." It worked. Wal-Mart cut their costs 12%. P&G gained by getting their money sooner. We need to seriously look at the insurance industry and health care with physicians. They hold and ride those doctors' and hospitals' money for as long as they can, and that's part of the problem.

It's about information systems and connectivity. I would like to show you what one of our partners, Siemens, has done. They have a little card which has a chip can hold 20-30 full pages of printed data. Your entire medical record and prescriptions can be on it. We're hearing somewhere between 68,000-98,000 people a year are dying because they're eating the wrong prescriptions. A number of things can happen. This is no different than the thumbprint and the eye scan we're doing with ATM machines.

As to security issues, it's got to be dealt with. I personally believe that security issues on the Internet are as much as a perception as a real problem. I think there's a better chance of me getting ripped off forgetting my receipt at the gas pump with my charge card number than there is over the Internet. I'll tell you I've traded over $2 million worth of stock on the Internet myself, and I've bought thousands of dollars worth of product. I've never had an issue. However, the perception is out there. As we all know, perception is everything.

Another thing this card can be: we believe we've got to start rewarding healthy behavior in this country. We've come up with a concept called "healthy points." If you come in and you buy a book at Barnes & Noble Health & Lifestyle, if you get your healthy exam, if you work out , you will get—much like the airlines—healthy points. You can trade those points in. Someone can trade it in on a manicure, facial, or massage at the village. It's interesting to note the boomers are the

wealthiest generation in the history of this country, but they shop at Wal-Mart. They love their coupons.

In closing, it's about access and consumer friendly. Until we realize that if we want the best health care in the world—million-dollar health care—we can't get it with a $10 co-payment. Our government somehow has got to start saying that to us. I know it's political disaster, but the fact is, with the projections what they are, the government will not be able to finance health care.

Mr. Thomas X. Lonergan: I have two questions for Mr. Ward. How do you finance the village, first of all? Isn't it just like Kaiser Permanente with flowerpots?

Mr. Ward: I love it. Well, yes, it is similar to Kaiser's model, but what our model does is (and there is a whole business strategy to it) it wants doctors to have ownership and risk and reward in it. We feel we're going to increase efficiency and quit having doctors go to Kaiser and tell them they want that new $5 million machine out there. If the doctors own half of it and have to come up with $2.5 million, they'll think twice before they do what they do to hospitals. Indeed, we're talking to Kaiser right now about it. We don't think that hospitals can, although they talk about it, really operate in that consumer-friendly environment that they're all trying to. Some of them have done a great job with it, but the dissatisfaction continues to be at an all-time high.

As far as financing, it's been very difficult. Wall Street is down right now on health care. But they also see it as the largest industry in the world, with growth projections that dwarf technology. They want somebody to bring a new concept. A group of my colleagues and myself are financing the first two Villages. Physician investment's helping finance it. The power of the real estate is helping to finance it right now. I will also mention that the technology in there, the phone systems, the fiber optic, the computers for the physicians that most of them don't even know how to type is a utility, much like the light and the water bill in there. That's how we're getting physicians to start looking at. It's a crawl-walk-run thing, so we don't have all the answers yet.

The bottom line is it doesn't matter what the current financing system is. The HealthCare Village is a flexible model that will adapt to that. In Houston there are 80 doctors within this powerful, large, and demographic area that are moving in. They're moving from one location to the other, but they're all in this facility. Now, will all of them be able in the beginning to use that lab and those other things? Probably not. Again, it's a crawl-walk-run. First thing is to get them all in one area.

Mr. Sean E. Donohoe: According to economic theory, if I needed heart surgery but I couldn't afford it, I should buy less of it. Just a rhetorical statement. Mr. Smedinghoff, how much do you think the Hippocratic oath has to do with our health-care situation at the moment?

Mr. Smedinghoff: To answer your question, the Hippocratic oath is virtually irrelevant. Very few medical students take it anymore. Most medical schools

design their own oaths. In fact, some students even write their own oaths. That's irrelevant. As far as the heart surgery, I separate out heart surgery, or any form of critical illness, as something you would buy insurance for. I don't know exactly what part of my talk you're referring to, but what I tried to show was this idea of every health-care service being purchased through a reimbursement mechanism is obviously causing a lot of problems. I have no objections to buying health insurance or the insurance mechanism for health care.

Mr. Roy Goldman: I have a couple of comments, not necessarily a question. Terry mentioned a couple of times about how physicians will be accountable. You mentioned that the HealthCare Village is sort of independent of how health care is financed. Gerry talked a lot about how it's financed and how the economics are not relevant to health care. But we're trying to run a health-care system regardless of the economic theory. There was actually a good article in *The New York Times* I think last week about prescription drugs, neither of these prescription drug plans following the basic theory.

However, I am surprised that both of you are so pejorative towards managed care. You've made statements that managed care has created and contributed to the chaos. Gerry mentioned length of stays, an illustration of how we're delivering less. You also mentioned the lower quality. Most people would think lowering length of stay is increasing quality.

Terry, you mentioned that you had looked at the history of health care. I actually agree with both. We shouldn't have employers be the only one financing health care. I agree that we're in a mess and we need to improve it. But continuing to take the populist role that part of it is due to managed care without acknowledging that cost decreased from 1993-97. The fact that we're talking about all these issues—Gerry's comment about information is good—is because of managed care that this information is first coming out, that we're beginning to look at how physicians make decisions.

Mr. Ward: I certainly agree with you. I think the bottom line to what you're saying is that managed care cuts the inflation rate in health care. We have taken our information based on what hundreds of focus groups and consumers and doctors have told us. Again, we don't have all the answers. We feel like we've addressed a lot of the issues, but until we get one of these up and operating there are a lot of unknowns.