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I N D E X

P R O C E E D I N G S

MS. MATHIAS: Welcome. This is about the 27th hearing that we have had on health care competition law and policy.

We are very pleased that you could be here. Also, we welcome all the people who are listening in on the conference call, as well as the FTC employees who are watching over our Cisco System. So welcome to all.

This morning we have had a slight change. Bill Kovacic was supposed to be here moderating. Unfortunately, due to a conflict related to the Do Not Call List, Bill couldn't attend. So I will be stepping into his place, although there is no way I can fill his shoes.

First, I would like to introduce Commissioner Mozelle Thompson, who was sworn in as a commissioner on the Federal Trade Commission in 1997. Mr. Thompson previously held the position of Principal Deputy Assistant Secretary at the Department of Treasury, where he was responsible for --

COMMISSIONER THOMPSON: Keep it short.

MS. MATHIAS: Okay. I'm going to wrap it up. This is Commissioner Thompson. Welcome.

COMMISSIONER THOMPSON: Good morning. Thanks a lot.

Well, you know, I avoided classes this early when I was in law school. There was a reason. Well, thank you all for being here, both of you. No.

First of all, good morning, and I want to extend a welcome. Thank you for joining us for this almost final day of our health care hearings. I also want to have a special word of thanks for our international colleagues, who have come a long distance.

The purpose of our hearings was to learn about the health care industry and how it interfaces with competition laws. Now, we in the United States, have been examining health care policy for quite some time. We have considered who is served, the services offered, the quality of care, what it costs, and who shall pay.

What we have learned so far is that there are no easy answers. But we do know that competition plays an important part in answering all of these questions.

Now, in my years of working in the health care area, I know that America is not alone in examining this field. Today we are fortunate to have colleagues from around the world to share their experiences and enlighten our discussion.

Now, so far, the FTC and the Department of Justice has invited not-for-profit hospitals, for-profit hospital networks, doctors, physician associations,

physician hospital associations, patients, employers, HMO insurers, and others to talk to us about what is so special about health care and what makes it different from other industries that we look at.

What I am also hoping is that through our hearings, we might also learn how this field is similar to other industries that we work with every day.

So I'm going to keep it short so we can get to the meat of our presentations, and I wanted to thank you all for your participation and look forward to continuing these exciting sessions.

Thank you very much.

(Applause.)

COMMISSIONER THOMPSON: And for our foreign guests, you can say whatever you want to because you're not in your country, so you won't be held responsible. So it's okay.

MS. MATHIAS: Thank you, Commissioner. Now, it is my pleasure to introduce our distinguished panel of world-renowned antitrust competition law experts and participants in the area of law.

One thing I did want to note is we are very indebted to the fact that all of you could travel so far to participate in this panel. We are thrilled that you could come from Ireland to Taiwan to Australia, because

we think that there are very different aspects of looking at competition law and policy in health care that is represented by each country and we are looking forward to learning from each of you.

Now, as was obvious with the introduction of Commissioner Thompson, we kind of do focus actually on very light introductions, because each one of you is distinguished and we could spend the whole time going through the introductions rather than actually getting to the meat of the subject, which is what we'd prefer to talk.

So we do have a handy little bio handout for everyone to get a more full explanation of how distinguished our panelists are. But to give everyone a brief introduction and to welcome them and actually to also explain that they will be presenting in the order of their introductions, and I'll just go from my right to left, or I guess your left to right.

We will start with Commissioner Sitesh Bhojani. He is Commissioner of the Australian Competition and Consumer Commission. Commissioner Bhojani was reappointed for a further four-year term commencing on November 10, 1999 and as a full-time Commissioner of the ACCC.

Next to Commissioner Bhojani, we have Mr. Bruce

Cooper, who is also from Australia. He is with the ACCC and is currently Director of Profession Compliance Unit in the Enforcement and Coordination Branch of the ACCC.

I should have already welcomed, and I apologize for not doing this sooner, my co-moderator, Bruce McDonald, who is with the U.S. Department of Justice.

MR. McDONALD: Just glad to be here.

MS. MATHIAS: We're glad you could be here, too.

Next to Bruce we have Dr. Liu. I apologize if I mispronounce that. He is doctor and professor and is Commissioner of the Taiwan Fair Trade Commission.

Next to Dr. Liu we have Declan Purcell, who was appointed as a member of the Competition Authority by the Irish Government in April 1998 and was reappointed in November 2001 for a second term.

Declan is head of the Competition Authority's Advocacy Division.

Finally, we have Michael Jacobs, who is Professor of Law at DePaul University College of Law in Chicago, where he teaches antitrust law and contracts. He is an expert in the area of competition law and focuses on health care.

We welcome all of you and without further ado, we -- just so you know how this also proceeds, as

everyone will talk, everyone gets about 20 minutes to give a presentation. After everyone has given their presentation, we will take about a ten-minute break so that everybody can gt a drink of water, and then we will move into moderated discussion, where Bruce and I get to ask questions of the panelists, and the panelists, also, if there are questions that arise, can ask questions of each other.

Unfortunately, we do not open questions to the floor.

Anyway, with no further ado, Mr. Bhojani.

MR. BHOJANI: Good morning, ladies and gentlemen. Thank you very much, Sarah and Bruce, for that introduction.

Can I take this opportunity to thank the Department of Justice and the Federal Trade Commission for this opportunity to participate in these hearings. We do commend both agencies on the foresight into holding these hearings.

We think that antitrust in the health sector is a really, really important issue not just for America, but around the globe, and certainly as far as Australia is concerned, and we look forward to the report that these hearings will provide and the insights that it will give us in terms of antitrust analysis for the health

care sector.

So thank you again for this opportunity to participate in these hearings.

I would like to start my presentation by giving you a bit of an insight into the Australian health system and some of the work of the ACCC. My colleague, Bruce Cooper, will go into details about some of the other aspects of what I will be talking about in a general form.

We have brought forward material to assist our colleagues at the Department of Justice and Federal Trade Commission, which I will be leaving with them, to give or to flesh out in a little bit more detail some of the issues that I will not be able to go into to the level of detail that people would expect in terms of a more rigorous analysis in the time frames that we've got, although the question and answers might flesh out some of those issues.

For the last decade or so, Australia's total health expenditure as a proportion of the GDP has wavered around 7.8 to 8.3 percent of GDP. Australia's health care system is funded by the Commonwealth Government, that's our Federal Government, the state and territory governments, private health insurers, individuals as self-insured people, and other payers, such as compulsory

motor vehicle third party insurers.

By far, the greatest expenditure comes from the Commonwealth Government, the Federal Government, in terms of 48 percent of all expenditure comes from the Federal Government. State and territory governments contribute about 20 percent of the expenditure, with health insurance funds funding ten percent of the expenditure, and individuals and other non-government agencies contributing the remaining 22 percent in various levels.

As most of you would be familiar, Australia, like the U.S., is a federation. We have a federal system in which the Commonwealth, as I say, has the bulk of the responsibilities and the states and territories have a substantial responsibility, as well. As I suspect you won't find particularly surprising, politics plays a significant role in funding issues and delivery of health care systems, and what we have in Australia is an agreement between the Commonwealth, on one hand, and the states and territories on the other hand, especially dealing with the Medicare funding.

This is part of the Commonwealth Government's funding in terms of the 48 percent, but the delivery of a lot of the services are done through the state hospitals, governed by state regulation.

So whilst it's the public side of our system

that I am talking about at the moment, politics does play a key role and a five year agreement has, just this year, in 2003, been signed up between the commonwealth, on the one hand, and all the states and territories, on the other hand.

But, again, just to give you an insight into the sort of issues that keep arising in the Australian health care systems, I've brought forward a copy of the Sydney Morning Herald from Australia, where the New South Wales Government, following the signing of the Medicare agreement, to use the short language on it, took out, as you will see, and I will have this available, a full-page ad talking about how what the Commonwealth Government, the Federal Government, has done has shortchanged the people of the State of New South Wales and how the health care is now at risk because the Federal Government isn't sufficiently funding these issues.

I don't believe for a moment that there is going to be any major surprise to you in relation to all of this. The clash between the level of funding that the commonwealth provides, on the one hand, and the states and territories, on the other hand, is a perennial issue.

It is exacerbated at the moment, in some people's eyes, because the Commonwealth Government has spent an enormous amount of money, taxpayers' money,

subsidizing the private sector.

So Australia has a dual model, the private sector model, as well as the public sector model. The Commonwealth, the Federal Government, has brought in various incentive payments and programs which are going to help subsidize the private sector model, to encourage people to take out private health insurance, to the tune of 30 percent.

So there is a 30 percent rebate for all Australian's who take out private health insurance.

So not only is the Commonwealth Government funding the public sector, it has a substantial interest in the private sector, to the tune, as I say, of at least 30 percent in terms of rebates to members of the community to take out private health insurance.

What that likewise tends to see happening in Australia is an ongoing, but, in my view, an unproductive debate about which is the better system, the public system or the private system. So we have both sides, obviously, wanting to defend and grow their side or their part of the system, the public sector calling for greater funding of the public sector, the private sector believing that it is contributing enormously to the pressures on the public system, and, therefore, needing to survive and grow to ensure that the public sector can

likewise survive.

The debate is an ongoing one which doesn't get resolved, as I'm sure was the case in many other countries around the globe.

What it does mean is for an antitrust agency, like the ACCC, there are issues in terms of what our role is in the health care system. By way of context, can I also explain that the application of our antitrust laws, the Trade Practices Act, the competition laws, to the health care system was really put beyond doubt only as recently as 1996.

Prior to that, for constitutional reasons, the Federal Government, which enacted the antitrust laws, because of its constitutional powers, did not have reach over non-corporate organizations, as I say, for constitutional reasons.

In 1996, through the implementation of a national competition policy, the states and territories signed up to a package of reforms that ensured that all businesses in the health care sector, including physicians operating their businesses, whether they be through corporate entities or non-corporate entities, were covered by the competition laws of the country.

Effectively, the states and territories mirrored the competition laws in Australia and applied

them as state legislation, but enforced and administered by the ACCC, the federal agency.

So it was effectively conferring power, state power onto the federal agency to enforce that legislation and compliance with it.

So in the last seven years, one would like to think that all jurisdictional issues about the application of competition laws to the health care sector have disappeared. I'm not a 100 percent convinced of that yet, but I don't think some of the jurisdictional issues or some of the arguments of it being tested; in particular, the effectiveness with which the states can confer power on the federal agencies like the ACCC.

But leaving aside those sorts of legal issues, which is not really the purpose of today's presentations, more just by way of background, one of the other things that I wanted to highlight is that in the upcoming year, 2004, Australia will be heading to a federal election.

The information that we are receiving on a regular basis, and, again, I will leave a copy of one example of it, the Australian Health Care Summit in 2003, which was, in many respects, a unique summit of various interested parties in the health care sector, the physicians, the hospitals, the health insurers, and the state and territory governments, all involved in trying

to get focus on health care reform in Australia onto the federal agenda, and, hopefully, as part of the agreements that were signed up, they didn't succeed in getting the reforms that they were seeking as part of the agreements that were signed up.

However, it is quite likely that the issue of health care reform will form a substantial part of the platform of both parties as we go into an election in 2004.

There is a belief in many quarters in Australia that the Australian health system is in need of radical surgery and reform, unlike the sort of reform it has seen certainly in the last decade to 20 years.

With all of that background, because I am now going to some of our roles as the ACCC in the health care system.

Given that we've only had universal application of these laws since 1996, the first thing that the ACCC sought to do was to try and educate and inform the health care players at the application of competition laws to their sectors.

That educative guidance was readily embraced by some. I wish I could say most, but unfortunately that's not the case. And as with, I suspect, many parts of the world, there wasn't a great willingness to believe that

competition law had anything really much to offer the health care system in Australia at all.

It was more an issue of concern as to why competition laws were applied to the health care system, and, in particular, to the medical profession or other professional, health sector professionals in Australia.

So the Commission has spent a long time explaining to those in the health sector the benefits of the application of competition laws to their sector whether their obligations are and what the benefits of the application of those laws are.

The end result, however, has still seen, in particular, the medical profession, seeking to exempt themselves from the antitrust laws in Australia. The crescendo came following a couple of enforcement actions that the ACCC has undertaken. So let me develop that historically.

As I said, the ACCC's focus was education and guidance. In the early years, we went around to all the states and territories trying to educate all aspects of the hospital sector, the private health insurance sector, the medical profession.

Sorry. One other thing I should say. In terms of pharmaceutical benefits in Australia, that is provided through the public system. So it is part of Medicare.

Script items are very heavily subsidized and to the tune of zero dollars, in many respects, for most prescription items. So that is a position in terms of pharmaceuticals. In the Australian system, it is part of the public system itself.

There are more and more items there falling off that public system, to fall onto private scripts or not being part of the system at all and out-of-pocket expenses, but by and large, pharmaceutical benefits in Australia are covered through the public system.

Sorry. Back to the story. The education worked, to a degree. The Commission realized, however, that it was not being taken seriously. In many respects, the colleges, for example, took the approach that in Australia, education of medical specialists is done through the royal colleges, whether it be of surgeons, physicians, dermatologists, whoever else, whatever other specialty they might be, including general practice, which is regarded as a specialty in Australia.

The reaction from most of the colleges to the application of competition laws to their sector and to their lives and their work was to simply ignore us, in the belief that this was some economic rationalist policy agenda that will disappear, just a passing fad that will go away in a little while.

So whilst some of the colleges took our approach for assistance seriously, most of them reacted by telling us to go away, perhaps some not quite as politely as that. So that was in relation to the colleges.

Most of the associations, likewise, saw no role for the ACCC in their particular sector. The end result from the ACCC's perspective was to get the message home that these laws are here and they are here to stay and that the Commission will enforce these laws. We had to beef up our enforcement program.

The first case that we took was a price fixing cartel against the Australian Society of Anesthetists in the State of New South Wales.

The allegation was that the Australian Society of Anesthetists and a number of the key individuals within the association had threatened a number of private hospitals in Australia that unless they were willing to agree to the payment of $25 per hour on-call allowance for those anesthetists to be available to service those hospitals after hours on an on-call basis, they would not receive their services, and it was an agreed amount of $25.

The hospitals had no discretion to vary the amount. It was effectively being imposed through the

Australian Society of Anesthetists, although being undertaken at the individual hospital level.

The end result of the case was that we did get undertakings from an -- and our enforcement process happens through the court processes, as is the situation in the United States.

The end result was the Australian Society of Anesthetists and various of the individual anesthetists undertook to the federal court not to engage in that conduct again. The message had got home. They paid our costs in terms of the -- contributed to our costs for the enforcement action.

The publicity ensured that the message got out, and that started us on this rocky road of whether or not medical specialists or medical practitioners should be subject to the antitrust laws.

The second case that the Commission took was against the three obstetricians in Rockhampton, a provincial town in the State of Queensland, on the east coast of Australia, where the Commission had alleged that the obstetricians had got together and arranged a boycott of the private health insurance sector in terms of no gap funding arrangements.

Again, it was hotly contested. As far as the AMA was concerned, this was the end of the world, as they

knew it, and rural Australia would see no further medical practitioners going to the rural regions in Australia if this sort of enforcement heavy-handed approach, so called, continued from the ACCC.

The end result, again, was declarations of the conduct that the obstetricians had breached the competition laws, injunctions restraining them from engaging in that conduct again, and refunds, because in this particular case, what had happened was that some 200 women who had been told by their obstetricians that they would be treated under no gap arrangement processes with health insurers were subsequently told because of the result of the boycott, that they would now have an out-of-pocket expense varying from $200 to $800 per individual or family.

Some were told a couple of weeks before they were about to give birth, notwithstanding that they were under the impression that they would have no out-of-pocket expenses all the way through their treatment.

So there was something like $95,000 in refunds that the obstetricians had to provide as part of the settlement process. Again, no issue of penalties.

The Commission did also take enforcement action against a doctor who was part of a lease arrangement in a shopping center, imposed on the owners of that shopping

center an obligation to ensure that any other doctors that set up in competition with his practice in that particular center, professional center, would not be able to engage in bulk billing.

Bulk billing in Australia is an option that medical practitioners have, which, if they engage in, will mean on out-of-pocket expense for the consumer. The doctor is effectively willing to take the amount of rebate that the Commonwealth Government, the Federal Government provides for consultation as full payment for his or her service for seeing that consumer.

Because the Medicare rebate levels haven't increased over a period of time, medical practitioners have been very concerned about the level of rebates. So bulk billing is on the decline in Australia.

Whilst as far as the ACCC is concerned, individual doctors have a choice whether or not to bulk bill, the imposition of that will on competitors by any means such as the one that was employed by this particular doctor in breach of the competition laws was something that we weren't willing to stand by and see happen.

Again, declarations that there was a breach of the competition laws and injunctions restraining the individual firm and the doctors from engaging in their

conduct, again.

The Commission did seek penalties against the Australian Medical Association in a case that we took in western Australia. The Australian Medical Association in western Australia consented to the breach of the laws at the time. They had penalties of some $240,000 imposed on them, $10,000 on each of the two, the president at the time and the CEO at the time.

That case, however, was fought by the people with whom they engaged in a price fixing agreement, namely, the hospital, and the Commission was put to its proof in terms of proving the case.

We were relying heavily on testimony from the doctors, who had, in fact, consented to the fact that they had breached the competition laws. However, the judge and, I should say, the doctors' testimony, in some respects, was changed at a very late stage in the proceedings, in one significant sense.

In fact, the morning of the day on which the particular doctor was giving evidence on behalf of the ACCC, the evidence was changed very significantly. The end result was that the Commission was not able to establish the contravention against the hospital.

So we have the odd situation where the Australian Medical Association had consented to a breach

of the competition laws, the Commission, put to proof in respect of establishing that contravention against the hospitals, being unable to do so.

As a result, the injunctions against the Australian Medical Association in that case have been dissolved or are in the process of being dissolved, as well.

The point of highlighting the enforcement actions was to highlight, also, the incredible power that the Australian Medical Association has at the political level. As a result of these enforcement actions, the Australian Medical Association lobbied intensively to gain exemption from the antitrust laws, so much so that the Prime Minister of Australia announced an inquiry into the application of the competition laws to the medical sector. That inquiry was conducted, and this is a copy of the report which I will be leaving with colleagues at the FTC and the Department of Justice.

It found no case made out for an exemption from the antitrust laws, although it did find a case for the ACCC to better educate the medical profession, to help them better understand the application of these laws to their sector.

But it's just a nutshell, I guess, of a history of how application of the competition laws to the medical

profession in particular has led to a huge political roller coaster ride in Australia for some time.

The end result of that report has been the announcement by the Prime Minister and the Treasurer of a consultative committee, comprising of the medical profession, an independent chair, independent of the ACCC, and ACCC representatives to further ensure that the medical profession has a better understanding of their obligations dealing with the application of competition laws.

One other aspect that I wanted to touch on in a general sense, because it differs quite significantly from the American context, is that in Australia, the ACCC, the antitrust authority has the ability to exempt, on a case by case basis, particular forms of conduct from the competition laws.

It is known as authorization. The statutory test that the ACCC is obliged to apply is whether the public benefit of the conduct that parties want to engage in, which may be at risk of breaching the antitrust laws, whether the public benefit of that conduct outweighs the anti-competitive detriment of that conduct.

It's a public process. It applies to every sector of the economy, including the health care sector, and it allows the Commission, in certain circumstances,

to exempt conduct or to confer immunity, shall I say, from suit for that conduct for parties engaging in the conduct.

There have been a number of applications in the health care sector. A number of hospitals have applied for collective bargaining against health insurers in respect of this sort of conduct. They are dealt with on a case by case basis.

Some have been allowed, some have been declined. Again, Bruce will give you a couple of specific examples in relation to that.

There have also been a couple of significant applications, one in respect of what was known, or potentially known in terms of price fixing at tiny little practices in suburban or metropolitan or rural, for that matter, Australia. So if we have the local medical practice of individual doctors all combining to provide a one-stop shop, agreeing on the fees that they charged, there was an issue as to whether or not that might amount to price fixing at that sort of localized level of three to five to ten doctors and, therefore, bring them under suit from the ACCC's perspective.

The Commission didn't see this as a major competition issue and has granted authorization for that conduct across Australia to, again, provide the sort of

protection that the medical profession was looking for in terms of the application of these laws.

The more substantial and significant application for authorization, however, that I'd just like to touch on is an application by the Royal Australia College of Surgeons, who are involved in the training of medical specialists, surgical specialists in Australia.

They are also involved in the recognition of overseas trained specialists, specialist surgeons, to enable them to be able to practice in Australia.

Regulation is dealt with at the state level. To be able to practice medicine in Australia, you have to be registered with a state or territory medical registration board or medical board.

The board itself doesn't have the expertise to determine whether you're not suitably qualified. It effectively outsources that to the College of Surgeons. The College of Surgeons makes an assessment of overseas trained surgeons and makes a recommendation to the board, which invariably it follows, because it itself doesn't have the expertise to engage in that exercise.

There has been a huge outcry in Australia both from local trainees trying to get into the medical profession, for example, in this context, the surgical specialty, and, also, from overseas trained surgeons

trying to get recognized to be able to practice medicine or surgery in Australia.

The end result, particularly in relation to orthopedic surgery, has been criticism leveled directly at the College of Surgeons for the tight control that it has retained on who it will recognize in terms of overseas trained surgeons and the limitation on the number of training places for locally trained surgeons.

Australia, probably unlike the U.S., also engages in this workforce advisory context for the government seeking advice, given the significant public interest -- sorry -- the public sector funding of the health care sector in terms of not wanting to open up the medical profession to every person that might want to seek entry into the profession because of the concerns about supply or induced demand, the belief being that if they have an oversupply of practitioners, this will enormously increase the bill that the Federal Government has to foot, because the specialists will generate their own demand by virtue of their existence of an oversupply of the practitioners.

That is one of the main factors that has led to workforce advisory committees being set up to advise governments in terms of the number of training places to control the level of entry into Australia for medical

specialties.

The College of Surgeons' role, not being covered by legislation, is open, as I was saying, to our scrutiny. We have scrutinized it. The College of Surgeons applied for authorization of their training processes in terms of the role in selecting the number of trainees in any particular state or territory, the number of hospitals, because they actually have to accredit training posts within a hospital before a trainee can actually be recognized as fulfilling a recognized training role within that hospital.

It also has an indirect role in where those training positions are going to be distributed around Australia.

Those issues were issues that were of concern to the ACCC. We have issued a determination in writing authorizing the college to engage in the conduct that it has been engaged in, however, with substantial reform in terms of its processes, to open up the transparency and accountability of the College of Surgeons in the way that it's conducting the recognition process and the training of locally trained surgeons.

It will also allow the state and territory governments, which actually fund these positions, to have a more substantial input into where the training occurs

within Australia, particularly in terms of as recognition of a shortage of specialists in rural Australia, as well as the number of training places and ensuring that those places are, in fact, filled by the college.

There have been instances where, notwithstanding recommendations from the government and government agencies, that a particular number of training places need to be created in a particular sub-specialty, for example, orthopedic surgery. The college has refused to fill that number of training places.

Again, is the college accountable for that refusal to fulfill that number of training places and how is the college going to be accountable? Those are all the sort of issues that are dealt with in our authorization decisions, authorizing that particular form of conduct, as I say, with greater accountability and transparency.

That is really an overview, I guess, of the application of the competition laws in the Australian context. I'm certainly very happy to develop any of these sorts of issues in more detail as we get along to the question and answer processes, but I hope that gives you a bit of a broad framework from which, I guess, Bruce can build on to some of the specifics.

Thank you.

(Applause.)

MS. MATHIAS: Thank you. And next we have Mr. Cooper.

MR. COOPER: Thanks, Sarah. I would also like to thank you for the opportunity to participate in these hearings. I have already found the discussions here today with various parts of the FTC and the DOJ very interesting. So thank you.

One of the similarities between our system and your system, I think, it's obvious that there have developed a number of markets within the industry and it is necessary to analyze those individually when you're looking at competition issues.

I would just like to focus, in my comments today, on a couple of issues that are arising in only a few of those markets, but, in particular, the market between the health insurance funds and consumers in the provision of a health insurance product, and, also, the market between the health insurance funds and hospitals in relation to what we call in Australia hospital purchase provider agreements, which you have a number of equivalents here, I believe.

I would just note, in passing, though, that from discussions yesterday, it's quite clear to me that the market between insurance funds and doctors is

substantially less developed at the moment in Australia than it is here.

One of the things that I was asked to comment on was how consumers inform themselves of issues in the medical field. One of the impediments to competition we see, at least in the market between consumers and health funds, is the information that consumers do or don't have. There's actually a lot of information out there. So consumers actually have to deal with perhaps an oversupply of information, but it's very difficult to compare the products of different funds the way the information is presented.

They're comparing apples with oranges and it makes life very hard. One of the initiatives that the Commonwealth Government had a few years ago was to encourage all the funds to introduce what I call a key features statement, which is effectively a standardized brochure that provided, in a simple form, information about the fund's products in a way that made it possible for the consumers to compare the products that were on offer.

And one of the interesting things to note is how little utilized that has been, partly because it's just not simple enough and partly because the funds aren't actually making them very easy to find.

I tried this morning actually to get from three of the biggest health funds in Australia, to get their key features statement from their website so I could show you an example. I couldn't find it on any one of them.

So they're not making it obvious.

Another issue for consumers is unexpected out-of-pocket expenses, and we've actually seen a number of the regulators in Australia get a number of complaints about these.

One of the things that I was also asked to comment on was whether consumers were asked what inquiries they were making of funds or hospitals.

It is not something that comes naturally, I think, in Australia, where we've had such a long tradition of publicly provided health services, and although funds now encourage their members to inquire what their entitlements and refunds will be in relation to a particular procedure before they go into the hospital and have the procedure, that's not happening automatically and it's something that continues to lead to problems.

I don't know whether you have an equivalent here, but the funds and the government are in the process of developing a system of electronic linkages between each of the funds, the hospitals, the medical specialists

and the government, that will allow a patient and a doctor to assess the health insurance status of a patient at the time of the consultation and admission and that will allow an electronic testing, if you like, of what benefits will be available.

I was actually asked to comment on whether there were any competition issues with the introduction of this electronic system. Although we didn't -- we see it actually as providing a really good opportunity for better informed financial consent for consumers in Australia and although it's six months off even in testing, it's something that I think will be a good initiative.

Another thing I would just like to comment on is how consumers inform themselves about the various products that health funds do offer and unlike in America, where there seems to be a predominance of employer provided insurance, in Australia, it's largely a private matter. You organize that yourself.

So funds advertising directly to consumers is a common thing. I think there has also been some research that indicates that in a lot of other markets, consumers are reluctant to change their funds once they are in a fund and I think sometimes that has led to some over exuberance in advertising from the funds of extravagant

claims and special deals, which have come to our attention, and I might just mention a couple of those cases.

Sitesh has mentioned the government recently introduced incentives private health membership. In 2000, there was concern that they needed to reduce the strain on the public health system by increasing the proportion of the population who held private health insurance, and they did that in two ways.

There is the carrot approach, which is the 30 percent rebate that Sitesh has mentioned, and, also, a stick approach for people who don't join funds now before they're 30 in Australia, there is an incremental increase in their policies for each year after 30 that they join.

So if you join at 31, you get a small penalty. If you join at 45, then you've got a big penalty. That has had the effect of increasing participation rates in Australia from about 30 to about 45 percent of the population.

And even over the last three years, that has started to trickle off a little bit and just started to drop below 45.

Also, as Sitesh noted, the interesting side effect of that is now the government has a very direct interest in the cost of private health insurance and has

started to see that they've got a lever on how private health cost premiums go up or down and what those insurance contracts cover.

I might come back to that, because it's quite interesting. The government, on the one hand, doesn't want to be seen to be over-regulating; on the other hand, every premium they pay 30 percent of. So they've got this conflicting role there.

Anyway, I'll come to a couple of misrepresentation type of cases. At the time, the funds were campaigning very heavily to get this influx of new members that were expected and our biggest health insurance fund made a number of or we are alleging that they made a number of claims that were misleading and deceptive.

In May and June, they advertised that the premiums wouldn't go up during the calendar year. In fact, they went up in July, in some cases, by quite a substantial amount.

They also said that anybody who transferred out of an existing fund into their fund would get a month free and there was no qualification apparently to that. When you did ask for that, there were significant qualifications and limitations that meant that it really wasn't an offer like that anyway.

And at the time, apparently, they attracted an additional 100,000 members. In the Australian market, that's a lot. And they have actually suggested to us that if they actually honored the representations they made, it would cost them up to $19 million.

So we commenced proceedings against them and they are ongoing. It's been a difficult case. And just let me mention the remedies as an aside, because they are quite interesting.

In interlocutory proceedings and strike-out application, the court confirmed that the ACCC couldn't obtain compensation for affected consumers unless those consumers were parties to the proceedings, and there are up to a 100,000 of them and a class action for that amount of money was just not viable.

So we are now seeking a specific performance tort remedy under a different section and that's a little bit uncertain as to how we might go on that, but that is something that we'd like to test.

Other things we are seeking are injunctions, obviously, that they don't engage in such conduct again; declarations that it was a breach of the law; and, corrective advertising.

Another two things also we're engaging in sort of similar tort conduct, where they advertised with very

vivid images of pregnant women and one them implied and the other one specifically said that free delivery, no matter how advanced your pregnancy is, and there was a disclaimer down at the bottom about -- that said a 12-month waiting period applied.

But it was just so counter to the representation and the image that we commenced proceedings in both of those cases, too. One settled. The other was contested and we won on the liability issue and got a remedy that they have corrective advertising, and that actually appealed the decision in writing of the corrective advertising, because they say, well, corrective ads two years after the original representation, what does that mean, it's stale, you shouldn't have made that order.

So that is also -- the appeal has been heard, but no decision has been handed down on that one yet.

So that's enough about consumer protection. I might just turn to some of the collective bargaining issues that Sitesh has raised, briefly.

Sitesh mentioned, if we look at the market between hospitals and doctors, doctors are a very strong lobby group in Australia and Sitesh mentioned that, and Sitesh mentioned the sort of general exemption from the Trade Practices Act and, at a federal level.

At a state level, where they don't have the sort of depth of competition law that we do, there has been some backsliding and, in fact, there's, in the ACT, which is the head of the ACCC, is the government now has specifically or has passed laws that specifically allow doctors to engage in collective negotiation with hospitals, and that law basically makes them exempt from the Trade Practices Act and takes that outside our jurisdiction, and there is talk about that happening in other areas, as well.

So just if we go back to the health fund/hospital market, Sitesh also mentioned there have been a number of applications for authorization in that market for collective bargaining.

The hospitals argue that, well, if we collectively negotiate, there will be benefit, because, A, there will be the reduced cost of overheads, because we're not all negotiating individually with health funds, and that is going to translate into lower costs, and, therefore, lower premiums and public benefit.

There have been two recent applications, as I said. One we have refused and one we have granted what you call an interim authorization, which is where we say, yes, we'll consider it a little bit further before make a final one.

Where we granted an interim authorization, there was a group of seven hospitals that were all owned by various orders of the Catholic Church and they sought collective negotiation -- the ability to collectively negotiate both in relation to hospitals and in relation to suppliers -- and we looked at them a little bit differently.

The hospitals are all in different geographic locations and, in fact, the hospitals argued, well, look, they are so geographically dispersed, if we ask you to merge, you wouldn't say no, so let's just let us collectively negotiate.

If I just look quickly at the collective negotiating, they also asked for collective boycott rights and we said, yes, you can negotiate and boycott in relation to suppliers, but you can only negotiate collectively in relation to health funds, and that sort of shows the distinction between the way we looked at the two different markets.

The distinction, I guess, is that in relation to negotiation with suppliers, the Commission thought that a joint purchasing network would never form a large part of that market, whereas in relation to the health funds, it could in particular areas.

So the one that we have given interim

authorization to is contrasted with the way we refuse and there were, in that case, only three hospitals, but they were all in the inner Sydney area. So they were in the same geographic location and the Commission saw the opportunity for a significant competitive detriment in those circumstances, and so refused.

It is interesting, though, just drawing a conclusion, to note that since the Commission granted the interim authorization, there have been a number of comments that indicate that perhaps the anticompetitive detriment of having a group of hospitals negotiating with funds may be higher than we first thought.

Some hospitals, if you like, must have, for various health funds, if the health fund is to be able to offer an attractive package to customers, for instance, there might be the only hospital in an area, only private hospital.

We've got the northern territory, which is a vast area, has only one private hospital. There are also parts of Sydney where some hospitals have specific specialties that have then greater sort of power in bargaining.

And although, as I've just sort of demonstrated, those hospitals can have power on their own, if you put them in a group, you can gain quite a

degree of leverage. You could imagine a situation where a health fund would be feel obliged to offer a contract to a hospital it did not otherwise wish to deal with or it may feel it has to offer higher prices across the board just because one of the hospitals in the bargaining group was one of those hospitals that had a significant degree of power.

And we've got a situation at the moment where, in this northern territory hospital, they have asked for a significant rise in what they are charging one particular health fund.

The health fund said no and it's gotten to a situation where the negotiations are now finished, but it's alleged that the hospital is encouraging all the members of that health fund to leave that health fund and move to a fund with which that hospital has a contract in order that the hospital gets the benefit of the higher prices from those other funds.

So you can see that where those issues of power exist, there is quite a significant opportunity for one hospital alone, let alone a group of hospitals, to manipulate that power in a way that we perhaps need to take into account in this authorization application.

So with that, I will close.

MS. MATHIAS: Thank you very much.

(Applause.)

MS. MATHIAS: Dr. Liu, Cecile will get you started on the laptop.

DR. LIU: Thank you. Ladies and gentlemen, it is a great honor and pleasure once again for me to be here joining this hearing.

During this session, I would like to introduce you to the competition law and policy applied to the health care market in Taiwan. The presentation includes three parts.

One is the introduction. Number two is the related cases, and number three is the conclusion and the major works in the future.

There is Article 1 of the Fair Trade Act. The purposes of the law are to ensure the older indigenous transactions, the interest of the consumers, and the fairness in competition, and to promote the stability and prosperity of the economy.

Therefore, the Fair Trade Act should be regarded as the predominant or underlying economic law in Taiwan and is applicable to all trades and all kinds of business transactions.

Moreover, according to Article 46 of the Fair Trade Act, the Taiwan Fair Trade Commission thus implements the Fair Trade At to some specific business

practices, not only focusing on competition issues, but also taking into consideration industrial policies by other relevant competent government agencies, so as to ensure the proper implementation of the Fair Trade Act.

Regarding the health care industry, the competent government agency is the Department of Health, DOH, which is in charge of the nationwide health related matters.

The DOH manages the establishment and expansion of medical organizations, the standards that are used for medical fields, the transfers of patients from one hospital to another, so as to ensure that the development of medical organizations and the reasonable distribution of medical resources, and to enhance the quality of medical treatments.

The main laws and regulations governing health organizations and medical practices are medical practice law, standards governing the establishment of hospitals, and the Physicians Act.

In addition, to promote the health of the citizens, national health insurance has been implemented since 1995, according to the National Health Insurance Act.

Most of the citizens are under the coverage of the national health insurance, which has been a mandatory

insurance in nature.

The sole insurer of the national health insurance is the Bureau of the National Health Insurance, BNHI, which pays most parts of medical expenses to medical organizations.

In order to control the expenses paid to the medical organizations, BNHI applies global budgeting by which the maximum amount paid to the hospitals has been set.

The patients, therefore, just only need to pay the registration fee charged by medical organizations and the minimum self-pay bills regulated by the BNHI.

Since the health care market and the national insurance market are both under the management and regulations of the DOH and the BNHI, the Taiwan Fair Trade Commission takes into consideration of these competent government agencies' opinions and the related laws and regulations to handle competition cases for the medical industry.

Related cases. Now, I would like to give a brief description in the aspects of concerted actions, mergers, and vertical restraints of the health care market.

Concerted actions. According to Article 7 of the Fair Trade Act, concerted actions are generally

banned. In order to prevent enterprises from using the trade association meeting to set up agreements to limit the business activities against other enterprises in the trade.

A fourth paragraph was added to Article 7 when the Fair Trade Act was amended in February 2002. Therefore, if a resolution of a trade association meets the aforementioned description, such resolution will be regarded as violating the fourth paragraph of Article 7 of the Fair Trade Act.

A case handled by this Commission was the concerted action of the Kaohsiung City Medical Association, KCMA.

In the members meeting of the KCMA on April 8, 2001, the subject of clinics are required to be closed on every other Sunday. What is discussed? And the following explanation was given.

While most of the hospitals have raised their registration fees, clinics need not charge patients a registration fee, no self-paying parts under the national insurance system. Such vicious competition will be bad to physicians.

Later, the proposal was passed on to the board of directors and overseers of the KCMA. The board had a discussion among it and a resolution was passed.

The members are required to be closed on two Sundays per month. The city will be divided into two areas, the northern area and the southern area. Clinics in the southern area will be required to close on the first and the third Sundays in each month and the clinics in the northern area will be required to close on the second and fourth Sundays in each month.

If there is a fifth Sunday in a month, all clinics may decide of operating or closing by themselves. It was decided that the resolution would be started from February 2002. In the next members meeting of the KCMA, the resolution was reviewed and was passed again, and it was decided that the names of the clinics not adopting the resolution would be disclosed from May of 2002.

The penalty of such violations were to be discussed and set up later. However, the Taiwan Fair Trade Commission cut such action before it was carried out and the penalty could be set up.

The Taiwan Fair Trade Commission consulted a case with the Department of Health and Department of Health, Kaohsiung City Government, before the investigation.

The DOH and the DOH/KCG expressed that such matter is related to the internal management of the medical organizations and should be decided

independently. Therefore, since the mandatory closure decisions by the KCMA would result in the decrease of medical services, the TFTC believed that the matter should be investigated.

In the resolution reached in a meeting of the Taiwan Fair Trade Commission on November 21, 2002, the requirement of the mandatory closure on every other Sunday imposed by the KCMA was in violation of the first paragraph of Article 14 of the Fair Trade Act.

The law says no enterprise should take any concerted action and such a requirement should be lifted. After the KCMA received the decision from the TFTC, the KCMA notified its members in writing that the requirement was lifted and all members were allowed to set up their own business hours according to their needs or operation conditions.

Mergers. According to Article 6 and 11 of the Fair Trade Act, merger comprises five types and if a merger meets one of the thresholds, such merger should be filed through the TFTC before it is started.

Regarding the pre-merger filing thresholds, the terms market share and shares mentioned in the Fair Trade Act apply to medical industry will be derived from the amount paid from the NHI, National Health Insurance, to the clinics.

The number of medical doctors and the number of hospital beds. There has not been any merger meeting the relevant conditions or thresholds in the medical market. In addition, the Taiwan Fair Trade Commission has started to concern itself with the mergers related to topics matters in the medical trade.

The Taiwan Fair Trade Commission came up with the following analysis regarding the possible merger modes, such as strategic alliance and group purchasing and their relationships with the TFTC.

Strategic alliances. Such strategic alliances is a general term in the medical market or all markets, but there is no such term in our law. In order to determine whether a strategic alliance breaches the Fair Trade Act, we have to take a close look at its nature and actual content. Such alliance may have nothing to do with competition and set up to treat illnesses, such as diabetes shared care network.

In the strategic alliances, all members are owned and managed by the same entity or that members are owned by different entities, but managed by the same entity.

It would be likely that such strategic alliances are under merger control and could violate the Fair Trade Act.

Group purchasing. Group purchasing is a type of strategic alliance, but maybe in different forms. A group purchase of several organizations owned by the same entity is unlikely to breach the Fair Trade Act.

In order to determine whether a group purchase of several organizations owned by two or more entities negatively affect the market, we have to look at the respective geographical locations, the content of the purchase, the market status of the organization of such group purchase, and the market status of the supplier.

If the result indicates such purchase does negatively affect the market, the Fair Trade Act will become applicable.

The Taiwan Fair Trade Commission has taken a close look at the Christian Health Care Alliance, CHCA, group purchase of expendable medical supplies.

The CHCA comprises 35 members that are in a competitive relationship with one another. Such group purchase might constitute a breach of the Fair Trade Act.

In a case, only 28 hospitals participate in the tender, and they represented less than 5 percent of all the beds in this country. Therefore, the inference exerted by the members of the CHCA on the market was quite limited and it was inferred that such group purchase did not significantly affect the market of the

expendable medical supplies.

The group purchase did not breach Article 14 of the Fair Trade Act.

Vertical transaction. According to subparagraph six, Article 19 of the Fair Trade Act, no enterprise shall lessen competition or to impede fair competition by limiting his trading counterpart's business activity by means of the requirements of BG&E'S engagement.

Large hospitals used to enter condition or term of the purchase prices, may not hire then the ones sold to other hospitals or organizations in each stock purchase agreement.

After investigation, the Taiwan Fair Trade Commission found out that large hospitals are the main buyers of the drugs and, hence, a single drug sale is at a disadvantage position with respect to these large hospitals.

If these sellers do not attend the purchase contracts from these large hospitals, such service will not be able to survive in the market.

In addition, a large hospital may use its advantage to lower the purchase prices of drugs in a purchase agreement and this action may force other hospitals, drug shops and clinics to buy the same drugs

at the higher or same prices.

The trading terms required by large hospitals causing unfairness in medicine market competition. The aforementioned action of large hospitals has been regarded by the Fair Trade Commission as a breach of paragraph six, Article 19 of the Fair Trade Act.

However, because the said condition has often been entered in the contract, the Fair Trade Act Commission decided to have a different approach; that is, requiring large hospitals to reduce and revise the condition and terms of their purchase contracts to meet the relevant stipulations and the requirements of the Fair Trade Act.

Conclusion and the major works in the future. National Health Insurance has been in place since 1995. That is four years later than the promulgation of the Fair Trade Act in Taiwan.

After introduction of National Health Insurance, hospitals tend to form groups to reach the economy of scale. The grouping of medical organizations would not exert significant inference on patients' rights to proper health care and costs, but a grouping buyer may have more bargaining power than the single buyer.

So it is possible that such group may use improper conditions or terms for its own sake to restrain

the seller's BG&E activities. It is also possible that the members of such group take up a concerted action. In order to prevent such group, we would probably exert an inference on the operation of the extreme medical enterprises and then cause a grouping of these medical suppliers.

It may affect the consuming public. The Taiwan Fair Trade Commission will keep a close eye on such grouping inference on the extreme medicine and the medical device enterprises in the future.

Thank you for your attention.

(Applause.)

MS. MATHIAS: Thank you, Dr. Liu. Mr. Purcell? And, hopefully, we can get the computer to work a little better. I do apologize, Dr. Liu, for the computer difficulties.

MR. PURCELL: Thank you very much, and good morning, everybody. Like my colleagues on the panel, I am delighted to be here. Unlike some of them, though, I really feel like a near neighbor. I only had to come 3,000 miles. In fact, it's not widely known that Dublin is about as far away from the east coast of the USA as San Francisco is. So in that sense, we are quite near neighbors.

As regards the subject matter, well, I really

thought we were unique in Ireland in terms of the problems that we have with our health care sector, but it seems we're not. We all face the same kinds of problems, it seems to me.

So in a brief time, what I want to try and do this morning is just to paint a picture of the Irish health care system and some of the competition issues that it throws up.

First of all, I'm going to say a word about the law in Ireland and the competition at our Irish anti-trust agency, that I am a member of.

I will follow that then with just the briefest of overviews about the health sector in Ireland and the split between the public and private elements of it.

Then I'm going to pick out just a couple of particular topics that I suspect are quite common around the world, and I will just finish up with some personal comments, I suppose, about where all this might be going certainly in Ireland.

In Ireland, the Competition Authority, which I am one of five directors of, is a public body established in 1991, which is relatively recent certainly compared to the U.S. experience, and both the law and competition and our functions are now codified in a very recent piece of legislation, the Competition Act of 2002.

Among other things, the 2002 ACT enhanced our advocacy function, as well as our merger control function and our investment and our enforcement and investigative powers.

So broadly speaking, we have basically four functions. First of all, we're responsible for the detection and prosecution of cartel offenses and related monopolization offenses.

Secondly, since the first of January 2003, all mergers above specified thresholds, regardless of sector, there are no exceptions, must be notified to and cleared by the Competition Authority, although there is a high court appeal, but we are the deciding agency.

Third, our advocacy function has been enhanced, and that is concerned with monitoring, just like all our colleague agencies, I guess, with monitoring and studying competition policy primarily in regulation markets and advocating the removal of unnecessary or disproportionate restrictions on competition, as well as monitoring and studying the operation of competition in mainly state regulation markets, I'll have to say.

The authority also advises government and government bodies and individual ministers of the government on both new proposals for legislation and the impact of legislation, on competition.

Then we have the final catchall function of carrying on such activities as we consider appropriate so as to inform the public. So we have a public education role in relation to competition.

The Irish health sector, I'll just bore you with one or two numbers and then move quickly along. As with everywhere else, I guess, health care in Ireland is an enormously important sector, not just from a social and societal point of view, but from an economic and fiscal viewpoint, as well.

In our case, in 2001, 6.5 percent of GDP was accounted for by health care expenditure, amounted to ten and a half billion U.S. dollars and climbing.

The vast bulk of that came from public sources. In other words, it is primarily a publicly funded system. In fact, it is such an important sector that it comprises over a fifth of all public expenditure or $2,300 for every man, woman, and child in the country.

How would you typify our system? It's a public/private mix is the way we like to put it. It purports to be an integrated public health system. These have been continuously criticized, mind you, and they could most kindly be described as confused, at best, and, at worst, unaccountable and inequitable. Not my words. These are well known criticisms.

In terms of coverage under the public health system, the population is broadly divided into two categories, two types of patient. Category one, who account for about 30 percent, 31 percent or so of the population, and category two, the remaining 69 percent.

Qualification for category one status is determined on the basis of income limits set by the government. No real surprise there, perhaps. So in general, people who can't, without undo hardship, arrange local medical practitioner services for themselves or hospital surgical services for themselves and their dependents are entitled to free access to local medical services, general hospital surgical services, and to free prescriptions, free medicines on prescriptions.

Also, since July of 2001, everyone over 70 years of age is also entitled to free coverage, regardless of income. Those who are eligible, incidentally, have a choice of doctor, choice of local doctor, and about 75 percent of all local general practitioners in Ireland have a mixed public and private practice.

As for the remaining 69 percent of the population, well, they must, in principle, pay for their own medical care, but there is lots of overlap. For example, category two people, yours truly, for example,

are also entitled to care in the public hospital system on the payment of a daily charge, and the charge for category two patients occupying a public hospital bed is less than $50 a day, and that is a lot less of the economic cost of actually providing the bed.

Also, category two patients can have prescribed drugs and medicines subsidized by the state under a number of community drug schemes. I suppose the most important thing to note, though, is that entitlement to free care under the Irish public health system does not equate to timely access to many medical and surgical services. Anything but, in fact, and therein lies one of the key problems that we face.

Despite the fact that we are a small economy, the organization of public health care is pretty fragmented. It goes back to 1970, the current setup, and it is based on a system of ten regional publicly funded health boards, each responsible for the provision of health services in their own catchment areas.

These services are delivered under three core programs; general hospital programs, in other words. Acute hospital services, in general. Surgical hospitals, special hospital programs, principally psychiatric and geriatric public hospitals; and, community care programs.

Community care programs are probably familiar

to most people in terms of prevention programs, home nursing, home help, midwifery services, and so on.

The health boards, whose membership is mainly political, at the local level, get their government funding through the national Department of Health, which is also responsible for the development of national health policy.

As well as the ten health boards, there are as many as 53 agencies, some autonomous, some not, each with executive powers operating at a national level with responsibility for administration, service delivery, and other regulatory functions. In fact, the level of non-medical personnel who operate in the Irish health system has often been severely criticized, with ratio of something like six or seven to one. There are more administrators, back office people, program people, and so on, many, many more than there are front line medical personnel.

Maybe we're not unique in that. I don't know. The funding of the Irish public health service is predominantly through general taxation, through people's income tax.

Of the remaining 20 percent, the bulk of that comes from literally out-of-pocket expenses incurred by users of outpatient services and inpatient care in public

hospitals.

Performance of the Irish public health service has been strongly criticized over the last number of years, mainly on the grounds that it's not delivering value for money. So what's new, you might ask.

Since 1997, public spending on health care has increased by about a 125 percent and yet the popular perception is that the quantity and the quality of medical services provided has not improved. In fact, it's gotten worse, according to several people.

Certainly, public waiting lists are still long, very long in some cases. There are anecdotal stories of people, many of them elderly, spending up to three days on trolleys in emergency rooms waiting for admission to public hospitals or people waiting for five years for elective surgery for hip replacements or routine cardiac surgery.

In fact, there are even horror stories of people who are waiting two years to get on a waiting list, which sounds pretty horrible.

So a number of official reports over the last three years have pointed to very severe organizational issues and inflexibility as the chief causes of failure within our system, and the consensus is that radical overhaul of the system is needed, with emphasis, strong

emphasis on greater financial accountability and on the need to do something about the existing array of multiple agencies.

For example, with the creation of one single executive body in a country as small as Ireland, with responsibility for managing the system as a unitary service.

On the other side of the public/private divide, a sizeable private health sector has developed in Ireland. For the 69 percent of the population not fully covered by the public service, GP medical services, prescription drugs, and hospital service must generally be privately financed and funded either out of pocket or through private health insurance.

In addition to their limited entitlement under the public system, almost half the population have private health insurance coverage. However, unlike many other countries, there's very little competition in that sector. There are only two mainstream providers of health insurance. One is state owned, Voluntary Health Insurance Board, with almost 90 percent market share, because it was a statutory monopoly until about ten years ago, and the only major entrant, BUPA Ireland, a subsidiary of a UK insurer has the remainder.

The private and public sector systems are

entwined, intertwined at almost every level, with the same people often delivering services to both public and private patients, and, indeed, often in the same facility, and probably the main difference between public and private care seems to be speed of access to that care, and most certainly not the quality of care, per se.

That has led to allegations that the Irish-held system is essentially a two-tier system. In that context, private insurance is often seen as a mechanism simply for avoiding the often long waiting lists for public care.

In other words, you can jump the queue if you've got private health insurance, but the quality you get is just the same. It seems rather inequitable, but there you go.

If you can pay, you get the treatment. That's the perception a lot of people have, or you certainly get it quicker.

So there are a number of perceived problems with our system. At the most general level, as I mentioned, there are questions about waiting lists, despite enormous increases in funding. Still excessively long waiting lists.

Medical inflation runs at about ten percent, way ahead of general inflation, which, in Ireland, is

still quite strong at four percent. It really has the potential to undermine the market for private health insurance.

One policy response to the problems of medical inflation and growing waiting lists has been for the government to buy medical services abroad because it can't buy them at a reasonable price in Ireland, even within its own system.

There are questions about the ability of the health system to expand to meet growing and diverse demand for medical services.

There are also very strong questions, often asked by the Competition Authority, I have to say, about the role of the state, which often acts as the regulator, the supplier, and, indeed, in some cases, even the consumer of medical services.

Down at the individual market level, there are questions about hospital capacity. I mentioned the congestion in emergency rooms. There are concerns that competition and the provision of primary care is not as strong as it should be.

With collective bargaining between the National Department of Health and Children and insurance companies seeming to be commonplace, unfortunately, brings that out, the fact that the

minister and the government are involved tends to bring that beyond the reach of the Competition Act, and that is probably a familiar story.

There are also concerns that the prices paid for many services are totally out of line with those charged in other countries, most notably in relation to specific services like the MRI services.

There are issues in relation to medical professionals, issues about entry to professions, about demarcation between them and demarcation lines between them, and about pricing. Those questions are asked most often in relation not just to general practitioners and hospital consultant doctors, but also in relation to dentists and pharmacists and optometrists right across the board.

Speaking of pharmacists, whether the Department of Health and Children does well as a buyer of drugs on behalf of public patients is an open question. There are also many competition concerns in the retail pharmacy sector, and I will come back to those in a moment.

So just to pick a couple of topics very quickly from that long list, which I think you will agree is long, but it is certainly not exhaustive. Health insurance, first of all. Before 1996, as I said, the state-owned private health insurance company had an

effective monopoly.

That came to an end in 1996, but the new entrant still only has 13 percent. So not surprisingly, PHI is still dominant and competition is perceived to be weak.

Now, while, in principle, the market has been opened to competition, barriers to entry are significant. Potential barriers include the very system of regulation of the health insurance market itself, which is underpinned by the principle of community rating and open enrollment.

Combining these two, the implication is that private health insurance is guaranteed to all members of the community, should they choose to buy it, regardless of the health or risk status each individual presents. Furthermore, premiums are allowed to take no account of the risk characteristics of the insured.

Of course, it is recognized that that kind of health insurance system is potential unstable. In particular, new entrants have the incentive to cream skim low risk individuals from the incumbents.

To counteract that, a system of risk equalization is being instituted, although it's very uncertain as to precisely how that's going to operate.

However necessary risk equalization might be,

it undoubtedly represents a barrier to entry to the health insurance market, as, of course, does the uncertainty about how the whole scheme will operate.

While a separate authority, called the Health Insurance Authority, will actually administer the scheme, the government minister for health will still retain a degree of control and given that the minister is jointly with the minister for finance, the principal shareholder of the 90 percent private insurer, the minister, you might argue, could have conflict incentives. Leave that one there.

At present, BUPA, the 13 percent minority market shareholder, is in the European courts arguing that risk equalization transfers are a state aid and that they are, therefore, prohibited under the European treaty, the EU treaty.

The European courts haven't actually agreed with BUPA so far, but an appeal is currently in process.

As well as that the Health Insurance Authority is undertaking a study of competition, I'm glad to say, in the health insurance market just at the minute and will actually have to address this whole issue of risk equalization, as well, indeed, as the issue of privatization of the state-owned PHI.

Will it happen? Will it not happen? Well,

there are divided views about that. Some feel that PHI is actually too big to privatize as one private company and that a splitting of the company in two might be required if privatization were to go ahead, but the jury is out on that just at the moment.

In relation to hospitals, we've got a mixture in Ireland. The public hospital system is essentially organized as an integrated system and comprises both private and public elements. It is integrated in the sense that there is no purchase or provider split in the delivery of public services.

So even where ownership of the public hospital lies in the private sector, as is the case with many, which are called public voluntary hospitals run by religious orders primarily, services are delivered according to provider plans agreed with the Department of Health or the appropriate health board.

You could characterize it really by saying that the emphasis is really and has been to date on cooperation; that it is most certainly not on competition. Competition doesn't seem to be a recognizable concept in the hospital sector in Ireland, not even in the private sector, one might suggest.

As well as the public hospitals, there are, of course, a significant number of private hospitals. About

15 percent of total hospital bed capacity is privately owned.

Intriguingly, though, about 20 percent of beds in public hospitals have been designated for use by private patients, although that percentage is even exceeded regularly, probably closer to 30 percent.

So overall, about a third of hospital beds in the state are effectively available for private use. A particular competition issue in the hospital sector concerns the manner in which private insurance companies are charged for the use of public hospital beds by private patients. Specifically, insurance companies are charged less than the economic cost of providing the beds.

For example, in 2001, the cost per inpatient bed day in the major public voluntary public teaching hospitals was around $600 a day. Yet, private patients were only being charged $275, implying an implicit subsidy of private care from the public purse of $350.

So to the extent that the public hospitals charge below cost for beds used by private patients, private providers of hospital beds are competitively disadvantaged. The implication indeed is that the public hospital sector has probably inhibited the growth of the private hospital sector.

I will comment later on, if you wish, on some possible reasons why that is the case.

Moving along quickly to the pharmaceutical sector. There have been competition problems with that sector for many years. The retail pharmacy sector in Ireland is relatively unconcentrated, the biggest chain owning only about 4 percent of the outlets, the numbers of outlets nationwide.

Value of the market about $1.4 billion a year, or just under 1 percent of GDP. Pharmacies, of course, are considerably more valuable assets than other forms of retail outlet, reflecting their restrictive regulatory environment in which they operate and the ensuing rents to be made by incumbents.

We're all probably familiar with the three defining characteristics of the consumer medicines market worldwide. First of all, it's the eternal triangle. The existence of public or private health insurance coverage. This means that consumers' normal price incentives don't apply and, therefore, the normal drivers of price competition don't operate.

Secondly, the escalating cost of health care, particularly in relation to medicines, prompts governments to intervene by way of price or profit controls at various stages of the distribution chain.

This is probably the case in most countries outside the U.S.

Finally, the third leg of the triangle is somehow a myriad of non-priced regulatory interventions, such as controls on medicine, supply, and sale, as well as severe barriers to entry, chiefly by way of controls on ownership, establishment, and location of outlets.

The two most important barriers to entry are a chronic under provision of degree course places for the past 25 years, mainly and ironically, through the granting of a monopoly by the state on pharmacy education at 25 years ago to one university.

And, ironically, at the same time, a statutory restriction on overseas-trained graduates, including Irish students trained overseas, which effectively prevents them from ever opening their own outlet, strange, but true.

The most controversial restrictions affecting the establishment of pharmacy businesses introduced in 1996 to control the number and location of outlets was actually revoked in 2002, following a legal challenge to their validity.

Although there aren't any specific controls on ownership of pharmacy outlets in Ireland, there are some in several other countries worldwide, as we know. A

government-sponsored review has recommended that such controls on ownership be introduced, specifically that in each health board area, there should be a limit, a cap of eight percent of the total number of outlets in the ownership of anyone entity.

There may actually be some legal difficulties associated with doing that and the government hasn't moved on it yet and as you might expect, the Competition Authority is arguing strongly against it, with quite powerful lobby groups involved in the retail pharmacy sector in Ireland, on the pharmacy profession in general, like the medical professions, in general, I guess.

Under a longstanding agreement, government and drug manufacturers and importers fixed the import prices and maximum wholesale prices of the vast bulk of retail medicines in Ireland. At retail level, pharmacies charge routinely a 50 percent markup on medicine supplied to most consumers. That is in addition to prescription fees.

That practice has existed for many, many years and doesn't appear ever to have been explicitly agreed or altered or even challenged by the government.

The overall effect is that Irish pharmacies benefit from the highest overall retail margin on medicines in Europe, averaging 33 percent across the

board. Nice business. Good business to be in.

Finally, on professional regulation, the enforcement of competition law in respect of medical and para-medical professions is complicated by the fact that many of the restrictions on competition are bound up in public regulation and, therefore, risk going beyond the reach of direct enforcement mechanisms.

So the clear implication is that there is an expanded role for competition advocacy in respect of the professions involved.

In 2002, the Authority commissioned a wide-ranging consultancy report on competition in eight professions, including three in the medical field, medical practitioners, optometrists and dentists.

That consultancy report was published in March 2003. It is on the Authority's website. Quite a site, with a bit of work. Its preliminary findings indicate three basic classes of restriction on competition; restrictions on entry, restrictions on behavior and conduct, and restrictions on organizational form, none of which I guess may be any surprise to colleagues.

There are considerable restrictions on entry to the medical profession, some of them indirect and subtle in relation to under provision of education.

Shortage of doctors and consultants, when

combined with the inability of consumers to directly approach consultants, having to go through their GP first, we are going to have a special look at and we may recommend direct access being allowed to consultants in certain circumstances.

The second example: the amount of advertising that practitioners can undertake. Members of the medical profession are generally prohibited from advertising, certainly from comparative advertising, but nominally, any advertising at all, other than by a listing in the phone book.

This will have resonance for you. I'm sure they are also precluded from making any unsolicited approaches to consumers or potential users.

They are prohibited from advertising specialist expertise knowledge and even press advertisements are subject to certain size restrictions.

On organizational structure, both medical practitioners and dental practitioners are not allowed to practice through limited liability corporations or by way of multi-disciplinary practices.

So what are we going to do about it? Well, as we work through each professional sector which this consultancy report dealt with, we'll be publishing draft recommendations for public comment and then seeking

changes to existing practices, primarily by beating down the door of regulators and arguing for change.

We do publish everything we do, and try to stimulate public debates.

Government support for any changes that we propose is obviously crucial, but there is some sort of evidence of gathering interest and gathering public opinion and public interest in professional regulation and what lies behind it, that is what we find, and, indeed, increased interest by media, particularly the print media, which we find is very useful to encourage.

A key factor, of course, underlying everything that we try and do on the advocacy front is the principal of proportionality.

That is, only those public restrictions or regulations that achieve objectives in the most efficient and non-distortionary factor should be retained and where more effective and non-distortionary alternatives are available, they should be implemented.

So where do we go from here? I think the notion of competition is often, as far as health care is concerned, being seen as not relevant, in principal, because somehow it's the old health care is different debate, health care is unique.

Well, not for me it's not, I must say, and not

for the Competition Authority. In principal, it may be no different than if I leave my car in to have the brakes fixed. I'm putting my life, effectively, in my car mechanic's hands. The same happens every time I step on a bus or on an airplane. So the fact that medical professions are so-called dealing with people's lives and health doesn't make it unique. That's my view.

The second notion of competition being not relevant in health care is often put forward because markets don't exist or that the information asymmetries and principal agent problems are too severe. Well, there is something in that probably. The trick is to try and carve out some space for competition, wherever that space may be.

The third problem is that competition is not along, because public regulation may prevent it, and that is where the argument and the role of competition authorities in relation to advocacy comes in.

As well as our efforts in relation to competition in the professions, in the medical professions in particular, we are currently, a bit like the FTC and the DOJ, preparing a report on health care in general for publication, focusing on actual and potential health care markets and the role of competition in them.

Our attention is focusing really on the

following issues: collective action, although that may really be more an enforcement issue; pharmacy, pharmaceuticals, in particular, drug pricing, medicine pricing, and the retail pharmacy sector: competition in the professions, I mentioned that one; Health insurance. And there is one I don't have time to go into, but an increased incidence we see of public services actually being outsourced at a very micro level to private providers and very little evidence of competition being involved, even for tendering for those services.

The role and challenges of advocacy for competition agencies is really where it's at in relation to health care, as far as we're concerned. We're a small economy. It is very difficult to catch bad guys doing bad things, very hard to prove conspiracies, although we try and really we see the way forward in relation to health care and competition being one of advocacy.

Persuading legislature and policy-makers that the presence of markets and competitive pressures can improve outcomes for consumers; that public relation that confers market power on producers should be removed or replaced by less restrictive measures; and, also, more subtly, there is a need to stay up with the play, so to speak, particularly vis a vis professional associations and lobby groups, particularly difficult that in a small

economy, where everyone knows everyone else maybe.

There is a relatively easy access to legislators and to government ministers, for that matter. So the role of the authority, the role of the division that I had is to get out there and stimulate debate, whether at conferences or hearings like this or, most importantly perhaps, through being available to an inquiring public opinion and an inquiring media.

I have tried in a very short time to give you a flavor of what our system looks like, what the problems and issues are and, in particular, what the competition questions seem to be.

You would get the impression, though, that while our national systems and cultures and approaches to health care may be different, the competition issues seem strikingly similar. Hardly surprising, really, since although institutions may differ, people are the same then world over really.

So that is pretty much what I want to say. National systems may differ, but the problems are familiar.

Thank you very much.

(Applause.)

MS. MATHIAS: Thank you. I was thinking that before we move on, we would like to take a quick break.

We have been going for about two hours, and I think everybody could do with a quick water break. Why don't we reconvene in ten minutes.

(A brief recess was taken.)

MS. MATHIAS: I think it's about time to begin again. We will start with Mike Jacobs, and then after we -- I've got to get the conference call back online. So, again, we'll start again.

We will begin with Professor Jacobs and then we will move directly into the moderated questions. Since I have been hogging the mic, I figure it's only fair Bruce to get the first question.

MR. JACOBS: Let me just add my thanks to the many that have already been offered for having an opportunity to be here today. Thank you all very much. It's a real pleasure.

I wanted to say, and I had to just check, no offense, with Declan to make sure about this, but I'm the oldest person in the room and I say that with just a tinge of regret, because I started practicing law in 1972, when, as you know, in 1975, the Goldfarb case was decided in the United States and the professions began to be regulated quite seriously in an anti-trust sense.

So my professional life has overlapped with the increased attention to professional regulation health

care competition and, at the same time, I have been fortunate enough to travel around, mostly to Australia, and witness, I think, six of the seven years of what Sitesh described as aggressive health care regulation there, aggressive and effective health care regulation there, and I have also been in Europe and have seen, through the Italian Competition Authority, some of what's gone on there.

So I might -- certainly, I have been around a long time and I hope I have developed some perspective. So I would like to bring that perspective to bear on what the previous speakers have said and on what I hope to be the issue in general.

I think that there are two large questions that almost everyone, maybe everyone, alluded to and that seem, in a sense, to haunt, I say advisedly, the application of competition principles to health care markets, and I'm speaking mostly about service markets, but what I'm about to say doesn't apply exclusively to service markets.

What we seem to have across the world at large are markets that have a public/private mix. They operate under fiscal constraints. They are, although deregulated now compared to what they used to be in certain important respects, still quite regulated.

They are certainly markets in transition. There are new players and new kinds of players appearing on a fairly regular basis, and they have odd features that people have noted since health care markets were mentioned, but I'm going to set some of those odd features aside for a moment when I talk about the issues that are pertinent to me.

But I do want to mention that the markets are heavily subsidized. There are direct subsidies, educational subsidies, government subsidies, subsidies that increase purchases by consumers more than they might exist in an unsubsidized market. There are cross-subsidies. There are indirect subsidies. I won't speak directly about rural health care markets, but I think there is a wide consensus of opinion in the world, certainly in the U.S. and Canada and Australia, that rural health care markets simply don't work competitively, that they don't pay themselves, they are not economically profitable, that they need to exist, but they don't need to exist because the market wants them. They need to exist in spite of the fact that they are uneconomic and that's a problem that is related to this hearing, I think, but it's a problem of different order. So if you don't mind, I'll just set it aside, but perhaps we can come back to it.

The two issues I want to talk about have to do with really the application, in general, of competition law principles to health care markets. The first issue is this: It is clear from everybody's talk that there are lots of discreet competition issues to which antitrust enforcers can turn their attention, and they have done so. Some of these are the low-hanging fruit of competition law issues, simple price fixing or market allocation devices, refusals to deal and the like.

But when you put aside the discreet issues for a moment, it seems to me that there has been very little thought given, and this isn't an accusation, it's just an observation, but there has been very little thought given to the industrial policy issues that pertain to health care markets.

I don't know that anyone has articulated, at least I haven't seen articulated a clear notion of where all the regulations should take us at the end of the day, and this is what I mean, in part.

One of the phenomena that has accompanied the transition in health care markets has been concentration. Dr. Liu referred to some concentration in Taiwan. Certainly, there has been concentration in Australia in the health care sector, in the insurance funding sector, physician sector, and we here in the United States know

certainly about all the concentration that has occurred here in the last dozen or 15 years.

But there is a real tension, of course, between concentration and perfect economic markets.

If the goal, if the large goal of competition policy in the health care sector is to produce competitive markets or even contestable markets, then it seems important to look for a moment at the effects of concentration on this goal.

I should say, first, though, that the concentration is not an undesirable phenomenon. The concentration is payer driven. It is meant to be a response, in part, to desires to achieve cost efficiencies and economies of scale and to avoid duplication.

Most of the concentration, let's assume, for argument sake, is efficient in that sense, but concentration means, of course, that there are fewer players in the market rather than more, and a market with fewer players is a less perfect market than a market with more players.

One might think, one might hope that concentration might lead to the production of more useful information. That is another predicate of perfect economic markets, but it seems that in many markets,

there is almost no information at all. In some markets, there is a mix of information and noise, advertising that doesn't provide you with information, but just provides you with some incentive to go buy the product, without telling you much about it, and I'm thinking more about the pharmaceutical sector now here than I am about the services sector.

It is just not clear. It is certainly not clear, I think, whether this concentration is going to provide us with more information or better information, and even whether we could absorb too much more information or better information.

Third, it seems that the increase in concentration will exacerbate a problem of mobility; that is to say, easy entry, easy exit in health care markets by raising the ante of both entry and exit. There will be more sunk costs for almost every sector and it will make it harder for new players, as Declan was describing in the insurance market in Ireland, new players to enter. It will make it hard for old players to leave and in health care markets, perhaps exit is viewed with some sadness and, again, emphasizes a tendency to try to subsidize folks who might have to exit.

Finally, of course, when we concentrate markets, we're not going to make the product of issue

hospital services or physician services anymore homogeneous. That's the fourth predicate of perfect markets.

We wouldn't want it, I would imagine, to be more homogeneous. We would like an array, one would think, of choices and of perhaps even an array of quality levels, although that's a very open question in health care competition law.

But in any event, we have no guarantees that the move to concentration, an efficient economic move, I say again, is going to improve the preconditions of perfect markets at all.

I'm not saying this to put a fly in the ointment, but I am saying this to suggest that there hasn't been much coherent thought given to the industrial policy issues behind regulation.

Of course, it makes excellent sense to try and stop all of the bad things that have historically constituted enforcement policy in countries with competition laws, mentioned them before, but I think it makes good sense, too, to try to at least imagine what the markets are going to look like at the end of the day, so that one can assess whether one's enforcement efforts are leading to the desired end or not.

I should mention, too, just a fifth factor. It

is not often mentioned when one talks about perfect markets, but, again, Declan alluded to it in his talk. I think in a perfect market that had principals and agents, agents would be faithful to their principals' interests.

But, again, in the United States, as we see health care insurance markets change, there is a very heated debate about whether insurance companies are faithful agents for their insureds and I think, again, there is just not enough data about that and there's no guarantee, again, that this move to further concentration in health care markets is going to improve agents' fidelity to their principals.

So all of these things seem very much issues that are worth exploring and very much important to the overall picture.

That's the first issue.

The second issue I wanted to talk about, and I think I am much freer to do it, of course, than people who work in the enforcement sector, is the question about the culture of competition and the role it plays in health care antitrust enforcement.

It is clear to me, from having observed what has gone in Australia, and I think Sitesh described it very well, is that there is an ongoing battle in Australia between enforcement agencies and the people,

physicians mostly, that they regulate, about whether competition laws should be applied and if so, just how much, to the activities of physicians.

The head of the AMA, the Australian Medical Association, prior to the current head, ran on a platform virtually that said that the ACCC, the enforcement agency, should just stay away from organized medicine because it really didn't know what it was doing and because medicine shouldn't have to live up to the dictates of competition law.

Here in the United States not too long ago, just a few years ago, all of the dentists in Puerto Rico organized themselves into a virtual so-called trade union in order to try to wrest higher prices from the island's insurers.

It seems like a fantastic idea, an idea built on fantasy, that dentists in Puerto Rico would somehow think that they could do this, but this suggests to me, the Australian experience and the U.S. experience, that certainly doctors haven't caught on to the culture of competition.

And there is a simple answer perhaps from a regulatory point of view, which is they are just profit maximizers and they don't want to give in and do what's right, but the answer just might not be as simple as

that.

The answer might be much more complex and it might be more complex because health care is different. One of the things that suggests that it's much more complex is that it is not clear whether consumers have bought into the idea that health care competition should be applied across the board.

Now, of course, again, the low-hanging fruit I think everybody can agree on. Nobody wants there to be overt price fixing or market allocation.

But the idea that every stricture of competition law is good for health care markets doesn't seem to have caught hold. It certainly doesn't seem to have caught hold in Europe or in Canada on a wide scale basis.

Nevertheless, enforcement agencies perhaps have to insist on it, but are insisting on it in the face of widespread professional and, to a lesser extent perhaps, social opposition.

Everybody here today spoke about the advocacy function of enforcement agencies, but it seems to me that one part of the advocacy function that has gone unexamined -- I shouldn't say unexamined perhaps, but less examined that it might be, is the debate about the extent to which competition laws should be applied in the

interests of consumers to health care markets, and not just on the simple question of price and output, but on broader questions about entry barriers and exclusion of various physicians from PPOs or from managed care groups, and on the mergers of hospitals, and on the treatment of rural care providers, and on all of these issues, I think it is incumbent upon enforcement agencies to make the case for enforcement not to the people who are regulated, although to them, too, but to consumers.

I think this is a very important matter that has, in some important respects, gone untreated.

Now, it could be that there are stages in the development of national competition laws and that the longer competition laws are in effect, the clearer it becomes not just to the regulated people, but to consumers, as well, that, A, competition laws are here to stay and that, B, they make sense and that, C, therefore, they are worth complying with and understanding.

But, again, on the evidence of the United States, it doesn't seem perfectly clear that the professions or hospital management have bought into those notions as strongly as actors in most other areas of the economy have, and on the evidence in Australia, it seems pretty clear that those notions are still quite contestable notions.

So I think a great deal more thought must be given, in general, to the linkages between competition policy and the cultures in which competition policy is sought to be applied.

I think advocacy, to the extent that people feel there is a good fit between competition law and health care services, needs to be directed as much at consumers as at the people who are to be regulated, and I think if that is to be effective, then thought needs to be given about the first issue that I discussed.

Where is this all going? How will the world end up and will the world make markets more perfect, not just because we want markets to be made more perfect, but because we presume, we in the antitrust world presume that more perfect markets lead to greater consumer welfare.

And if, in health care, more perfect markets do not lead to greater consumer welfare, then we need to re-tune our thinking and figure out how we can make consumer welfare better and whether consumer welfare hinges in health care as it does certainly everywhere else on this drive among antitrust regulators to perfect markets and service delivery.

So I hope that is provocative enough to get a couple of questions on the floor, and I will just stop

with that. Thank you.

MS. MATHIAS: Thank you.

(Applause.)

MR. McDONALD: Professor Jacobs comes up with some -- goes to the heart of some of the real problems, and let me pick up on a couple of those.

First, Professor Jacobs, you said that the perception among not only providers, but also among the public, is that health care is different and that perhaps typical antitrust regulations should not apply in the various health care markets.

Mr. Purcell, you noted that some people think that health care is sacrosanct and, therefore, by government regulation, it is not subject to ordinary rules.

Let me ask the whole panel. What is it about health care that is different? Is it the fact that health care services actually are very expensive? Few people could afford the most expensive services and the allocation that private competition would make of health care services among the citizenry would be politically unacceptable and that's maybe the simplistic answer.

What do you all think?

MR. JACOBS: Maybe I'll just start by queuing up the Australians on this point, but I have been to

medical conferences in Australia where physicians have stood up and said, to wild applause, that the last thing they want to see in Australia is American style managed care.

This statement draws wild applause not just from fellow physicians, but from the public, as well, because the public associates the cost, the consciousness of managed care with a diminution in quality and an attention to financial matters that the public thinks shouldn't characterize the provision of medical services.

And, finally, with the depersonalization of medical services, which, in at least smaller countries and communities, is thought to run counter to people's expectations of a more personalized, less cost conscious kind of care.

And to the extent, and we are very poor, as all of us would acknowledge, in measuring quality of care, but to the extent that patient satisfaction has always been and still remains one of the important indices of quality of care, I think these claims about the terrors to a company managed care haven't been fully addressed.

MR. PURCELL: Could I add a comment?

MR. McDONALD: Please do.

MR. PURCELL: I think it probably runs even slightly more deep even than that. I have always felt

that there is a mystique about liberal professions in general and it is a mystique that professionals, I'm afraid, do like to cultivate and encourage.

There is a certain element of the pedestal in society kind of syndrome about it. Certainly, in Ireland, it used to always be part of folklore that there were three professions, if we want to put it that way, in a local community whom people always looked up to; the doctor, the priest, and the bank manager.

Certainly, in recent years, maybe some of the gloss has gone off the bank manager and, dare I say, even in the priest in some cases. The doctor, though, as a person and as a professional, still occupies a unique place in society from a cultural perspective.

People look up to doctors. My own father, who is dead now, absolutely go by every single word his doctor said, "but Mr. So-and-So said this, Mr. So-and-So said that," and nobody would ever argue with him and nobody could argue him out of that way of thinking.

The other cultural thing attached to the medical professions, I think, in particular, is that people are at their most vulnerable dealing with a medical professional. Maybe their best judgment sometimes goes out the window in a way where if they were dealing with some other professional, whether that

profession was a lawyer or whomever else, I think consumers would be much more likely to take issue with either the money they were being charged or the opinion they were being offered or the service they were being given.

However, if I go to a doctor, it's the old asymmetrical information thing, I think, that if I go to a doctor, I want them to tell me that I'm okay. I don't care what he charges, in general, and if I'm talking about private medicine, just tell me I'm okay. Tell me I'm going to live another ten years.

And there is just a reluctance in people's minds to challenge any sort of status quo; that maybe medical professions earn a very good living, they may have their own interests to pursue, their own associations to form and so on, their own lobby groups to form.

There just does seem to be an innate resistance in the minds of consumers to actually challenge these things, and that's not a culture that is resisted by the professions themselves. It can be cultivated and encouraged.

MR. McDONALD: I would like to get the thoughts of any other panelists who care to comment, but I would note that the first two comments suggest that health care

is different because of a preference, almost a personal preference of the consumers of health care not to have the impersonalization of American style managed care, and also a preference that recognizes the mystique or wisdom of the medical profession.

Is health care different in your countries for those kinds of reasons or are there any reasons that you might hear in a cold light of a medical think tank?

MR. PURCELL: I would just add a rider that what I was describing there was how the perception exists, in consumers' minds, in particular, that health care is different.

I would imagine for competition professionals, health care isn't very different. It is certainly not unique and we would be, certainly, in my Authority, we would be quite skeptical of anyone who puts forward that kind of philosophy that somehow health care is unique.

So is almost every other profession and so is almost every other walk of life in its own right. Everything is unique in some way, but health care, to us, is not that different.

And the distinction I just want you to make is between -- it depends on who is doing the talking. Competition people would say it's not that different. Consumers probably would feel its different because

they're in a vulnerable position and the professionals themselves and indeed sometimes the people who regulate them are somewhere in the middle who don't want to rock any boats and are quite happy to have the status quo prevail.

MR. BHOJANI: From an Australian perspective, I think perhaps it's a bit of a halfway house, because I think it's a bit more than a perceptions issue from the Australian community's perspective.

I think Michael has hit the nail on the head, to some degree, in the sense of almost an expectation from the community that government will be involved in delivery of health services and their expectation that we will be able to have it on a personalized basis, we will be able to have it.

Maybe it's because of an historical expectation, but that it is something that we fundamentally regard as a right, that we will be guaranteed maybe because of an historical perspective in the way the services have been delivered in the Australian context, maybe other issues, but there certainly is this paranoia or real apprehension that we would be going down the U.S. path in terms of managed care, and Michael is quite right.

It is viewed with a great degree of fear by all

sectors, not just the medical profession, but even consumers who believe that they will lose control over what they will be able to get in terms of services.

So whilst they do want things to be improved, I think there is a significant degree of cynicism or skepticism about whether allowing the health insurance fund to tell them what they can and can't have and who they can and can't go and see is, in any shape or form, better.

And I think the medical profession in Australia has been very effective in getting that message across about U.S. style managed care service that health insurers have had to re-label it in terms of the war, ongoing war of words between the health insurance side of the fence and the professional side of the fence.

The health insurers have had now to combat with effective campaign of labeling the doctors group as running a managed care campaign and to deal with the managed care issues.

MR. JACOBS: And you all must know at the FTC very acutely from your work with mergers and the Iowa merger and the merger in Missouri, where geographic markets have been expanded based upon the notion that managed care providers can just get their insureds to go a few more miles, sometimes quite a few more miles, to

get less expensive care, it is crucial in a certain kind of antitrust analysis here in the United States.

But I think in most of the other countries with which I am familiar, you couldn't get a critical number of consumers to travel from -- what, was it Iowa City, was it Des Moines, maybe? I don't know. One of those Iowa cities, all the way up a 100 miles it was to Madison, Wisconsin, just wouldn't happen.

People wouldn't be told to go that far for care, because their expectations about how care is going to be delivered to them are very, very, very different.

MR. BHOJANI: In fact, that is a live issue in Australia at the moment, which is why there was such an engagement about what our laws might be doing to rural medicine in Australia, that we had the Prime Minister announce this inquiry.

That was, unfortunately, in my view, a scare campaign by the AMA that we were somehow, the ACCC, through enforcement, achieving compliance with competition laws was, in fact, inhibiting or at least risking future rural medicine for the sorts of reasons we have been talking about.

There was an immediate political strike that had people running all over the place. So it was very effectively strategically, from the AMA's perspective.

Unfortunately, as I say, at the end of the day, the report has found that there isn't a basis for the scare campaign that they were running in that context, but the community expectation just isn't going to be that we would run around all over the place for doctor services in terms of price.

That's the other aspect of this. Because the price signals haven't been there, at least historically, the consumers just aren't -- the signals aren't there. They are just not educated and informed in that way of making these sorts of choices.

It has always been delivered by the government. So there is a huge resistance to that changing.

MR. COOPER: Can I add, on the price signals, too, where, at the moment, the Commonwealth Government in Australia now is picking up 30 percent of the tab on private health insurance and one of the big cost drivers in private health insurance is prosthetic devices.

Yet, when a patient goes to see the doctor and the doctor says you need a hip replacement or a knee replacement or whatever, and the doctor says to the patient, "Well, I can give you a basic version for this or a Rolls Royce for that, but it's not going to cost you anything because the health insurance is going to pick it up," of course, the doctor and the patient will both pump

for the gold plating option.

And now we've got the government saying, "Hang on. That's putting up your premiums and that's directly affecting your revenue." So the government is really actively trying to reform the way that the prosthetic devices are purchased.

But because of this managed care issue, they are not, that I understand, prepared to manage the way doctors choose which device to implant, which is the appropriate device.

That's a professional judgment that the doctors don't want to be second guessed on, I guess, but it seems to me that unless there is some restriction or control imposed that makes the incentive to put in the appropriate one, not the best one available, that the costs are going to go up and up and up.

MS. MATHIAS: Just to follow along that line in that specific answer. Is there any consideration of tiering how much the insurance company would pay, depending on whether they use the standard, let's say, the standard prosthetic versus the Cadillac prosthetic, that maybe the insurance company would pay the full price of the standard and if somebody wanted the Cadillac of Rolls Royce prosthetic, that the citizen or consumer, the patient would have to cover that cost.

Is there any analysis going into that kind of tiering?

MR. COOPER: The government has imposed a regulation on the health insurance companies that all devices that are appropriate for a patient will be covered by the health care.

So if you need a Rolls Royce or a Cadillac, then your health insurance company will pay for that.

So to some extent, it is just a matter of controlling what you need, and that is the level to which I think the government is not prepared to intervene.

MR. BHOJANI: I think there is a real issue here about out-of-pocket expenses and community backlash, not just in relation to prosthesis, but as we're saying, in relation to medical services generally.

There is a major consumer resistance to having to say, one, I pay a Medicare levy on my taxes; two, you have now forced me with the stick Bruce was talking about in terms of having to take out private health insurance, as well as the carrot of the 30 percent rebate, but nevertheless, having private health insurance.

So I'm paying both of those and you are still telling me I have to have an out-of-pocket gap payment every time I get one of these services. Well, get real. It's just not going to happen. If you want to do that,

we'll toss you out and bring in another government that will actually give it to us or cover without any out-of-pocket expenses.

So there is a real resistance, I think, to try to go down the co-payment path or out-of-pocket add-on path, although that is certainly one of the options that is being looked at.

MR. BHOJANI: Maybe just to make one more point, if you don't mind. We can't have the conversation that we are having right now without implicitly acknowledging, sometimes explicitly acknowledging all the subsidies that are built into these purchasing decisions.

I just don't think, with all due respect, that there is another sector, apart from maybe the agricultural sector in the United States, where subsidies form such a foundational part of the market.

You can't even imagine. I don't think it's possible to imagine our health care market stripped of all the subsidies. I don't think anyone could contemplate it. So it is impossible.

We're not talking about a second best solution. We're talking about a fifth best solution here, because we have subsidies through the tax scheme in the United States. You have subsidies through the government in Australia. In both countries, we subsidize medical

training just as we restrict it in some cases.

In both countries, urban dwellers subsidize urban dwellers with respect to the provision of health care. So this is a system that has subsidies at every nook and cranny.

MR. JACOBS: Just to pick up that particular point. Perhaps other countries and the systems in other countries don't quite mirror the situation in the U.S., where there is so much private enterprise and perhaps so little state involvement in enterprise, I know you did mention agriculture as being a very heavily subsidized sector, that is obviously the case in Europe, as well.

But there are many other sectors that are very heavily subsidized and cross-subsidized, as well, energy and transport, to name just two.

So I don't think, certainly, across our side of the Atlantic, it's not an issue of subsidies or cross-subsidization that makes -- that might make health care different, whatever else it may be.

I was just going to make one other point, and that was that perhaps agencies like our own have failed to get messages across to consumers about competition and what it is and how it might apply to health care.

Consumers really have other priorities, apart from the one I mentioned earlier on about please make me

feel better.

Concerning consumers in Ireland and what goes through their minds and in the newspaper letter columns and so on, it's all about accountability within the health care system, given that this is a public health care system, in general, I'm talking about, accountability, funding, access to care, getting a bed in a hospital when you need it, the efficiency of the system.

Those are the kinds of lenses through which consumers are looking at health care, certainly in Ireland.

The idea that somehow there is a constituency of consumers out there at the moment that may feel like we do, to say, well, hey, let's at least have a debate about competition, there is a long, long road to travel certainly in Ireland. I don't know whether matters are similar in other countries. But the debate has only started really about competition in health care.

We are at the foothills, in our vision, trying to persuade consumers and ministers and legislators that, yes, there are specific angles to health care that make it different in some ways to some other sectors, but it ain't that different, and that is where we are starting from, which is a very fundamental foothills starting

point.

DR. LIU: Basically, we apply the same competition law to the health care industry, but we handle a case, we will consult a case with competent agencies, like Department of Health, and then we can decide it after hearing their opinions.

I've got a question for Professor Jacobs. When we deal with the health care case, how can we define a market share? Can we just only use the number of medical doctors and the number of hospital beds, or we can we use revenue standards to define market share in terms of the health care market?

MR. JACOBS: It's a good and a very complicated question and it might not be one that I could answer in just a few minutes. But if you would like, I would be very happy just to send you the literature from the United States on how we define these various health care markets, and I will be sure to do that.

DR. LIU: Thanks.

MR. McDONALD: This, again, for each member of the panel. Is there any aspect of your own health care system that you think would benefit by moving away from public or government regulation organization of the market and moving towards private competition and what would have to change in your country to make that

possible? Australia.

MR. BHOJANI: I'm sure there are aspects of our health care system that will benefit or would benefit from a greater degree of reliance on market structures rather than government regulation.

One that I think, in the light of what Bruce has said, as well, I think at least currently under consideration is in relation to the health insurance sector itself.

On the one hand, this government is so heavily subsidizing private health insurance today, it obviously has a vested interest in what prices are, because every time premiums increase, they're paying 30 percent of that increase.

But it's got to the stage where it's so regulated in the sense that they can't change the premiums other than on an annual basis and they can't communicate to their members without complying with certain regulatory requirements.

As I understand, they had to actually get approval to actually communicate to their membership on the regulation in some respects.

They are forced to offer a baseline premium to hospitals, whether or not they have a contract with them. So some of these signals are just, I think, in need of

deeper analysis as to whether they would benefit from less restriction to allow market forces to work somewhat better.

The big leap of faith in all of this, of course, is that health insurers are, in fact, acting on behalf of the consumers, who are the members. It is that leap of faith that I think one has to have regard to. In the Australian context, I'm not sure that we're there yet in terms of consumers believing that the health funds will act in their best interest.

MR. JACOBS: Just one note about the principal/agent issue in health care. It is such an interesting tension academically, because when an agent represents a large group of principals, of course, the agent's duty, from a legal sense, is to act faithfully for the group as a whole.

So the agent in that situation doesn't have to act faithfully for every single member of the group. The principal is the group and it is the collective well being that the agent has to act on behalf of.

But this abstraction doesn't appeal to a lot of consumers who are members of a group who might not have a majority of votes, so to speak, in the group and on behalf of whom the agent might not, therefore, have to act faithfully.

It's no consolation to think that the agent is going to act faithfully for the majority of the group if you are in the minority. So the incentive to form the group is greatly diminished by the prospect that you won't be in the majority and that the agent, therefore, won't have to act faithfully on your behalf.

MR. McDONALD: Thank you.

MR. PURCELL: Just a couple of aspects struck me, mentioned them sideways in my presentation earlier.

In relation to the medical professions in particular, whom, as we know, are quite heavily regulated by, certainly, in our case, by government regulation, as well as by self-regulation, but also by government regulation, certainly, you would think that removing the constraints on supply of professionals, if the government can do anything about that, would be a positive benefit, particular as regards, for example, the number of publicly funded education and training places that remain available.

These seem to be artificially constrained. That's one thing.

Second would be to remove, let's say, the most excessive controls on advertising. One can certainly see a role for constraints on advertising in the medical area, but it may be that they go too far to allow. A

certain modicum of advertising might not be a bad thing. It would have benefits for consumers.

A more informed consumer is a consumer better able to decide.

The third thing might be to remove some of the state controlled restrictions on organizational forum of professionals. There is at least a tradition, I suppose is the way I would put it, that professionals, particularly in the medical area, but it's not confined to medical, but medical professionals should not incorporate.

That is certainly the case in Ireland. It is the case in the UK, as well, as far as I know, nor can they combine their practices with other medical professionals. I don't mean other doctors. I mean one-stop-shop type medicine, dental, optical.

So allowing more freedom to decide on organizational forum would be a benefit.

The other thing that strikes me is the need to revisit the whole area of drug pricing, particularly at the retail level, but I wouldn't confine it to that, where governments do get very heavily involved and the least that I think would help would be more transparency and more information on the way drugs are priced at various levels of the distribution chain would at least

stimulate a public debate about the way these things are priced and how much consumers have to pay and whether they need to pay that much.

So food for thought. Those are certainly the ones that would seem to me to be the most obvious and off-the-cuff benefits that might apply to, that might accrue to removing some of the extent of government regulation that applies.

MR. McDONALD: Thank you. Dr. Liu?

MR. BHOJANI: I certainly have some observations on that. I would certainly agree with the issue about the supply side in terms of medical practitioners or specialists and so forth. I think that would be a benefit if we could achieve that in Australia.

The other thing that Declan said that does surprise me a little bit, whilst we have similarities, there are also differences, because in Australia, the doctors actually have been able to incorporate, so to speak, and they engage in multi-disciplinary practices in that sense. Lawyers have not.

So there's a historical culture in Australia that lawyers are not allowed to incorporate their practices, but for doctors, it has been possible for a long period of time.

MS. MATHIAS: I'm afraid we have to cut this

off now, because we do like to respect the time that you have all given us, and we promised you we would end at 12:30 and it is now 12:31.

This has raised a lot of interesting food for thought and things for us to consider and look at and areas to hopefully lower barriers and expand markets, potentially, and learn from each country.

We will reconvene at 2:00 to look at Medicare this afternoon. I wanted to thank all of our panelists for the time that they have spent, the time that they have spent working on this, thinking about it, traveling here, and the quality of each and every presentation that we had today, and I would like to applaud them and thank them.

(Applause.)

(Whereupon, at 12:32 p.m., a lunch recess was taken.)

A F T E R N O O N S E S S I O N

MR. HYMAN: Good afternoon and welcome to the next to last session of the hearings on health care and competition law and policy, jointly sponsored by the Federal Trade Commission and the Department of Justice.

My name is David Hyman, and I am special counsel here at the Federal Trade Commission.

Unfortunately, the Department of Justice, for scheduling reasons, isn't co-moderating this, as would be their tendency, and they send their regrets for that.

We have a very distinguished panel here. As has been the case throughout the hearings, the panel is so distinguished, we could use up a considerable percentage of our time simply introducing everyone. Their mothers would probably like to hear the florid introductions, but I think the audience is here for the substantive element. So our rule is essentially one-sentence introductions. We have prepared a handsomely bound book of biographies that you can pick up outside and read the exploits of this panel and the panels that preceded it and the final panel of these hearings tomorrow. We'll hear from people in the order in which they are actually seated. You are free to sit here or go up to the podium. I can't think of any intermediate solutions that will work, but if you can and you're reasonably close to a microphone, go right ahead.

Each of the speakers will have 15 to 20 minutes to give their perspective on the issues that are on the table, about which more in a moment, and then we will take a break, I expect, after everybody is done, a ten minute break, and then we will use the remainder of the time to have a sort of moderated roundtable discussion, where speakers can respond to one another directly, ask questions of one another, and, if you all are shy, I get to ask questions instead.

Just a few words about the subject for today or for this afternoon, which is Medicare. Medicare, in some respects, is a somewhat unusual, Medicare and Medicaid, but primarily Medicare for today, Medicare and Medicaid are somewhat unusual subjects for competition policy agencies, the Federal Trade Commission and the Department of Justice, to take up, because as entities of the Federal Government and the state, they are essentially immune from the antitrust scrutiny and the consumer protection issues.

You would not make yourself very popular by going after them either. But the reason we have them on the schedule is not because there is direct regulatory authority over them, which is the case with pretty much everything else that we have considered over the course of the hearings, but instead because Medicare and Medicaid are dominant realities of the American health care system.

They influence the nature of competition. They influence the areas in which competition can exist and the rules under which it has to exist, and the risks and rewards, and the institutional framework within which all of those things take place. At least that is what I thought when I came up with the idea for this session and I look forward to the panelists telling me different or the same, and expanding on that subject.

So, again, we have assembled an entire crew of people who are not known for their shyness on these subjects, and so we expect to have a quite vigorous discussion.

Our first speaker is Joe Antos, who is a scholar at the American Enterprise Institute, focusing on health care and retirement law issues.

Seated immediately to my right is Walt Francis, who is an economist and policy analyst, who has focused his work on the evaluation of public programs.

To my immediate left is Jeff Lemieux, who is a senior economist with the Progressive Policy Institute and has spent a considerable part of his career at the CBO, as has Joe and Walt, as well, or just Joe? Walt is innocent. Well, not guilty is the technical term. OMB. I'll give credit for OMB as well.

Dan Crippen, while we're on CBO, is a former

director of the Congressional Budget Office and has actually held a variety of posts in the Federal Government involving health care and budgetary issues.

Then, finally, representing the lonely provider perspective is Joe Cashia, who is CEO and founder of National Renal Alliance. Some of you may know, Medicare is essentially the sole source purchaser for kidney dialysis performed in the United States dating back to the early '70s, when Congress enacted legislation providing that as an add-on to the Medicare program, and we invited him to give his perspective on what it's like to provide services in that context.

So with that, let me just turn things over to Joe.

MR. ANTOS: Thank you, David. I think we all can heartily agree that Medicare, especially Medicaid/Medicare, forms the backdrop for the entire health care system, not just because these are programs that spend a tremendous amount of money.

This year, the two programs combined, we spent something over $500 billion. It will affect -- well, it's a little hard to know, because there's double counting, but it might be 70 or 80 million people directly, and, in fact, everyone, directly or indirectly.

Why is that? I'm going to focus on Medicare,

Medicare in particular. Medicare's administrative requirements shape the business environment for everybody in the health care sector, for physicians, hospitals, other providers, and changes to the Medicare program have spillover effects on the rest of the market.

Some of those spillovers have, in fact, been to help improve the functioning of the health system and have benefitted consumers. I think I would point to hospital prospective payment as the key example there. The effect of that was to really revolutionize the way hospital care is provided, reducing length of stay, which reduces a patient's exposure to hospital borne diseases, for example.

That's a good thing. Reducing length of stay also reduces costs, reduces unnecessary costs, and we can get into a technical discussion about what really happens to costs, but unnecessary costs go down.

And something that people don't always think about, but this shift actually helped to promote the development of new technologies to treat more serious conditions in outpatient settings.

So it's been a big win. Well, more often than not, however, Medicare policy has failed to promote innovation and efficiency in the health sector.

There are lots of reasons. Political gridlock

is certainly one. Another one is the conflict of interest that is inherent in having a gigantic government agency be both a payer and the de facto regulator of the entire health system.

So there are major problems. The Federal Trade Commission and the Department of Justice -- one of their jobs is to promote vigorous competition within one of the largest single sectors in the economy and certainly one of the fastest-growing.

The objective, Tim Muris said last year, is to achieve lower prices, higher quality, greater innovation, and enhanced access to care.

Well, unfortunately, FTC and the Department of Justice are both fighting this battle with one hand tied behind their backs.

Medicare and Medicaid continue to rely on regulation and micro-management rather than competition and consumer choice, and that is the dominant factor in the business environment in the health sector.

I want to say that I think the Federal Trade Commission could, in fact, be a little more activist in its statements. You don't have direct regulatory power, but this point should be made strongly to Congress and the Administration. They don't seem to get it.

I'm going to address three topics as quickly as

I can that relate to this that were laid out in the prospectus for this session. I'm going to talk about improving consumer information. That is something that the Medicare program has access to mass amounts of data and those data could be used more wisely and more vigorously, but there are very large technical, legal, and political barriers that have to be overcome in order to do that.

There are other actions that are more ambitious and in the case of Medicare, there are opportunities, every year there are opportunities. There are opportunities this year for Medicare to become a more competitive, more consumer friendly program, opportunities that haven't been taken lately.

Then, finally, I wanted to just mention an example of policies that are adopted by the Medicare program that yield some short-term improvements in that program, but could and often do undermine broader efforts to empower consumers in improved health care.

Okay. Consumer information. Consumers need a lot of information to navigate the health system at various stages. They don't need all the information all the time, but at certain points, you just need to know things.

Many consumers actually have choices of health

plans or insurance programs. If you are working for a big employer, you probably have some choice. If you were in the individual market, you have a tremendous amount of choice.

Every consumer, at some point in their lives, if you're lucky, it's late in your life, if you're unlucky, it's early in your life, you end up picking a primary physician or some care giver that you are going to entrust literally your life to, and, increasingly, consumers are actively involved in, with their physicians, in treatment decisions.

In other words, what will happen to me, I'd like to know, I would like to have a voice in the matter. To make these decisions, you need some information. It would help if the information were objective, reliable, timely, accessible, and understandable.

Well, it's sort of no, no, no, for most people most of the time. So most people still go to single best source of health care information that people have, a relative or a neighbor. "Well, you know, how did it go for you?"

That is not a great way to make decisions. We need more information. The Medicare program, as I said, has access to a tremendous amount of information. Medicare contracts with almost every provider, that is,

physicians, hospitals, nursing homes, and so on. Almost every provider in America is tied directly to the Medicare program.

The Medicare program is also responsible for paying for the covered services of 40 million people; essentially, the entire elderly population and a very large segment of the disabled population. These are people who use health care a lot. So this isn't a case where the Medicare data is a little sketchy.

For certain conditions, it's a 100 percent of all the information that is available. For the big providers, hospitals, for example, it's a very large fraction of the information available on their performance, as well, and so on.

So this information could be used, but we have to be careful about it this. We have to be careful about not violating individuals rights to privacy. We have to be careful about not jeopardizing the confidentiality of sensitive information from providers and health plans.

We have to be even more careful about how the government uses the information that it might exploit as it chose to. Clinical information, in particular. We have to be careful that the government does not become overly prescriptive in the way it uses the clinical information that it has at hand.

There are large variations in practice patterns across the United States that clearly indicate that medical care is practiced in peculiar and often inefficient ways, depending on where you live.

But the de facto imposition of national standards through the Medicare program runs the risk of stifling innovation and imposes cookie cutter medicine on patients.

But there are risks here. Nonetheless, Medicare's existing database is a tremendously valuable resource that was tremendously costly to develop. I'm not talking about the cost of providing the services. We're going to pay that anyway, if you look at it that way.

So the data aspects in what is now called the Centers for Medicare and Medicaid services, a tremendous amount of investment has gone into that and a lot of money passes from the taxpayer to dozens of Medicare contractors to process data.

It turns out that the Medicare program itself doesn't actually latch onto all that data. There are reasons for that. But nonetheless, there are data sources that are ready to be exploited. It's very hard to do.

However, it is worth making the effort and groups, business groups and other consumer oriented groups, LIPOD group comes to mind immediately, would

absolutely latch onto this information if it was more readily available.

One of the problems that I would identify is that the CMS makes it all very, very difficult and, in come cases, impossible to access data collected by the expenditure of taxpayer dollars.

Improving consumer choice. I am not going to dump all over the Medicare program and failure to reform that program. The fact is that the ongoing debate in Congress over Medicare reform reflects a continuing and probably growing tension between the program's regulatory routes and the demand by consumers for long needed improvements.

Beneficiaries in traditional Medicare cannot use their purchasing power to demand a drug benefit, for example, as they could if they were in private insurance.

The only recourse is political. It literally takes an act of Congress to make even modest changes in Medicare. This is not the model of a competitive market.

Now, some people claim that there was a competitive reform in 1997. That competitive reform produced something called Medicare Plus Choice. The program is a failure, not an abject failure.

I'm not going to go over all the ways that it's a failure. It hasn't worked. That doesn't mean that

competition cannot work in Medicare. It means that competition has yet to be tried. Medicare Plus Choice, the problems in Medicare Plus Choice are simply new variations on the problems of the regulatory Medicare model that has increasingly failed to meet the expectations and needs of consumers and providers alike.

There are pricing problems. There are problems of incredible inflexibilities in the administration of the program, and Medicare has -- the government is a genius at destabilizing the business environment. The fact is that if you are a businessman trying to decide whether to go take a very expensive and potentially risky venture, expanding your services into the Medicare program, you can look forward to unpredictable, but potential very major changes in the environment that you are working in every single year.

Those changes come from Congress. They also come from the Centers for Medicaid and Medicare Services. It is a very serious problem.

Medicare must be reformed if we are going to meet the needs of seniors and get the best value for the taxpayer's dollar.

Fortunately, the Federal Government does have an example of a major public program that relies on consumer choice in a sensible way, with good, solid federal

oversight to provide good, solid consumer protection, where it's needed, that works. It is the Federal Employees Health Benefits Program.

Politicians love to cite it. They don't always like to propose legislation that emulates it, but that is where I think we probably ought to be heading.

I'm not going to go into the details of that. We could discuss that. Giving seniors an effective market voice would create powerful new incentives for health plans and providers to seek more cost-effective care. The fact of the matter is that right now, with fee-for-service Medicare, the name of the game is provide more services.

It would be great if the care worked, but this is a very fragmented type of a system, as fee-for-service insurance has always been. Medicare is the last holdout, in a sense, and we just need to make it possible for there to be significant financial rewards for the system to work right.

We now have major financial rewards for the system to not work right.

Now, because Medicare is such a dominant actor in the health sector, this kind of reform would have, I think, very positive spillover effects in the private market. We have seen this in years past with the advance of HMOs into markets.

In those markets where HMOs expanded in the late '80s and early '90s, we saw major changes in business practices and clinical practices that tended to reduce costs.

Well, if the entire Medicare program were to empower consumers, you would see, I think, similar kinds of changes that would absolutely effect the business environment of health care and would absolutely spill over into positive effects for everybody, not just for seniors.

Now, one last thing. Promoting innovation. Medicare is not very good at it, as I said, but Medicare is very good at exerting its tremendous power over the market to get what it wants.

Now, some of that power is because it is spending money. That is purchasing power. A lot of that power is because it has legal authority to require actions on the part of everyone.

So people who argue that Medicare is just going to be using its purchasing power when it establishes fee schedules and determines federal prices for things, should not delude themselves. Providers accept those prices because they don't have much alternative, given both the size of the Medicare population, the importance, the economic importance, and the fact that the government basically says do this or you can't participate.

It is pretty persuasive to me. It is pretty persuasive to your physician.

Now, as a matter of fact, if Congress could muster the political will, it could force the system to do some things that would be pretty dramatic and might be pretty unnatural, but such actions often sow the seeds of their own destruction through unexpected, undesirable consequences that are not sustainable politically, socially, or economically.

In other words, Congress can make pigs fly, but not for long.

A good example has to do with setting prices for pharmaceuticals, if there is a Medicare drug benefit. There are plenty of people on the Hill who are, one way or another, interested in doing just that, either directly or through indirect means.

Medicare's extremely potent market power. Again, the money, the legal authority ensures that the program could set pharmaceutical prices at levels well below those available even to the best customers in the private sector. Sounds good.

But don't be confused. This is not negotiating prices. This is price setting. There would be negotiations, but the negotiations would tend to focus on new drugs and here is where I think the problem lies.

The Secretary of HHS would be able to withhold access to any new pharmaceutical, at least in terms of payment through the Medicare program, and that would be a powerful threat that would lead to low negotiated prices for new drugs under Medicare.

Again, sounds like a good thing, but there are some adverse side effects that we might want to avoid.

The most important adverse side effects have to do with patient care. If the government says we're not going to pay for this this year, we need to study it some more, meaning, well, we need to study it some more, but we might also want a better price, that could hurt some patients.

Secondly and more importantly, the threat of a low launch price set by the government would deter the research and development of potentially valuable life-saving drugs, particularly for the population that the government is trying to protect. The seniors. That's going to be the big market. They are the ones who are going to get the most benefit and these kinds of actions could lead to low prices in the short term, which are very seductive if you're looking at big budget deficits, but over the long term, can discourage the kind of innovation that I think we all want to see.

Let me just conclude. Government policies

implemented through Medicare obviously have a major impact on the health sector and ultimately the health of every American.

Medicare is one of the largest purchasers. It has tremendous legal authority and because of that, because of this extra special authority that this program has, there is a far greater responsibility on Congress and the managers of the Medicare program to consider the greater public good in establishing policies and procedures. Regrettably, that is often not the case. Actions that might achieve important goals, narrowly speaking, for Medicare and for Medicaid, often post inefficiencies on the private health sector or unnecessary constraints on consumers.

Looking forward to the FTC doing something about that. Thank you.

(Applause.)

MR. HYMAN: Thank you, Joe. Walt?

MR. FRANCIS: Joe and I usually agree so much on things that I am pleased to report that I disagree with two things he said. One of them is you talked about making a pig fly. I think you should have talked about making an elephant fly, because that was the title of a very elegant article on how to try to reform Medicare and why it couldn't be done.

MR. ANTOS: I was probably just thinking about pork.

MR. HYMAN: Secondly, I wouldn't characterize the Medicare Plus Choice program as an abject failure. I think it's one of those glass is half full and half empty cases.

But it is certainly a pale shadow of what it could have been and it is unlikely to be looking a lot better in the near future.

In preparing for today, I thought I would do something and there is going to be a quiz on this, so you need to look at this page that we handed out. What I swore to do was list all the health care regulations that I could get on one page and I would stop at that, and I had to cheat the margins and squeeze the thing and all that, and I grouped them and I did all kinds of things, but believe me, there's a lot more than is shown on this page.

I listed some, contrary to the mission of this group, that are not Medicare or HHS or CMS, whatever we want to call it, however we want to characterize that set of rules, on this table, I call them CMS, Center for Medicare and Medicaid Services, because there are so many other rules and regulations that have such a profound impact on the American health care system and on consumers

and on the topics that we're dealing with that it is unfair to at least mention that they exist, things like the huge distortions created by the tax system, the insane system of state by state regulation that, in effect, prevents the sale nationally of insurance products that ought to be sold nationally, and so on and so forth.

Anyway, there are a lot of actors in this and there are a lot of effects of lots of different regulations and there's lots of interactions and there's lots of secret effects.

Point number one I want to make is there is a huge panoply of regulatory restrictions that affect American health care. Many of them have effects that were totally unintended. Many of them are good effects, as Joe said, and I won't belabor it. I have listed some good effect examples here, and most of these have mixed effects. So none of them are purely bad.

For example, I list on here somewhere a little known reg. I used to be the regulatory review czar at HHS, and I never heard of this reg, partly because it was never even issued as a regulation. It was issued as a letter by the general counsel's office, saying, in effect, that it is illegal for any American employer to simply say to his employees, "I am going to give you each a $1,000. Go buy the health insurance plan of your choice." I can't

get into it. I don't want to have a human resources department.

Think of a small employer who might want to say, "I want to help. I'll give you a sum. It's tax preferred money, but you got to go hire an insurance agent and do all that," the way tens of millions of people buy insurance.

It turns out it's illegal and it is illegal because of the bizarre interactive effect of several statutes that purport to protect people against unsavory insurance practices, but have the effect of making it illegal to sell illegal policies to an employer who is determined by law to be a group.

I won't go into the details. I mean, this is not a trivial issue. There are a lot of employers who would like to do that. There is a market that is crippled or, arguably, doesn't even exist in the form it ought to have because of that general counsel's letter coming out of obscure provisions in the HIPPA and COBRA statutes.

It is also the case that a lot of these facts sort of take on a life of their own. We have a huge panoply of clinical laboratory regulations, up to and including the tests administered in your doctor's office when you go in and they run your blood sample through an automated analyzer.

All of that results from one case of one bad actor -- a laboratory that didn't correctly analyze PAP smears. A serious problem. We could have had a law regulating PAP smears, but we didn't. We have a law regulating every laboratory in the United States and HCFA or CMS argued we can't exempt even the small physicians.

So we get weird effects that are national in scope. I might add that a number of these regulations, and I was going to have more columns, but I had this one page self-imposed limitation, one of the columns I left out was the primary intended effect of the regulation of Medicare and Medicaid or is intended to cover the nation at large.

A lot of these are intended to cover the nation at large. There's no bones about them. There's a whole set of regulations, they only get one line here, called conditions of participation regulations that say, in effect, if you are hospital doing business with Medicare, you have to obey the following set of very detailed rules and since we appreciate you can't have one set of rules for our patients and another set for all your other patients, it is going to be a set of rules that apply to all the services the hospital provides, regardless of who is paying for the particular patient.

So a lot of these legislative provisions and the

ensuing regulations are intended to regulate every health care provider in America.

I have to actually take exception to one other thing Joe said. There is one group that is largely unregulated by Medicare and those are pharmacies, and there are 50,000 pharmacies out there.

However, Medicaid gets them, so don't worry about it, and one of my bizarre regulations listed here. They're not all bizarre, but one of them is the way Medicaid pays pharmacies. We could get into some of these issues in the discussion period.

I would argue, again, as a cup half-full, cup half-empty issue, to be sure, the Medicare program provides essential health care to 40 million people and Medicaid to a like number, who otherwise couldn't afford it.

Now, there is sort of an alternate universe you might be able to construct, but there is no question these programs do an immense amount of good and we are, by the way, rapidly approaching the point, we'll be there in not too many years, when we will spend more per elderly person in this country, on average, for health care costs than we pay through Medicare, I'm not even counting the nursing home stuff, than we pay in Social Security benefits for that same person.

That is, the average Social Security benefit nowadays is somewhere around $10,000 a year and the average health care cost of a Medicare client is approaching $10,000 a year, if it hasn't reached there yet. Medicare doesn't pay all of that, but that is the kind of magnitude we're talking about.

Sure, lots of people get lots of vital health care, there is no question about it, but the system, I would argue, fails at a whole number of obvious public policy functions that a system ought to succeed at and markets generally succeed at.

It discourages and it penalizes purchasing, frugal purchasing choices by consumers and by providers. This is a huge problem, and there are estimates that up to one-fourth or more of all Medicare spending is medically unnecessary, and I believe those estimates. There's a whole lot of research out there in bits and pieces, going back to the Rand health insurance experiment, about how much money you can save if people make prudent decisions in purchasing health care, without any adverse health consequences. It is unbelievably large.

The system seems obsessed with and indeed it is obsessed with, politically it is obsessed with and always was, allowing every provider equal access.

Okay. We're not going to limit your freedom of

choice of provider. Well, this is our way of saying we're going to have no rewards or penalties for providers who are better or worse than average. You can't go to the better specialists in town and pay a little extra. That's illegal under the Medicare payment rules; illegal under Medicaid, too, I might add, and that's huge, if you think about it.

I mean, can you imagine buying a car and not being allowed to pick a better car, because the government won't let you? You can't pay a little extra and so on. It's mind-blowing. Or clothing, anything you buy, food.

One size fits all. Payment levels tend to produce one-size-fits-all service levels, and the system as a whole, and I put more of the blame here on these other, the tax system and the state regulations and some other things, that on Medicare, substantially discourages expansion of insurance to the young, uninsured low-to-middle-income people, the 44 million, by the latest estimate, people in this country without insurance, makes it very expensive for those people, much more expensive than need be, doesn't provide a large number of those people equal --

The taxes actually actively discriminates based on whether or not, in effect, you work for a Fortune 500 company that runs a cafeteria style plan and does some

other things, or whether you work for anybody else. You get a different tax break. It complicates the tax system immensely. It costs a lot of money.

So there's a tax equity issue. Innovation in health care delivery is a huge problem. Medicare actively impedes innovation in many ways. My favorite examples, and I listed one or two of them on this page, Medicare won't pay for a physician visit unless you see the physician.

Now, that's probably kind of a sensible rule when you are paying by the visit, which is how they pay. Well, there's a little problem with that, in the day of the internet, which is maybe I would like to consult with a physician at the Mayo Clinic or maybe my physician would like to get a second opinion from that physician at the Mayo Clinic.

Maybe he would like to send an electronic copy of my x-rays to that other doctor, okay, and they might want to have a conversation. Well, they can have all that, but it's on them, because it's illegal for me to pay them and it's illegal for Medicare to pay them.

It's just unbelievable. Some of this is inherent in the system, by the way. The system, quite apart from the failure to cover drugs, which I take -- again, you really have to blame the Congress more than the

bureaucrats on most of these things, so I want to be clear on that point.

But the failure to cover drugs is not just inequitable because some people have high drug bills and so on. It is also a major impediment to the rational delivery of health care.

What you would like to see in a health care system is what is sometimes called internalizing the externalities, but that's maybe a more highfaluting way of saying it.

But the notion of a managed health care plan, the basic underlying notion of HMOs, which actually works to some degree, more than the bad rep they have, suggests is that if they are prudent, they will give you an inexpensive drug today to keep you from having a heart attack next year and going in the hospital.

You can spend a few hundred bucks now and save a few tens of thousands later, all at managing care, even though that's a hated phrase these days. Call it disease management. Call it a lot of things. Disease management seems to be the current popular catch phrase.

Medicare can't do that because there's no one in charge of your care. There's no one that has the -- the doctor doesn't save anything if you don't go to the hospital two years from now.

There is no financial effect on him at all. It might be a beneficial one, in fact, if he can be your physician while you're in the hospital, but there is certainly no financial advantage to him to keep you out of the hospital. A Hippocratic oath is good for something, but it's not all the incentive that is needed.

So we have an atomistic, fragmented system inherently flawed and the only way around it is to get people to organize health care plans, like the FEHEP that Joe mentioned, like the M Plus C plans.

It looks, as we sit here today, as if the Medicare reform that has, I think, a considerably better than 50/50 chance of being enacted this fall will include no meaningful reforms to Medicare other than adding a poorly designed prescription drug benefit.

So we're not going to get sort of the -- some of had this naive notion that the price of adding a drug benefit might be to fundamental reform in the program, and we are very unlikely to get that.

Let me just talk a little bit about information, because it is something I deal in. I wear various hats in my life and right now I make a living selling health information over the internet.

I write this book on health insurance plans for federal employees and where I really make money is I sell

it over the internet. By the way, speaking of the FTC, you are not a subscriber to Checkbook, and I can't believe it, nor is the Antitrust Division of the Justice Department.

We have literally dozens and dozens of agency subscriptions, including such esteemed institutions as CBO and OMB.

MR. HYMAN: This is clearly a market failure.

MR. FRANCIS: It clearly is. But let me mention something else. I have a book here. It is a marketing failure, but we sell it so ridiculously cheap, I hate to tell you. It's not worth a cost of a phone call to the FTC.

MR. HYMAN: No money down and easy payment.

MR. FRANCIS: Some good things happen in the CMS context. I did want to mention one. One of them, of course, they used to publish this book themselves. They stopped doing that. But they collect a lot of data on hospital mortality outcomes and they will make it available to the private sector, and my publisher, Watch Consumers Checkbook, puts it out, and this book tells you how likely all -- whatever the current number is -- 3,000 hospitals in the United States are likely -- you know, are you likely to live or die if you go in for open heart surgery and a lot of other things.

Here is another piece of consumer information you can't get out of CMS data and probably never could. Rating doctors is extremely difficult for a whole lot of reasons. Rating a hospital is actually quite difficult. There's a lot of sophisticated statistics that go into something like this and there are debates over how well they -- some hospitals deal with harder cases, for example, so how do you adjust for that.

Rating doctors is even tougher and you're dealing with very small sample sizes in the sense that your doctor only deals perhaps with a handful of cases of a particular kind in a year.

So there are other approaches. Checkbook used the approach of asking physicians, and they have also, in the past, used the approach of asking nurses, okay, which I think is actually the best way to do this, asked physicians which doctors would you refer your patients to. So it's about by reputation basis, reputation from experts, in effect.

So there is consumer information out there. CMS helps, to some degree, to make it available, but most what they do is, I would argue, fairly pathetic.

Let me give you a simple example. I promised to myself I wouldn't talk about organ transplantation, which is an area in which I'm genuinely expert and which there

are many things wrong, or consumer information on the web, but let me give you one small example from that.

If you go on the CMS website and you look up M Plus C plans available in your zip code, because you'd kind of like to maybe find out some information, if you think of yourself as an old folk, one of the things they do is tell you how this plan fares under something called NCQA, which are a bunch of ratings on a bunch of things that turn out to be, for most people, irrelevant and probably not even under the plan's control.

Not things like do their patients live or die, but things like did they get kids their shots, which I'm not saying is irrelevant information, but it's hardly first on anybody's list of what they care about.

And you look up how these plans do on these more or less relevant and useful pieces of information, you will find that their standard comparison is how does the HMO or two, and it never is more than one or two in your zip code area, compare with other HMOs in your area.

So they have a big, fancy bar chart and it's got two bars on it, one for HMO A and one for HMO B, and there is no possible basis for interpreting that information.

What you would like to have, I mean, it's ridiculous, no reason why immunization performance or mammography performance or whatever should be different

from one zip code to another. Why aren't they giving you the national average on that bar chart, so you could see now I can see something about how my HMO really compares to the real world that everyone else experiences.

The government makes lots of mistakes of that kind. CMS makes thousands of them. I don't blame CMS, as a bureaucracy. I think it's staffed by very able people. I have an awful lot of friends there who I admire and respect. But they screw up lots of stuff.

What is the prognosis? Well, leaving aside the possibility that FTC and Justice might jump in and do a few things to nag the system, I'm basically not very optimistic as to any foreseeable kinds of reforms that would help bring the system along, partly because the Congress isn't going to enact them.

What we really need are radical changes in the way health care is delivered to the elderly. To make this point a slightly different way, what magic button switches off the day you turn 65 and says you have to leave the health care system you now have, the provider network you now have, the health care benefits you now have, and enroll in this government one-size-fits-all system that says we're going to pay -- seven grand is the current number -- we're going to pay $7,000 a year towards your health care, but if and only if you do it our way, not

your way, and we're not going to change that, probably.

But there are small things you could do. There is some possibility that CMS could be broken up. I would love to see the quality and safety and that whole set of regulatory issuances in another agency. They are not integral to the Medicare or Medicaid programs' missions.

They are really intended to be national systems and regulations, and there is no reason they should be run by the same people that have to worry about running price controls.

That's these things I mentioned and you're going to hear about the renal one, I'm sure, in more detail. I was there when the renal dialysis payment system was born, by the way. I was in on it. I'm not sure you'll let me leave alive, but it saved a lot of money, too, I'll tell you that.

There are organizational things you could do because I think if certain CMS functions were in a separate agency, you would have a much better shot at getting the kind of regulatory competence we get out of an agency like Food and Drug Administration, which, believe me, is head and shoulders more competent than CMS as a regulatory body.

Indeed, so much more competent are they that one whole set of regulations was taken out of CMS and put in

FDA some years ago, mammography regulations.

We'll do stories in the Q&As. So it would be possible to have that organizational change and that could be useful. It would be useful if there were an agency in HHS whose mission and function was to worry about the provision of private insurance to Americans at large.

We don't have such an agency in the Federal Government, for that matter. Looking at insurance issues outside of the narrow Medicare context is a byproduct for CMS. They know something, but they don't know a lot, because they're not in the same world as all other health insurance in America. It's a whole different universe in terms of the way it works.

It would be nice if we had people worrying about that who were not in CMS. They don't care about the tax system. It doesn't impinge on Medicare.

Well, I worry about the tax system and, sure, we have people in the Office of Tax Analysis and so on in Treasury Department and we have bits and pieces in FTC, I know in Justice. The bigger Justice Department presence on health care issues actually is in the fraud and abuse area.

But let me stop there. We don't have an agency in the Federal Government that looks in any kind of holistic way at health care delivery and health care

insurance and ways to improve those functions in America, and I think that is one reason that the Congress is not as sensitive as it ought to be to some of the issues it ought to deal with in a more rational way and a whole lot of things fall between the cracks.

That's it. I will pass it on.

MR. LEMIEUX: Thank you all very much. I will try very hard not to repeat the wise comments from Walt and from Joe.

Yesterday, I was called by a magazine reporter who asked this question. He said, "Do the Medicare negotiators in Congress who are trying to put together a prescription drug and Medicare reform bill have 'too many balls in the air.'" I thought about that for a second and I responded that it's probably not appropriate to think that they're doing something so easy as juggling a few benign and harmless balls.

They are essentially trying to cross a tight rope on a flaming bicycle juggling chainsaws blindfolded, and there is a reason for this story, which is that Medicare has grown so complicated and legislative fixes to Medicare have grown so complicated and administrative regulations to implement the legislative fixes that were already very complicated have grown so complicated that something has to change.

And the reasons are more than just that the system has gotten so complicated and we have these sorts of examples of the unintended consequences of some of these laws and regulations, but the reason is also more profound, I think, which is that health care is changing and I hope that the FTC can help oversee the competitive and market implications of some of this change as the pertain to Medicare in the following way.

Health care used to be mostly about patching us up when we fell ill or got hurt, and our health care system is very good at that and the clinicians call this acute care, taking care of a severe health crisis, effectively, and our health insurance system, including Medicare and perhaps in particular Medicare, has gotten very good at paying the bills when someone falls ill or suffers a health crisis and has to be hospitalized or achieve or receive a large degree of health services, a large number of health services, a large number of health services.

What this system doesn't do very well is help people who have long term or chronic illnesses that need to be managed on a day-to-day basis. It was explained once to me by someone who is much smarter than I am that acute care takes place with health care providers and hospitals and so on when you visit them or when you are

hospitalized, and chronic care takes place when you are not visiting a doctor or a hospital or a health care provider.

Chronic care is what happens between visits or between hospitalizations and, ideally, good chronic care can help patients with long term illnesses avoid over many physician or hospital visits.

So how does this relate, how does this transformation relate to what's going on in Medicare and what are the competitive implications?

It seems that as Medicare tries to adjust to chronic care, in one way, by providing a drug benefit, since medicines are a key part of good chronic care; that the regulations and the laws, and the complex laws just seem to be piling up on top of each other and this year's drug proposal is no exception. Its complexity is borderline absurd.

So there has to be, at some point, a transformation to a better way of running Medicare so that it can handle the sorts of things that people with chronic conditions need and so that it can pay for them appropriately, and all of those things are going to have competitive implications.

I fundamentally agree with Walt and with Joe when they suggest that ultimately we're going to have to

try to convert Medicare into a system where people choose a health insurance product or a health services collection rather than just receiving a list of benefits that goes on a mile long, at a list of prices that goes ten miles long, under a list of regulations that goes many light years long from the government, and that this will be a more efficient way for people to sort out what they need.

Some people might just want coverage for acute care because they can't envision needing chronic care services. Others need highly specialized and targeted disease management services for their particular set of chronic conditions.

So as Medicare tries to go to a system where people have more of these choices, that will inevitably involve simplifying the payments we do now for all of these services to simply paying a few dozen health plans and options in various areas, but that's not so simple.

That will require a great deal of work to make sure that those reimbursements to health plans and competitive systems that are set up and the sorts of premiums that people will pay are fair.

The second complexity of shifting Medicare toward chronic care that has competitive implications, I think, is innovation within the government run fee-for-service program.

Most people, about nine out of ten in Medicare, are in the government run fee-for-service health plan, which we have described as being highly regulatory and full of separate payment rules, not an encompassing or holistic system.

That needs change. I've seen a few ideas on how to start doing that. All of them will require oversight on the part of the government and accountability on the part of Medicare managers to make sure that as that changes, it doesn't create new distortions in the health sector or otherwise create competitive problems.

Let me give you an example. I think that rather than designing regulations to implement -- in Baltimore, CMS headquarters -- to implement laws, complex laws passed in Washington, it would make a lot more sense to take the people in Baltimore running the Medicare program and move them out into the field, various local areas, maybe dozens, maybe over a 100 local areas where health care can be put together based on what is needed in that area.

So instead of having ten people in Baltimore writing regulations, take those ten people out and put them each in a separate area, give them a local doctor, medical director, local nurses, and give them the power to work with local health care providers, seniors groups, hospitals, and the budgetary flexibility to make

adjustments as they work with those groups to do the best thing for seniors in that region.

Now, giving the power to pay bills on behalf of Medicare patients in new and creative ways to local bureaucracies involves a tremendous need for new oversight and accountability to make sure that the taxpayers are getting their money's worth and that these people are actually out there doing the right thing and improving health care faster than what otherwise had been the case.

And so what we need to set up is an oversight regime and an accountability system that tracks exactly how well things are improving in the various regions, how well are people in northern Louisiana doing treating the problems of that part of the country, whether it is diabetes, whether it's heart disease, whether it's any number of other things, compared with the people in southern Arkansas.

If the HCFA administrators and medical directors in southern Arkansas are seeing their trend lines go down and northen Louisiana sees theirs going up, then we need to get rid of the people in southern Arkansas and replace them with people from northern Louisiana to do a better job.

So this transformation of Medicare toward a more competitive choice of health plan system and this

transformation of the government run plan toward more local flexibility will require a great deal of oversight and it will require a great deal of study as to how these actions are affecting local health care markets and how they are affecting the availability and the delivery of health services.

We think that this sort of experimentation will be helpful for seniors and for the country, but we'll have to take a very careful look at how it works out.

The second thing sort of goes back to the drug benefit itself that I mentioned at the beginning they're having such a hard time with. I think that it makes a lot of sense for there to be a drug benefit in Medicare, because it's so important in chronic care, and I have tried to suggest some simple ways that the government could do this.

However, the thing that I am very most interested in is that the drug benefit have at least some element of universality to it, so that everyone at least is covered to some extent.

That way, Medicare will know or its researchers will have the ability to know the sorts of patterns of drug prescription utilization that are out there in the country.

If Medicare knows who is prescribing which drugs

to which sorts of patients and for what reasons in various parts of the country, it can use that information for a couple of purposes. It can use that information to help the local administrators or the national administrators target disease management programs to people who need them.

It can use that information to help adjust payments to health plans. If it turns out that one health plan has an awful lot of people who are using an expensive medication for a very expensive condition, .that could be a signal that that health plan needs a higher reimbursement.

Anytime you have this sort of data being used for these purposes, there are both privacy and competitive issues that will need to be looked at by groups like the Federal Trade Commission.

Then, finally, as a further tangent of the drug debate, I would like to mention drug pricing in general and pose the question of whether or not the FTC might like to take a look at the nature and the economics of drug pricing to see if it can't help inform the Congressional debate.

It seems to me that in many sections of the economy where goods aren't transferrable very easily or transportable very well, companies will try to price

discriminate. They will try to sell to people who need it the most at the highest prices.

You can see this with airline fares. If you have to travel tomorrow, you'd have to pay a high price. If you can plan ahead well in advance, then you can get a low price, and the person who got the low price well in advance can't transfer his or her ticket to the person who needs it desperately. The good isn't transferrable.

Drug companies, when they make decisions on how to price their product, they price discriminate not only among people who have coverage and who don't. The people who don't have coverage pay the highest prices. People who do generally have someone bargaining on their behalf, either as a bulk purchaser or a bulk insurer, to help them get lower prices, and they also price discriminate by country.

In the United States, where there are very few government price controls on drugs -- where there are only limited sectors of the economy that have government price controls on drugs, they tried to extract a fair amount of the contribution toward their large fixed costs.

In poorer countries, where people would otherwise not be able to afford medicine, they might try to sell for much, much lower prices.

But if Congress, in an attempt to reduce U.S.

drug prices, tries to make drugs more transportable and transferable, the upshot is the movement toward one world price. This isn't the perfect terminology, but something akin to a purchasing power parity where your dollar or your rupee or your peso buys about the same amount of medicine no matter where you go and at the prevailing exchange rates.

But I would argue that having one world price for drugs, even if it would save Americans a lot of money, would have some moral concerns that are troubling. I don't think we'd want one world price where people in India or Peru or other poorer countries couldn't afford any medicine at all.

In a sense, we want drug companies to price discriminate by country with the rich countries paying more and the poor countries paying less.

So what that means and where the Federal Trade Commission might be interested in this issue is that if we agree not to go toward one world price, but instead allow drugs to be priced by the relative richness of the country, then it might make sense to consider drug pricing as an international trade and intellectual property issue, with competitive implications internationally, and that might be an area where FTC study and analysis might be extremely helpful to Congress and congressional staff and

policy-makers learning about this whole drug price issue that they are facing so much political pressure on.

Thank you.

(Applause.)

MR. CRIPPEN: Thank you. Before I begin, I do want to take the time to thank you and congratulate the Commission and its Chairman for undertaking this task.

I'm not aware, this is probably a statement of ignorance, of other activities by the Commission in this scope. This is hearing 27 or 25, somewhere in there. I think it's number 27 out of 28, but you have taken, obviously, months to do this and will take more months compiling the record of the hearings, the data you have generated, and just a huge amount of work that I think we will all benefit from.

I just wanted to take a moment to thank you all and to congratulate you for these kind of endeavors.

Those of us who grub around in numbers know that trying to just develop this kind of data is a gargantuan task, let alone the hearing record you have established and other areas you have gone into.

I am just going to take a couple of minutes, actually, and probably not anywhere near my full time, to pursue a rather simple minded, and when I'm done, you will say obvious notion that I would like to explore, but I

think may have some relevance, obviously.

Namely, that health care costs are a function of both price and quantity. It is not just the "P" that we should worry about.

But we often focus on price, especially in cases involving antitrust concerns. The cost of health care can be driven at least as much by the type and quantity of services utilized.

Let me give you a few examples that I hope might help make this point and hopefully not too many examples to lose your attention.

Virtually, since passage of Medicare in 1965, the government has looked for ways to limit costs to taxpayers and beneficiaries alike. Often, these cost controls were actually price controls by another name for individual services.

But despite their best efforts, costs continued to rise. When controlling P failed to control costs, other techniques were employed. The development of bundled prices, for example, setting prices of reimbursement for treatment regime or spell of illness was one response. As Joe mentioned, the creation of the prospective payment system and the DRGs associated with it in the early 1980s is a good example.

While it is thought that bundled payments have

helped control costs, as Joe said, and provided incentives for efficiency, the system is certainly not without flaws and can be gamed, as we have seen over the course of its history.

In the end, per capita Medicare costs have continued to grow well in excess of the growth in the economy.

More recently, the failure of regulation and administered prices to control Medicare Part B spending resulted in the creation of essentially a global budget for physician services. Pardon me for dredging that term from an old health care debate.

A budget wherein prices, better known as reimbursement rates, are adjusted year to year to ensure compliance with specified spending totals.

Most of you are familiar with how well that has all worked out recently and Part B spending continues to increase well above those budget targets.

Another example, the cost of pharmaceuticals is another place where price is often mistaken as the driving force behind spending.

In recent years, the cost of pharmaceuticals has been rising much faster than most other health care spending, a phenomenon often attributed in the popular press to price increases.

In fact, the primary factor in increased pharmaceutical cost is increased utilization. The number of prescriptions being filled annually is growing rapidly.

In the Veterans' Administration, for example, where a strict formulary and tough price negotiations have resulted in relatively stable prices for existing drugs, pharmaceutical spending is nonetheless increasing rapidly, as well.

I should note the obvious, however, that in the VA and elsewhere, prices for new drugs are higher than those that they are replacing, which generally have higher launch prices, as well, than in the past.

That will continue to be the case, especially for more specialized formulations aimed at even smaller numbers of patients.

But nonetheless, the increase in pharmaceutical costs that we have witnessed in this country in the last five years is much more a phenomenon of utilization than it is of prices.

I would like to introduce one other well-known fact before I move on, as I said, to a simple-minded and obvious observation, but that fact is, namely, that a relative few number of people drive the vast majority of health care costs.

For example, 25 percent of Medicare

beneficiaries, or about 10 million out of the current 40 million, incur about 90 percent of Medicare's annual spending.

Let me repeat that. A quarter of the beneficiaries incur about 90 percent of the annual spending.

A number of these sick elderly are in the last months of their life. More actually remain chronically ill over a number of years. They tend to have several chronic conditions, with a bevy of specialists. In some cases, we found 10 to 15 specialists, lots of prescriptions, maybe up to 50 a year, and numerous hospitalizations, and no one in the system is in charge of coordinating their care.

Why is any of these relevant or at least relevant to the FTC's current investigation? To me, these various examples illustrate a critical point. The role of prices in health care is much different than the role of prices with many other goods and services.

More important is the demand for services, demand that may not be price sensitive and is often induced by other health care providers, such as physicians.

For example, when a doctor tells my elderly father that he needs to be hospitalized, he responds not

to the price of hospitalization, not to his co-pays or deductibles, not to the fact that there are now only two hospitals in his home town instead of three, but because it is what the doctor advises him to do.

Giving my father more information, more options and even more resources to exercise those options will likely not change his rate of hospitalization.

Hospitalization is, to my father, not a discretionary act.

Perhaps even more to the point of this hearing, there exists the potential for something akin to anti-competitive behavior, not manifest through higher prices, although that is certainly a possibility, but rather through behavior that induces or changes demand.

Nationally, hospitals have excess capacity, for example, at high fixed costs, filling empty beds is usually a money maker for them at this point.

Getting folks into the hospital, not necessarily keeping them there, is the key to many hospitals' survival.

Envision, for example, the equivalent of a revolving door between nursing homes and hospitals, resulting in repeated hospitalization, with stints of nursing home care between.

It is easy to qualify the sickest elderly with

multiple conditions for a trip to the hospital. It's also easy to put them back in the nursing home.

On examining the growing body of evidence of regional variations that other members today have mentioned in the practice of medicine and its cost, you find some other interesting facts.

Again, looking at Medicare, research indicates that after controlling for every imaginable difference, sex, age, cost, prices, health status, even patient satisfaction, it may cost 35 percent more for the same treatment, depending upon where you live.

Medicine is simply not practiced uniformly across the country, no matter what the prices.

Are these essentially local practice patterns, treatments that cost more with no discernable difference in outcomes, due to bad behavior? Likely not, but they do suggest cooperative or group or social behavior that looks like coordination of some kind.

And without questioning anyone's motives, as the number of provider options gets reduced through consolidation, the more possible it is to envision behavior that generates demand and increases quantities consumed.

Any investigation into the effects of changes in the health care industry, such as hospital consolidation,

needs to examine patterns in utilization in addition to patterns in prices.

Ultimately, in all our health care discussions, we need to remember that the lion's share of health costs are borne by relatively few people, utilizing expensive services, such as hospitalization, and who comes to the elderly probably doing it repeatedly.

The cost of the day's stay in the hospital has less impact on total health care costs than the number of days and the number of visits, and the prices physicians charge for their services generally has much less impact on the cost of health care than the other services they in turn prescribe.

Understanding what drives utilization in the end is the key to understanding what drives health care costs.

With that, I will retire.

(Applause.)

MR. HYMAN: Finally, we have a PowerPoint presentation. So if you panelists want to go sit in the audience rather than careen and turn around, it will probably be easier, and then we can just reconvene.

MR. CASHIA: Thank you. I would like to echo Dan's comments, and thank Sarah and Dan for inviting me here as being the lone provider to speak with such a distinguished panel.

I actually woke up this morning feeling pretty optimistic about my company's success, but after sitting here for the last hour, I'm not exactly sure anymore.

But as they mentioned, I own a small little company in Nashville, Tennessee. We are renal providers; that is, provide outpatient dialysis services throughout the country.

Again, I want to thank you for the opportunity of being here. What we are going to talk about a little bit is the agenda about who National Renal Alliance is, what end-stage renal disease is; that is, specifically, dialysis services; the dual role of Medicare as it relates to my business; the issues providers, such as myself, and possible solutions, as I see it, and, of course, after that, we can have some questions and answers in going forward through this.

Our mission, like other providers, is we want to offer an equal level of care to our patients. We're in business to take care of people who are ill.

Unfortunately, this type of business, there are people who are chronically ill, who need this service. If they don't get it, they literally die.

Our strategy and how we do this, which sort of differentiates us from other providers, we locate clinics in under served areas. It's very important as it relates

to the Medicare system, because in under served areas, not only is Medicare the predominant provider, in many instances, it is the only provider.

Our idea is to bring the services to the patients as opposed to having the patients travel to the services. In many years, in our industry, patients have had to travel 30, 40, 50 miles one way to receive a dialysis treatment, which they get three times a week for the rest of their lives.

Another strategy is we want to partner with local hospitals to identify the needs, recruiting local nephrologists to who live in the community as opposed to these nephrologists who live 50, 60, 70 miles away, who do not, as someone mentioned, routinely see their patients, if at all, and optimize our clinical outcomes by improving access to care and utilizing state-of-the-art technology.

Our growth and how we plan to do this. We were founded in 2001. Currently, we're a year and a half old. Our first unit was acquired in 2002. We have ten clinics now in six states. This is my fourth company. I'm the founder of three other companies that have been successful in the past.

We're opening four more clinics in Q-1 2004 and we have pending contracts with two major university hospitals, one in the northeast and one in the southeast.

Our plans are to open anywhere from 10 to 12 clinics per year for the next five years. This shows you our map a little bit of how we exist right now. By design, we're primarily in the southeast, but these are the areas that we term as under served; that is, markets that have less than 10,000 people in their populations or so.

What is ESRD? As I mentioned, ESRD stands for end-stage renal disease; that is, patients with chronic irreversible disease that, if not treated by dialysis, these people would literally die.

There's over 400,000 people who have ESRD in the country right now, of which about 300,000 have to receive every other day dialysis for this life sustaining treatment.

What does that mean for the future? We literally have an ESRD explosion. The causes of renal epidemic right now, number one and number two causes in the country are diabetes and hypertension.

As health care providers, not only in dialysis, but other health care providers, we got better at controlling these diseases. That's the good news. The bad news is that these patients are living longer, going into more co-morbid factors that require hospitalization, require earlier intervention into other disease processes,

such as dialysis.

Predictors of this are going to be continued growth, aging population, lower mortality rates, as I mentioned, earlier intervention, by opening up additional facilities and improving access to care.

This shows a growth of dialysis patients and what you have seen happen from 1984 to 2001. It has grown over 360 percent, now to over 300,000 patients.

The patient count could double, depending upon who you talk to, in the next seven to ten years, despite a 24 percent mortality. That number is phenomenal when you think about that.

On average, we're growing about eight percent, but for every one patient -- for every four patients that come on, one die, and it's still going to double in size.

The growth in rural markets is 25 to 30 percent higher than the overall industry. Why is that? I'll argue the point that the reason why that is is access to care. Other providers, such as myself, are now going to communities where this service was never offered.

A drop in mortality rate from 24 to 20 percent can increase the patient growth rate over 50 percent. That's tremendous, when you think about it as a provider. We as clinicians, I'm a former clinician, what we want to do is provide a good level of care for our patients.

But why is, in America, the mortality rate 24 percent, where in the UK or Europe it is in the low teens? What is the differentiating factor?

It's pretty much like McDonald's. If you go to McDonald's in California and get a quarter pounder, it's much the same as you're going to get a quarter pounder in New York.

What's the difference? Well, the difference primarily is reimbursement in what is being paid there versus here.

This is a graph that shows what could happen if we dropped our mortality rate 24 to 20 percent and it shows what happens to the patient population. It could literally increase that number. Instead of doubling in seven to ten years, it could double in five years.

Rural centers, more graphs that show, again, based upon urban versus rural, from '93 to 2001, there were approximately 1,811 to almost 3,000 dialysis centers. It's a 6.3 growth. Rural centers grew at an average of a little over 8 percent compounded annual growth rate, which is 29 percent higher than the market industry.

Freestanding centers data. Again, the same growth. Freestanding versus hospital based programs and what you see there. Although it has expanded to almost 4,000 centers now, it's 6.8 percent growth rate,

freestanding centers, vis-a-vis non-hospital-based, are growing at 33 percent faster than the overall industry, and hospital based programs, as you can see, are beginning to exit out, which goes to the strategy of acute care versus outpatient services.

These are treatments by types. You can see here in the industry, 90 percent use outpatient, which is faster growing. Ten percent use home treatment, which is down from 18 percent, the high in 1993.

Coincidentally, that was the same year that Medicare then decided to reimburse home dialysis on the same level as they did chronic dialysis inpatient.

So you can see what happened. Everybody went back to the centers. The number of patients, a strong 3.4 percent each of the last five years for home dialysis.

The dual role of Medicare in my industry specifically, they are a purchaser of ESRD services. In 1972, which I guess it's nice to know someone who was there, Public Law 92-603 was passed, mandating that anybody in the country who developed end-stage renal disease who contributed to the Medicare system was automatically covered for dialysis services.

It's the single largest purchaser of health care service, accounting for 70 percent of dialysis treatments or over 85 percent in my companies.

Medicare has a fiduciary responsibility to the taxpayer to control cost. Other payers often follow Medicare in setting reimbursement rates. And what do we do about that? What is the inherent problem with that?

The regulatory of ESRD has that Medicare has an obligation to beneficiaries to ensure safe and adequate care. How do they do that? They set rules, they set regulations, they set parameters. They price control, too, at the same time.

Department of HHS, including Centers for Medicaid and Medicare Services, as well as the Office of Inspector General and state agencies, license or regulate every dialysis facility, but the licenses and regulations of those facilities differ from state to state, differ from intermediary to intermediary.

There is no consistency in how to do it. So what are the conflicts for Medicare? They have to control the costs, but they want to ensure patient safety, monitor adequacy of care, broaden access to care vis-a-vis open up additional centers to accommodate this growth that is happening in the industry, that is growing unabated.

I think Thomas Jefferson once described slavery as holding a wolf by the neck. You didn't really ever want to let go, but you didn't dare want to be involved in it, either, and that is what we essentially have here now.

Licenses and regulatory oversight, enhance clinical outcomes, and, at the same time, the issue for providers and what we have to do. We have a rising operational cost, no big secret here. Labor cost and supplies go up every day, but yet our reimbursement remains fixed, if anything is being decreased.

An increasing capital expenditures per clinic. In order to enhance the technology, we have to invest money back into our business. Where does that money come from? Flat reimbursement from Medicare, lower reimbursement in rural areas. This is very important here.

Just because I provide services in a rural area versus in a metropolitan area, I get lower reimbursement. Why is that? They say the wage-price index in these areas are smaller than what they are in rural areas. These wage-price indexes were set in 1985. They have not been adjusted since.

Fully 19 percent higher costs for urban providers than in what I get. But I would argue for me to get competent nurses and competent staff, it is more difficult for me to get them in rural areas than it is in urban areas.

And the oversight for Medicare via the states. Medicare contracts directly with the states for oversight

in the business, but there is no consistency in what that oversight is and how it works.

The length of the licensing process. For example, I just opened up four clinics in South Carolina. I had to endure three surveys that have amounted to over 90 days, but the state expected me to be fully operational, fully staffed, fully open to patients, but they will not reimburse me for services until they come in and give me the stamp of approval.

In Kentucky, for example, I have opened up a facility there. Not only will they have to wait for them to come, they will not retroactive my provider number back. They'll give it to me as of the date of the survey.

So I have to take the bite for 90 days of services free of charge. What choice do I have in that? None.

If I want to be a participant in the Medicare provider system, this is what I have to do.

Inconsistency in state oversight. That's an understatement in itself. There is no interpretative -- well, there are a set of interpretive guidelines, but each state, each state surveyor interprets their own set of the interpretative guidelines and what their whims are or what their wishes are for that given day and how things develop.

Solutions to this. I guess I'm not as smart as this panel and I won't pretend to be, but as a provider, I think some of the solutions we can do are annual reimbursement increases. We don't have the luxury to even get a medical CPI increase every year.

If you look at our dollars of reimbursement based upon 1985 dollars, when we received our first large cut, we're getting 30 percent, 30 percent of what we were getting as providers in 1985 in 2003 dollars.

I would dare any other business to stay in existence with that type of reimbursement.

Streamline and standardize oversight. These are all easy things and, to me, very logical as a provider.

Shorten licensing process. You can have quality control, but shorten the process. Why does it take 60 to 90 days to have three different inspectors to come out and look at the same facility and have the same findings? To me, there is no rational reason.

Enhance uniformity in the state survey process. Why can't each state, 50 members of the states, come to one Federal Government agency and say this is how we're going to inspect these programs and this is what we're going to look for?

Level the field for rural development. Parity for reimbursement. Again, if you look at my particular

clinics, I'm paid a $121 versus a clinic here, for the same treatment, in Washington, D.C., that's paid $144. Why is that? There is no reason.

At the same time, the Federal Government will readily admit, Medicare will readily admit, as a provider and payer for CMS of dialysis services, providers lose money when they issue a dialyses treatment.

They make a small margin on the drugs they give, but right now CMS is looking at whether or not Medicare should be purchasing drugs, in their definition, at retail rate versus a wholesale rate.

So they're looking at the opportunity to increase my reimbursement in drugs, so I will not only lose money on the treatment, but lose money on the drugs, but yet they want me to provide access to care, enhance technology, and improve my quality of care.

I got going there for a moment, because I feel pretty strongly about this, but as a provider, we all really want to do a good job. I mean, I think I can speak for my industry and health care as a whole.

You don't enter into health care just strictly for the dollars and cents aspect. We want to take good care of patients and ultimately I believe we do.

But we have to do it in a partnership with the payers, a partnership with the Federal Government, who is

our single largest payer.

Thank you.

(Applause.)

MR. HYMAN: Why don't we take a ten minute break and we'll reconvene for our panel discussion.

(A brief recess was taken.)

MR. HYMAN: Why don't we get started again. Before we continue, Joe wanted to make a brief advertisement for a program that he is running on Thursday.

MR. ANTOS: Thank you, David. One of the big issues that is closely related to the Medicare reform debates, but is a more general issue, has to do with this push by a lot of northern tier Congressmen to allow importation of drugs from Canada and other countries more freely.

Right now there are severe restrictions against that. The rule is that the Food and Drug Administration has to agree that any importation is safe and it's unlikely that they are going to agree to something like that anytime in the near future.

So there are proposals in Congress that would lift that restriction and allow importation and make some changes that would hopefully deal with the safety issue.

We're having, at the American Enterprise

Institute, on Thursday morning, starting at 9:00, a panel including Representative Gil Gutknecht of Minnesota, the Congressman. He is one of the leading proponents of this kind of proposal.

Everyone is welcome to attend. We would enjoy seeing you there. That is at the American Enterprise Institute on Thursday, 1150 17th Street, Northwest.

MR. HYMAN: Thank you, Joe. Before we sort of just start with questions, and I want to encourage all the panel to ask questions of one another, I just thought I would give the early speakers a chance to comment on or dispute, as they see fit, anything that happened after they spoke.

Joe got in first and now he gets to go first again. Anything you want to comment on, Joe?

MR. ANTOS: Well, let's see. There is so much that one can agree with that it's a little hard to find disagreements with the panel.

I think that Jeff's point about the complications and complexity in the Medicare program, the need to find some way to simplify the program, I think, is really a compelling point, to me, and there are several dimensions to that that I would emphasize.

Most people talk, especially in the context of a Medicare drug benefit, in terms of making the program more

simple for beneficiaries to understand, and that is certainly important, but I think it is even more important to make it possible for providers and health plans to understand the program and for providers and health plans to actually operate in a reasonable way in the program.

Certainly, part of that would be to change -- Walt made reference to this -- to change the rule that says that if you want to serve people over the age of 65, you can't be the health plan that you are for people under the age of 65. That just seems utterly ridiculous.

Yes, your health might change because you had a birthday, but that's not very likely. Your needs, your fundamental needs really don't change in terms of the kinds of services you need. The intensity may change, but the kinds of services, the kinds of assurances that you need. If you were in the Federal Employees Health Benefit Program and very happy with your Kaiser plan, if you were under the General Motors plan and very happy with whatever they have, why should it be that you have to change plans? Why are you excluded from the rest of the market when you got a little bit older?

I think that's a really, really serious problem and that is one of the things that has impeded real competition in Medicare, and, in a sense, may impede competition throughout the health system.

The fact of the matter is most people don't have a lot of choices in their employer sponsored plans. If Medicare became a lot more competitive, I think the fact that when you turn 65, you actually had a better deal in that sense, would be to effect what unions and other people do when they talk to their employers about what kind of health plan I'm going to get.

MR. HYMAN: Walt?

MR. FRANCIS: I think we're stuck with a surfeit of agreement. Even though it's interesting, we all approach -- we all use somewhat different vocabularies and somewhat different ways of putting it, but there's this common theme in all the discussions at the last, which I want to come back to, is this fragmented system that faces the elderly, just at the time when -- well, it's perfectly true their health doesn't change the day they turn 65, but over time, an increasing percentage of them need something that is not a fragmented system, because their health care is less the acute episodes and more the chronic care.

We're all in agreement. The chances of getting there, unfortunately, I think are slim to none. Another general point about health care generally, let's talk about health care plans. Let me focus on the plan products.

These plans have multiple attributes. They are

a complex bundle of goods and services, and our preference functions, our utility are complex. I counsel thousands of people. I spend a lot of time on what do people want in health insurance, just because it was one of the things I do for a living. People want a lot of things, but they tend to want things like I want the doctor, I want to be able to pick my own doc, want to have a good panel of doctors, I want to keep my doc, if I've already got one, I don't want to have my health plan changed every year, et cetera, et cetera, et cetera.

Far down that list are some things, some of these quality measures that people aren't very interested in. Cost is very high on that list, and so on.

Well, then you look at how health care is delivered in America. Even in the under 65 market, we now have a system in which it is very common for large employers to see a real or perceived advantage from switching to the single plan, Plan A they are using this year, or the Plan B they're going to offer their employees next year, thereby disrupting everybody's provider networks and expectations, to say we haven't got this worked out yet.

But the one thing I think we're all agreeing is that on a scale of one to ten, where ten is perfection and nirvana or something, and zero is ridiculously bad, I

think Medicare may be even below the zero line as far as rationally organizing medical care.

A comment on the renal dialysis I think completely illustrates, it is a very nice way of showing the tension between the regulation of quality health care and the HCFA mission.

The current HCFA Commissioner Tom Scully or Administrator Tom Scully likened himself to a price control czar. He says, "I'm in the business of controlling prices and I'm pretty good at it, but I'm not good enough, but I wish you'd fix the system so I didn't have to." Okay.

But that is the business HCFA is in. They are a price control enterprise. At the same time, they're supposed to be assuring quality and access and other things, and, by and large, they don't do a terrible job of reconciling, I would argue, because they don't dare push too hard on the system, because it rebels and people go to the Congress and say we're not being paid enough, as the doctors are about to do.

But it is truly dysfunctional in so many ways. For example, Dan's point about utilization. I think, I'm not sure I threw the word "utilization" in here in enough places, but when you fix prices, it pops up the other place. I think I heard -- I guess it was in the papers.

Rick Foster, the HCFA actuary, was quoted as saying "expects the Medicare Part B premium for next year to go up 14 or 15 percent, despite no changes in the prices paid," because they squeezed long enough the docs are just scheduling a hell of a lot more visits.

I also want to just comment on the FTC, a bit I hadn't really focused on. We don't know a lot about the effects of health care regulation. I think our ignorance is surprisingly vast.

CMS spends almost no money on researching the effects of its own systems. They don't do significant amounts of research on dialysis. There is good research, but it tends not to be on the effects and particularly the systemic effects of some of these kinds of regulations. I think they do minimal research on how much could you -- for example, this huge sort of pot of gold, if we could just manage the chronic care cases better.

I mean, there is potential savings. Disease management is en vogue. HCFA is careful to put in its regulations everybody has got to do disease management, but that is meaningless and the question really is, and we don't know yet, just how much can you save, where and how. The only thing I'm positive of is it's precisely these things that aren't commonly done now and which the private plans will lead the innovation in, things like the care,

following you up at home.

I'm back to your distinction, Jeff, between acute care is what you do in the provider setting, but chronic care is what you do in between visits.

Are people taking their pills? Can you use e-mail to make that happen? Can you actually -- and this is the big promise of Medicare drug benefit, that the pharmacy benefit managers may actually bring some rational, some sensibility to the notion that we're going to look at patients and consider whether or not they are getting what they need and not taking things they don't need, and so on.

So there are greater opportunities, but the current Medicare program is going to find it very, very hard to accommodate them.

MR. HYMAN: I have some questions and I want to encourage the panelists to be forthcoming in their responses and engage with one another.

The first thing was sparked by something that both Joe and Walt said in their original remarks, and I think heard echoes of it in some of the other remarks, as well, which is that when it comes to innovation, Medicare is not very good at encouraging it and implementing it internally either, I take it.

I guess the question that I had, in two parts.

First of all, is that a consequence of its statutory framework, where there's limited regulatory authority, and are you focusing on delivery side or financing side, possibilities of innovation, because in terms of critiques of Medicare, one of the things that is commonly heard is Medicare pays too much for too many doodads, too much fancy technology, and, in effect, the problem is once it opens its purse strings, you get a cornucopia of technology flowing out into the community, and so the problem is, quote, too much innovation or doing high tech, high cost fixes to things instead of -- whether they're the things that people desire is a different question.

But nonetheless, the innovation point, I just wanted both of you to flesh that out a little bit, if you could.

MR. ANTOS: Well, a wise man once said that in Medicare, if something isn't mandatory, then it's prohibited.

Congress, from 1965 on, has taken the view that it is going to try to eliminate all uncertainty associated with the Medicare program for beneficiaries. Now, they're not committed to eliminating uncertainty to providers. You guys have your own problems dealing with them.

But we're going to -- the whole idea here is protect the elderly. When you have that view, you also

tend to protect them from fulfilling their own desires. But this point of view, then going back to the question of innovation, then has locked the program very much into making sure that they're going to err on the side of certainty.

So they're not going to approve things unless they're already out in the community. One of the interesting realities about the way the Medicare program makes its coverage decisions, coverage is the decision to pay for something new that they hadn't paid for before.

There have been very few national coverage decisions. In fact, coverage decisions are made by the so-called Medicare contractors, the carriers and intermediaries. It used to be all the Blue Cross/Blue Shield organizations. Now it's a little more diversified.

But the fact is that all innovation, for good or for bad, that has entered in the Medicare program has been through the fee-for-service sector and has been through this process that, well, everybody in Boston now does X. So, well, since everybody is doing it, I guess we'll pay for it.

In fact, it has regularly surprised the administrator or the Medicare program and his fine fellows and gals in Baltimore, it has regularly surprised them what they pay for.

Sometimes you have to read the Wall Street Journal to find out what the Medicare program has been paying for for years in certain regions. It is very, very complicated and difficult.

So there is no really systematic way, at least traditionally, for Medicare to make these decisions. I have to say that maybe that's not a bad thing, however.

If we started in 1965 with the idea that there were going to be national coverage decisions, then you would have a program that was covering literally everything that was going on in 1965 and you wouldn't have had the unleashing of this vast torrent of, well, I'm going to call it innovation. It's really just change.

Some of it is innovation. A lot of it is variation on a theme. You wouldn't have had all of that and it's hard to know where the dividing line is really between what is good and what is bad.

I feel confident that the Medicare program has paid for a lot of things that, in retrospect, were probably not very good ideas and spent a lot of money doing it.

On the other hand, there has been a smaller subset of specific medical procedures that have become very efficient. I mean, cataract surgery is the classic example. We no longer hospitalize people for a week with

sandbags on their head.

That is only because the scale of operation and the financial incentive to make that better occurred. Medicare was paying for all of them.

It's a very mixed bag on the sort of medical practice. There is no question, on the financing side, except for situations where Medicare has been under strong budgetary pressure to do something else, and I think the hospital DRG system is a classic, and, frankly, it exists only as a political fluke, the system was enacted under the false theory that the Medicare program already had an active project going on proving that it worked.

In fact, it wasn't active at all, but there was a lot of political pressure and a lot of budgetary pressure to do something there.

That could have been an abject failure. I would say that the physician payment system, which, to many people, looks very similar, was an abject failure. There is no question that, at least in my view, Walt and I disagree on this, that competition with health plans has been an abject failure and, again, because of the rules, because of the need to make things certain.

So this tendency to want to avoid risk and want to protect people from the consequences of their own decisions I think has been a major, major problem.

MR. FRANCIS: I don't disagree with anything Joe said. I have another whole take on it, though. Let me add one of my favorite examples to his list.

Medicare was paying for heart transplants for two years before it knew it was doing so. And if you really want to hear a horrible story, we'll talk about leather covered seat lift chairs.

MR. CRIPPEN: When did it start paying for anti-rejection drugs?

MR. FRANCIS: Only a decade or two later. I think the fundamental difference, if you will, in governance between Medicare and the FEHEP is startling and I want to -- we haven't talked much about that, but FEHEP is a system in which the Federal Government, the Office of Personnel Management says to health plans, "Have a good benefit package. We don't care what it is exactly. We'll review it. We're going to make sure it's a good package, take it as a whole, but we don't care what your benefit package is. Just come in with one, and market yourself to people and if they buy your plan in the annual open season, that's great. That's fine. We care about costs, but we have a system that sort of uses average costs across the plan. So we don't care very much about your plan, company A, and how you deal with benefits."

This system has been in place actually do to

another political accident. When the Federal Government came to health care in 1960, very late compared to other large employers, it grandfathered in, because of political pressure, a whole bunch of existing health plans.

So the politics of that process prevented them from enacting a Medicare type system, which is what, in fact, the U.S. Government proposed at the time.

So we've had 40 plus years of all these health plans competing annually for enrollment and so on. What happens? I want to talk about the benefits.

Every plan every year changes benefits, sometimes a couple items, sometimes a couple dozen items. It will raise its deductible. It will lower its deductible. It will screw down on prescription drugs. It will expand on prescription drugs. It will add this, it will subtract that, and so on and so forth.

Painlessly, over 40 years, these health plans have all, without exception, adopted catastrophic health care insurance, which does not exist in Medicare.

They have all adopted robust prescription drug benefits, which does not exist in Medicare, and they have done a bunch of other things and they have done it without political muss or fuss.

The lobbies aren't up on the Hill saying we got to get our thing covered because the answer always is some

health care plan -- the acupuncturists are covered in half these health care plans and the whole model is we don't enact an acupuncture benefit into law.

Medicare is totally the opposite. Every benefit is enacted into law or specified in regulation, or both. Every single detail, except for this contractor flexibility out in the field, this black box that people don't know about.

But by all the important things, there is a Part B deductible. It is set in law. There is no deductible for federal employees, or, I should say, there's 200 plus plans participating, there's 200 different deductibles.

Some plans have a physician deductible and some have a hospital deductible and some have both and some have neither and so on.

I'm going to use as an example, now, going to innovation, 10 or 15 years ago, most of these plans, certainly the fee-for-service type plans, paid for prescription drugs on essentially the following model. You take your prescription to the drug store. We will pay 75 percent of the retail cost. You will pay 25 percent. That was the standard, more or less.

Some were paying 80 percent, some were -- you know, there were variances. Some had a deductible, some didn't, but that was the basic model.

It turned out that model was not very good at controlling costs. So they did some radical things, plan by plan, year by year. Today, the dominant prescription drug approach in the FEHEP is a six-tier benefit system, three tiers for in the pharmacy and three tiers via mail order.

Mail order is always cheaper. You pay a small dollar co-payment for generic drugs, a somewhat larger dollar co-payment for name brand drugs that are on the formulary that are favored drugs, and a third and higher level of dollar co-payment for the latest and greatest and most expensive name brand drugs, and you get to decide, as a consumer and with your doctor, kind of how you're going to sort things out.

This model has been shown. There is a recent JAMA article by some Rand researchers to save beaucoup bucks compared to the old fashioned kind of model. We're talking about maybe spending a third or more less on total prescription drugs, spending by the health care plan, than otherwise would have been the case.

There is no murmur. There was a brief four-year protest when people -- when Blue Cross said we're going to give you a better deal if you go mail order, but I won't -- basically, the political furor over these changes has been minimal or negligible.

Once Medicare enacts a drug benefit into law, that flexibility will never exist. I mean, Medicare is not going to go to the six-tier model or if it does so, it will be in a paroxysm of legislation 20 years down the road or something.

In the FEHEP, plans make innovations all the time, painlessly, without approval of government bureaucrats, without approval of the Congress. It's hard to even compare it to Medicare, where to be sure, 90 percent of what goes on is probably the same in the two systems in the sense that Medicare is paying for the practice of medicine in physicians' offices and hospitals as is the FEHEP, and most of that is sort of, in some sense, fairly -- it's what doctors do and they know what they're doing and they are not second guessed a lot in either program.

But the ability to control costs, for example, by innovations in payment policy is -- you know, in Medicare, the innovation is they'll screw down harder on HMOs or physicians this year. Next year, the political outcry will be too loud and they'll loosen it up again.

So it's kind of a yo-yo effect. There was a period of years when, in Medicare, you call it innovation, I guess, if you want, medical equipment, things like hospital beds and walkers and so on, they changed that

damn statute every year for about four years running.

It takes CMS about three or four years to write a regulation to implement an act of Congress. So they never could have regulations in place that reflected the current law, let alone last year's law. I mean, the whole world was going crazy over this.

These problems don't exist in a system that's market oriented, market based, and end of speech. But innovation in the sense of we're going to improve service -- in the FEHEP, they'll pay for the Mayo Clinic seeing your x-rays. Take that simple example.

MR. CRIPPEN: And this may not have a lot to do with, ultimately, your report, but just for the fun of it, think of one of the factoids I was playing with flipped.

That is 75 percent of Medicare beneficiaries generate only ten percent of the total costs. That's 30 million people today and, after my generation is retired, it's going to be 60 million.

They generate so few costs relative to any measure, that why don't we just let them go? Why do we bother to regulate them? Why do have these discussions about whether they can go to an acupuncturist or not? Just give them maybe a budget and a smart card with a budget on it, and we can income relate it and Jeff would be happy and we could do all kinds of things we want to

do.

But for most of them, we don't need all this regulation, because they don't spend enough money to make a difference. It's only those folks who are sick, really sick. One definition is if you go to the hospital, that's where you really want to start looking at people in terms of the costs they're going to generate.

So you could have a -- the screening mechanism could simply be until and if you are hospitalized, we don't care. You can do what you want and here is some money to go do some of it with, and you get rid of, for many of these people, all of the trauma and all of the paperwork and all of the intermediaries and all of lots of things, and still have 30 million very happy beneficiaries.

MR. LEMIEUX: Maybe a slight modification of that theory is to have two separate Medicare programs; one for people when they're 65 to maybe 75 or 78. It's less common to have severe and debilitating illnesses. And then another program that is essentially for people over 75 or 80, which is essentially for maintenance of as good a health as possible as you really get old.

And then for some people with disabilities, we might want to get into the second system earlier, depending on how their health and life has worked out.

But it seems like that would be sort of a variant of the Crippen approach.

MR. HYMAN: The good news is we don't have to adopt either approach today, and can't, but the bad news is we do need to talk a little bit more about bringing competition and thinking about ways and incorporating it within Medicare and using Medicare to push it in the larger market.

So let me just push on that for a minute and ask what are the roots of the access regulatory approach to Medicare, and it's not, by the way, unique to the Federal Government. The states are prone to mandate insurance coverage, as well, and health care in general is known for lots and lots of regulation.

So why is it there are so many regulations? Is it fear of scandal? Is it consumer protection? Is it lots and lots of federal dollars on the table that need to be protected; fraud and abuse? Why the taste for regulation?

MR. LEMIEUX: I'll take a shot at it. Medicare didn't have a lot of regulation when it was first born in the mid- and late-1960s. They essentially just trusted the contractors and intermediaries, the payment companies, to make the decisions.

But that quickly ran up against the problem of

accelerating costs throughout the 1970s and into the 1980s, and it was only probably in the early 1980s where the first big, large scale regulatory effort started to hit.

There were some earlier, but the big, large scale payment systems started to change in the 1980s under budgetary constraint, and this is always the problem when the government is responsible for making sure that costs don't go out of control, without a lot of participation from consumers, either at the point of purchase, which a lot of people recommend, or at the point of selecting an insurance package.

Then the solution is an ever-expanding list.

The other thing is that health care was just so much simpler back in 1965. There was only certain numbers of things that you could do. One of the doctors I work with likes to joke that the first symptom of heart disease was often a fatal heart attack.

That doesn't happen anymore. We live with cancer. We live with heart disease. We treat diabetes. We have long-term chronic illnesses which have led to a wider and wider variety of services available and that just, again, expands exponentially the number of regulations that we have to have to keep track of all those services and figure out how to pay for them.

MR. CRIPPEN: Let me try one just very short, but slightly more -- theoretical is probably the wrong way to say it, but there is an inherent tension in medical delivery that is more adverse than some other like services.

That is, that a physician who is essentially the gatekeeper in our system and who resists other gatekeepers, by the way, wants to be able to provide whatever they feel would be necessary for their patient, which is a very understandable kind of incentive, and not be responsible for resource allocation.

In that tension, we have tried, at the Federal Government level, and others have, as well, to figure out payment systems that give incentives, incentives to give good health care, but maybe not too much, and incentives to be a little more efficient or to do things a better way.

But we have often found that those incentives have failed, that the financial incentives don't work the way at least the designers thought they would.

So we have had to come being with regulation. You really have, in the extremes, two ways to control not just costs, but the benefits and the administration of medicine. It is either have the right incentives in the system for patients and providers alike, but in this case,

mostly providers, or you just regulate the hell out of them, and we fluctuate depending upon what our mood is on a given day.

So we usually have found the incentives haven't worked very well and we've ended up with regulation, and we are just accreting it.

MR. CASHIA: Can I ask a question? Is regulation set up then to limit health care?

MR. CRIPPEN: Some of it, to limit health care costs.

MR. CASHIA: Not costs, but limit health care.

MR. CRIPPEN: Yes.

MR. ANTOS: Well, that's one way you limit health care, health care costs is to limit care.

Somebody has to ration and we end up, if we don't do it with a payment system, we end up with a regulatory system.

I would like to amplify a little bit on Dan's points. There is really a philosophical issue here, which is the usual problem. Do you believe in something that is concrete or do you believe in something that is invisible? Concrete. That's regulation. Invisible. Adam Smith called it the invisible hand.

The problem is that legislators tend to believe that if they take an action, it will have an effect, and

the entire legislative process, including the budget process, follows that philosophy. If you take an action, it will have an effect.

Three of us spent some time in an agency where we were paid to believe that we could even guess what that effect was, but nonetheless.

So you have to take an action to have an effect. That is the regulatory environment that we're in. What many of us are talking about is moving to a situation where it is incentives, the thing that you can't see, that people react to. They react to their environment.

So we're talking really about the invisible hand of Adam Smith and whether we can really trust individuals and providers to react in the way that we hope they would react that would reduce system costs and improve health care quality.

Well, the problem is that if you start with a regulatory system, you have a hard time transitioning to one where the incentives are aligned properly so that you get the invisible hand working the way we want it to work. In fact, the invisible hand works at all times. It's just that the institutional structure we have encourages the production of more services, not necessarily better services.

And the nature of third party payment is that

the person who is getting the treatment is paying almost nothing for it and is promised, well, it might do you some good, so let's go for it, whereas the payer, who ultimately is the taxpayer, but it's somebody in the Office of Management and Budget, is looking at it and saying, "Oh, I'm worried about cost and I can't measure this other stuff."

So we have a fragmented system in a fundamental way and we have legislators who essentially can only recognize what most people can recognize, which is, well, okay, if I make a law or make a regulation, that is going to have an effect. I wrote it into law. It says you have to do this and, lo and behold, it doesn't usually work out that way.

MR. FRANCIS: A different take. I'm not disagreeing with what anybody said at all. If I look at my laundry list of regulations here, and I was sort of thinking about your question, I am struck by a couple observations.

First, a lot of the CMS regulations don't have much effect on competition one way or the other. They have all these conditions of participation they lay on hospitals. Those are requirements for things like you will have a record system, you will have nurses watch the patients on a 24-hour basis.

It's pretty simple stuff and it's mostly stuff hospitals do anyway. And except for some weird aspects of it, like how you have to counsel people about viatical wills and so on, you know, there are some strange and negligibly costly requirements, but they aren't competition effecting requirements, by and large.

I don't mean there aren't any. Some of these regs have pro competitive implications. I think the prospective payment DRG system we have all mentioned favorably -- it replaced a system where we paid hospitals on a cost-plus basis.

Well, free markets don't pay people on a cost-plus basis. The DRG system says we're figuring out kind of what it cost to give an appendectomy and we're going to pay that cost and if you can do it for less, you get to keep the profit; if it costs you more, you're inefficient and that's tough.

So in effect, I would argue a lot of the beneficial effects of the DRG system came from trying to create a market-like structure where none existed before in health care payment.

Other regulations are clearly very antithetical to competition, and I won't go through the list, and others are antithetical because of their interaction with other things.

There are also certain endemic problems in these regs. A simple example. Providers are always looking for a monopoly. That's the big -- it's rent seeking by economic interests. Everybody is a rent seeker, to use the economist favored term, and HCFA is always or CMS is always balancing that.

But when you've sat in, as I have, on literally hundreds of meetings where the Secretary of Health and Human Services is trying to decide whether she's going to let clinical psychologists do a certain thing or keep it restricted to psychiatrists, those kinds of issues, they are endemic. They are throughout.

I am involved right now in an organization that is proposing -- it is a government-chartered monopoly, called the United Network for Organ Sharing. They are proposing a regulation that says no one may get an infusion of pancreatic eyelet cells, which is a non-surgical procedure, unless it's done in a transplant hospital under the supervision and direction of a pancreatic transplant surgeon.

Well, let me tell you why they want HHS to make that a federal requirement, and HHS will, I can assure you. Because the pancreatic surgeons stand to lose a 100 grand. They get a hundred grand for putting a pancreas in a patient.

If instead we infuse that patient with eyelets, it's a $5,000 procedure.

Why are we putting those people in charge under the name of quality and safety and all that and they have no expertise? I won't belabor it, but there are -- the world is full of those kinds of regulatory decisions.

I don't think, though, that, by and large, they are the problems that cripple Medicare's effectiveness as a health care system -- they're much more structural, and I'm back now to the FEHEP example or Dan's -- I liked -- you guys have both proposed variants of this, but I haven't heard the one for the cheap patients before.

That is actually very similar to something Joe has proposed for Medicare drugs. Give people a budget, put it on a card, and say, you know, you get to use it up, but use it frugally, because if you use up what is on that card, you're going to have to pay a lot more, and, by golly, you'll have huge effects on an actual behavior and you'll get people making responsible decisions and so on.

So without structural reform -- but it's not the regulations, per se, that create the problem.

MR. CASHIA: Ever felt like you were in a group of tuxedos and you were a brown pair of shoes or something? I think the aspects of the regulation in buying and selling, that all makes very, very good sense.

If you give somebody X amount of dollars and say this is what you're going to spend on this and this is the product you're going to get, if you go over that, tough luck. If you go under it, you get to keep it.

That's well and good. The process, if that is established, the problem is, whether it's a prospective payment system, whatever, the problem is you begin to ratchet that down over a period of time and that is where I asked the question about regulation.

Is regulation designed to limit health care or is cost control designed to limit health care?

If you set a finite bunch of dollars that are here and someone says, okay, I can do it for this amount of money, sooner or later, someone is going to come along and say you're doing it for less, why am I paying more.

So they cut it back again.

MR. FRANCIS: You are paid under the system. I was in on the birth of it. On my chart, it's called something like median based payment systems. It's sort of my term for them.

There are a number of health categories of provider we pay that, including dialysis centers. The basic model is we take the median, not the average price, at which people charge, and we say we'll pay whatever you charge up to a 110 percent of the median.

I don't know what the exact formula is for you guys, but it turns out that that seemingly simple formula has really potent cost reducing effects, really potent, because the guys above the median have a huge incentive to come down and that lowers the median and that's why dialysis payments are one-third, in real terms, what they were 20 years ago.

That is huge. We haven't done anything that bad at the hospitals, I can assure you. So the tension, I would argue, the payment approach is a rational one compared to the alternative of cost plus. But you have to be able to figure out where to set these prices that make sense.

Something you told us during the break that I hadn't realized, that ESR mortality rates while on dialysis have been going up for the last ten years substantially. That tells me that system isn't working right. That is a huge important thing, and CMS is probably not doing that one right.

MR. CASHIA: But they look to providers and say the issue here is the mortality, it's not what we pay. It's what you deliver, but you have to deliver high quality care under what we pay.

Again, it's the inherent conflict there that as a provider of service, my hands are tied. I can't do more

because it's going to cost me more, but if I do less, I'm not going to be a part of the system.

MR. LEMIEUX: That's why outcomes should be measured as opposed to just saying here is how much we're going to pay. It has to be another thing involved, which is the care improving continually, as well.

Can I just ask a question? And this is so far off point, you don't have to answer. But is the FTC studying combinations of health providers that might lead to the appearance or the reality of our restraint of trade or tendency toward monopolization, specifically among large hospital groups, as they get to dominating particular areas or physicians of a particular specialty banding together for no other purpose than to negotiate with health plans, and then on the flip-side, if there are areas where there are too few health plans to have a sufficient market for consumer welfare?

MR. HYMAN: The Commission not only studies those areas, it brings enforcement actions when it finds collusion and it has brought more than a dozen such cases involving physicians in the last year, most of which have been settled with consent judgments and cease and desist orders.

Insurance is much more the bailiwick of the Department of Justice and they have ongoing process of

scrutinizing mergers that come before them and, in at least two instances, challenging particular aspects of those mergers and settling those, as well, on terms that they found acceptable.

So that is the enforcement side, where this is in some ways a complement to the enforcement side and it doesn't directly feed into it, but we are interested in many of the same issues.

But let me follow up actually on a couple of the observations that just got made. I mean, all of this, the fact that we're paying a third of what we were paying in 1985 begs the question of which one is the right number and raises the larger question of whether paying for inputs, that is, services provided, creates real distortionary incentives.

Jeff's comment was we should be paying attention to outcomes. I guess the competitive based perspective would say why aren't we paying for outcomes as opposed to simply studying them.

So there have been some moves in that direction in the Medicare program. Is this one of those positive spillover kinds of regulation that people are thinking about or is it too early to tell? Anybody?

MR. ANTOS: Outcomes are oftentimes in the eyes of the beholder. This is one of the problems. Health

care is very complicated. A lot has to do with not just the inputs, the medical inputs, but also the patient input.

If the population is sicker in some specific way to that particular treatment, if you're going to get worse outcomes, and since you can't really measure these things very well, it isn't entirely obvious to me that rising mortality rates in any program tell you anything about whether things are actually getting worse.

It could be that the older population is just a frailer population. That could be part of the explanation; not all of it, but part of it.

So it's a little hard to say what to do.

MR. HYMAN: Can I just interrupt and ask you would you say the same thing if the providers of the services threw up their hands and walked out, would that be an indication that it was the prices that were too low or the regulation that was too high as opposed to something else going on?

I mean, the feedback loop can operate in a couple of ways.

MR. ANTOS: The problem with the Medicare -- I agree, if they actually walk out. The problem with the Medicare program is it's too financially important to almost every provider in the country.

So in the case of physician payment, we've had this little round of sort of global budgeting, as I think Dan put it, which bid a little bit last year. We actually had reductions in fees last year, about five percent.

Did anybody leave? The story line from Medicare is, well, no, we still have 95 percent or whatever it is participation by physicians. That's true.

The big question in some parts of the country, not everywhere, was, well, could I make an appointment with a specialist. So it is a very, very subtle, very subtle thing to measure.

I wouldn't expect to see providers just pick up and leave. I do think, however, that if we have an industry, as was indicated, the renal dialysis industry, where you see entry into the market, that that, to me, is a suggestion that it can't be a terrible business and since Medicare is the monopsonist, we can't point to other reasons why there is an increase, other than must be okay, payment rates must be okay.

Let's see. Where we were we going with this?

MR. LEMIEUX: Let me follow up, because I can follow up on that point, actually.

Private health plans have been dropping from Medicare mostly because in 1997, they delinked fee-for-service from the payments that were made to private health

plans, and those plans didn't see it as intrinsic to their survival to stay in the Medicare market, so they left, because payments that had previously probably been too generous and caused them to enter in great numbers got flipped to become too stingy, which was, again, a market signal of a payment failure or a payment problem.

MR. ANTOS: That's right. Now, let me just mention one other thing. The Medicare program has embarked recently on a little pilot project to pay for performance. I know that United Health Care is involved in it.

I think it is mainly related to hospital performance, but I actually haven't studied this, but it is just starting now.

There is an issue, however, and that is, like a lot of inspection systems, we have standards, we'll see if you did it, and then if you did, then we'll pay you some more money. You get a little favorable selection into that system, and there is some suspicion that the most eager participants in this demonstration program are the ones who absolutely knew they were doing great, and so this would be a little bit of a bonus.

It is really tough to handle this.

MR. FRANCIS: I've got to tell you. I was hired, when I first came to HHS many years ago, to work on

performance measures for federal programs. So I've had a 30 year experience, and actually even before that at OMB.

Outcome measures and performance measures, in general, are extremely difficult for a whole raft of reasons I don't think we need to get into, ranging from the fact that there are multiple attributes and you don't know how to weigh them.

In the medical context, you want to do, you are absolutely right about the point, a higher death rate may reflect harder patients or whatever.

When HCFA first put out its hospital rating book, its version of it, it was in 12 volumes. It was a whole bookcase that long, because they felt impelled to let each hospital write a letter explaining why the statistically measured death rate -- I mean, we're talking about death rates here -- was not really representative.

It was they had a bad year or they had a bad patient mix and just decisions to inadequately control for it and so on, a tough, tough set of problems.

In the world of organ transplants -- there is also the problem that providers don't want comparative performance measures published. They hate it. They go crazy. The reason HCFA -- the reason Bruce Fladdock, a progressive, liberal, decent human being, killed this book is that the hospitals he had been associated with hated

it. So he said we're not going to -- I know he did it.

I couldn't stand it, because they felt they were being treated unfairly in the ratings.

So I think it's just very, very tough. On the other hand, there are lots of places where you can use performance or outcome measures, in part, to calibrate what's going on.

Let's just go back to dialysis example. If the death rate, in general, nationally for patients on dialysis has gone up from 10 to 20 percent in the last ten years, I submit to you that something is probably going on and if someone isn't doing serious research and analysis, they're not doing the right thing, weighing that against the point that you still get firms entering and so on.

But I should also tell you that the record of CMS in dealing with performance measures, even where they have them and are required by law to use them to de-fund people, is ludicrous. The best example I know are something called organ procurement organizations, where this sort of how many organs do you procure per cadaver, and it turns out that that's a complicated question, but if you weight things correctly and so on.

We have huge disparities in different parts of the country. They never cut anyone off. They just don't do it. It never happens.

MR. CASHIA: I would like to address the issue of entrance into the market. I think what you saw, the data I showed you, you saw a big spike back in the 1990s. Some very important issue happened then and Medicare, in its wisdom of controlling costs, it used to be that if you were 65 years old or younger and you had insurance, Medicare did not become the primary provider of care until after 12 months after being on dialysis.

Medicare, during that two-year period, shifted from 12 to 18 to 30 months. Now, if you enter into the dialysis system and you are under 65 years old and you have a primary Blue Cross/Blue Shield plan, that plan is primary coverage for the first 30 months. Medicare doesn't kick in till after that.

That is the margin that people are functioning on. Now, what's happening now with the patient demographic data is this younger population, it's not there. People are getting older. People are 65, 66, 68 years old coming in Medicare primary.

Providers can't make it on those dollars anymore. You can't cost shift any longer. That's not going to work.

That was a plan that essentially worked, I guess, for ten years for Medicare. Now, that is not going to work any longer.

MR. CRIPPEN: Just one slightly off observation. Health care, as Walt was saying, providers essentially refuse to be measured and they have some good arguments about how it is difficult to measure them.

But you can look through the annals of history, starting in the early 1900s, where groups were trying to measure outputs and got killed very time they did, if providers refused to play.

But the whole health care arena we treat differently and with more kid gloves, if you will. The National Academy of Sciences report of a couple years ago that we unnecessarily kill 100,000 people a year or so, probably low, frankly, from some earlier studies, but that is the equivalent of one 747 crashing every day in this country.

How long would we let that go on if it weren't the medical profession? We just treat it differently and we let providers get by with these arguments in some ways; again, some of them perfectly legitimately, but nonetheless, we let them get by and we don't measure them and every time we have tried, we have failed.

MR. HYMAN: Well, that's a happy thought. I was going to ask how we can sort of advocate more effectively for competition, both within Medicare and Medicare using its power.

MR. CRIPPEN: The payment structure. That is what controls. I mean, one of the things Walt knows a hell of a lot more than I do about, but other -- I mean, several Administrations have talked about things along this vein.

For example, instead of paying the way we do now, we take out some procedures of Medicare. Solid organ transplants would be a perfect one. And we say we're not -- what we're going to do with those is bid, God forbid, this procedure, but we're going to award the bids based first on outcomes, and there's a half a dozen measures, again, Walt knows more about this than I do, that are not terribly contentious; did you live, was it by the procedure, were you re-hospitalized, how long did you live, those kinds of things.

So for liver transplants, we take bids, and the last time I looked, the winning bidder on first outcome and then price would be the Mayo Clinic; better outcome, lower price.

We could take the top ten bids and say we're going to pay the average of these ten bids and here are the ten places or 25 places in the country that have the best outcomes, and that is how we're going to establish our payment system, and we're going to let Medicare recipients know they can go anywhere they want.

This is what we're going to pay and these are the ten best places in the country, but we will give them that information. So we could, in our payment structure, start some of these places, particularly where there is a relatively agreed to set of outcome measures.

That's a place to start and then if Medicare payment structure changes along those lines, as Joe and others were saying, it's such an elephant, that we'll start changing non-Medicare payment structures.

MR. ANTOS: We might have to pay people the transportation to get there, but it would probably be cheaper and better health care.

One of the sad stories in all this is that this is an idea that was tried, like a lot of good ideas, tried in the private sector. Some very large corporations realized that they were having an aging workforce and it was more open heart operations.

They realized, well, if you send them to the local hospital, we'll spend a lot of money. They'll be essentially disabled. They'll be costing us forever. They're never coming back. We're stuck. Whereas if we send them to the next state over, they have a very good record, let's try it.

And some companies tried this. It turns out that most people would rather go to the hospital down the

road, because they want their relatives to visit them, then they would to live. So we've got some working to do.

I mean, they don't realize that there's an issue here. So we've got to do a little bit more. We've got to take a little bit broader view of what does it mean to pay for health care.

If you don't get the patient to the place, you didn't do it. So I think take a broader view and maybe we're going to get somewhere with it.

MR. FRANCIS: Your examples are both wonderful. I actually estimated, for the department, and published in a regulatory analysis, how many hundreds of people in the country die each year because they go to inferior transplant centers, and it's a big number. It's hundreds. It's not dozens.

But, of course, the publication of those data is hugely resisted. I mean, I won't go through it. It's just you can't believe, in particularly transplantation.

HCFA, meanwhile, has obsolete standards of quality for organ transplantation, published as federal rules that haven't been updated by and large in about 15 years, that are a living joke.

So leave aside any other issues, I mean, you can't even get the agency to update these things.

One example of competitive information, it

occurred to me I hadn't mentioned it, it's on my list, HCFA, by agreement with the American Medical Association, has given AMA a monopoly on the use, all uses of something called CPT codes, which are essentially the codes used for all medical procedures by every health care provider in America.

The way this legal monopoly works, and this has happened, if people try to start up a website on the internet to tell you what's the average cost of an appendectomy or whatever, so you can do a little shopping around, the AMA has their lawyers hand you a subpoena and say "do we have plans for you," and you're closed down immediately.

So the U.S. Government actively, I hate to use a word like conspires, but it was never handled as a public matter, actively facilitates and by giving the -- and has granted, I guess I'd call it a monopsony, I'm not sure if it's monopoly or monopsony to the AMA, so broad that you cannot get -- if anyone knows any way to get, I need to know, I am looking hard, have been looking for years, for any reasonably reliable source of information on the cost of, say, the 100 most common medical procedures in America.

I cannot find that information. There are occasional studies where someone goes through an insurance

company's files with their permission, but there is no ongoing routine source of that information in America today.

Now, think about a competitive market for health care or what one might look at it. Suppose your buying automobiles or cars or groceries and you are not allowed to know the prices or compare them or the quality.

Quality is harder. Prices aren't so hard.

MR. ANTOS: But is there -- I don't know enough about this issue, so I'm going to ask and I just want to know, is there an intellectual property rights issue here.

MR. FRANCIS: Oh, yes. In effect, they have a copyright on the -- it's done for the copyright law. Okay? But, of course, HCFA could say tomorrow, "We are going to only use codes that" -- they may be copyrighted, they should be, but where there is a royalty-free usage given to any user, they don't have -- the government, for example, on its own intellectual property products, which it copyrights, which it has copyright ownership of, nonetheless, in 99.9 percent of all the cases, routinely, automatically, without thinking about it, let's anybody use them, period, at no cost.

They didn't have to set up that system.

MR. ANTOS: But it is the coding structure that is the intellectual property, not the prices, right?

MR. FRANCIS: The codes are the structure. But the problem is I can't publish a price list if I can't put the codes down.

MR. CRIPPEN: But why can't, why don't, why doesn't CMS, in addition to maybe doing what you ask for, why doesn't CMS just require that it is reported to them what the real cost of procedure are. They could do it either for Medicare, they could do it for Medicaid. They could do it through FEHB. They could do it for VA. They could do it for a -- I mean, we have enough medical care delivery at the federal level, we could figure out a way to say part of the contract is you're going to have to tell us what your real, not posted, not pretend, what is your real cost for these CPT codes.

Then they could give it to you and me and everybody else and we would know what the pricing structure looks like.

MR. FRANCIS: They could, except they've got apparently a contractual agreement with the AMA that says that HCFA gets to use the CPT codes for free, but they can't do what you just suggested.

Look, I'm not -- the details of this are not important. There are lawsuits over it and everything else.

MR. CRIPPEN: No price is published anywhere.

That's the problem.

MR. FRANCIS: The point is that the nexus of the problem is with the CPT codes and the copyright over them and the government's failure, if you will, to have figured out a way to make price information available.

So you're absolutely right. HCFA collects it, it can get it, but how bad this can be, actually, things get complex. Prescription drugs, another whole area where price information is not, in a real sense, available. There are private companies that collect it and will sell it to you for a great deal of money, but you and I can't get it as consumers.

The government relies on published, allegedly, wholesale prices, which have been phony forever. I actually led a task force to try to come up with an alternative to using AWP about 20 years ago and we actually came up with an alternative based on using competitive prices from the market and figured out a way to make it work, and for various bureaucratic reasons and mainly resistance of someone then at OMB and now at CBO, who shall remain nameless, we never went anywhere with that proposal.

But there are lots of things the government can do with price information that it hasn't done.

MR. HYMAN: Let me ask another question. One

other question on the outline for today was reconciling the government's role as regulator and purchaser and Joe actually had that as a specific item on his, but it has also been a theme that has run through a lot of these.

So the first observation is, generally, when you've got a regulator that is not also a purchaser, it has a a tendency to over regulate, because it doesn't internalize any of the costs associated with it.

So being a purchaser is going to discipline that, at least to some extent, and that is the question.

Given the fact that Medicare purchases so much health care, why doesn't it discipline its regulatory impulses?

MR. FRANCIS: It does. I mean, I think -- I'm sorry. I thought we were clear on this. When HCFA has a choice between lowering cost or increasing quality, it's going to, 99 times out of a 100, come down on the lower the budget side of the equation. So my answer to is, yes, there is a tendency.

If the regulator were independent -- am I wrong on this?

MR. HYMAN: I think that's the intention as opposed to the reality.

MR. FRANCIS: Well, how well they do it is another -- but the point -- yes. The tendencies are

there. I would simply argue, in the real world in which we live, number one, they don't do either job very well.

Secondly, budget pressures are huge.

MR. CASHIA: I think we should define prudent purchaser versus just purchaser. I mean, I don't think they purchase very well, either. I think that you certainly could look, set up quality indicators and someone can go to someone and say I'm going to buy here, because you do a better job than the clinic down the road. They don't do that.

No matter what you do, you're going to get paid the same amount this person does.

MR. LEMIEUX: That's one problem. Another problem is that the Medicare program tends to view health providers and health plans in a sort of antagonistic fashion. They will say that these health providers and these health plans are trying to do things to maximize their reimbursement and we are always suspicious of them, and so a culture has come up that really does treat the health provider community as the antagonist rather than a sort of cooperative arrangement, like they have in the federal employees program, where they are actually trying to work together toward a common goal.

MR. ANTOS: And then to play the same record over again, the other part of it, of course, is that the

fact that we're saying the government is the purchaser tells us everything about what the problem is.

The government is purchasing the health care. The consumers aren't purchasing the health care. They are getting the health care.

If the consumers were also the purchasers, if you gave them the purchasing power or at least more of the purchasing power, they would be a lot more interested in what was going to happen to them. But we've basically trained a whole generation of people to say, okay, where do I go next.

That is changing, and I think there's going to be a consumer revolution over the course of the next starting ten years from now and on, when we baby boomers who aren't satisfied with taking orders, say, okay, well, I'm paying for part of this and, also, I'm pretty demanding and I want the best there is and I don't want to wait around for it either.

MR. HYMAN: Anybody want to make any last comments on the range of subjects that we have covered?

MR. CRIPPEN: I guess I still have kind of end where I began, which is a lot of, whether it's consumer driven health care or getting the incentives right, will certainly be useful and what Joe was just talking about of having more of the decision making responsibilities with

the patients and perhaps more information and outcomes and prices and things that you guys actually can help think about how we force making public some of the measures we'd all need.

Ultimately, still, though, at least for the Medicare population, it comes down to this group of people who are relatively sick and chronically ill for long periods of time and who end up in the hospital, and it is not clear to me how much all of this consumer oriented medicine will actually change the behaviors of either their physicians or the patients themselves, which is what we're talking about here, in order to keep them out of the hospital, if you're going to save costs; maybe keep them out of the hospital if you're going to give them better health care.

There may be behaviors in here that we can regulate away and we should certainly think about payment structures and if you guys have discovered things out there that would help think about that, I would encourage you to expound on them.

Payment structures that would help give incentives for people and to physicians, because ultimately, with very sick people, especially older, we may have to depend on providers to give them the incentives to do what makes the most sense inside the

system for efficiency and for outcomes.

So a lot of the discussion about revealing prices and other things is very important and I think would help certainly all of us understand what is going on better, which we would feel more comfortable about, but I don't know ultimately that we will affect the health outcomes or the costs for these very expensive handful of people, older people, and that, when we started judging Medicare reforms, may be the more important question ultimately.

So that's where I began.

MR. FRANCIS: I agree with you a 100 percent, and let me take another cut at it. If you look at Alan Eindhoven's book, "Health Plan," vintage 1978 or '80, thereabouts, he was -- Eindhoven was a consultant to Joe Califano when Joe was secretary, and wrote this report to the secretary, which became the book, about how you ought to have competition among health plans, et cetera, and his model was the HMO.

For various reasons, it hasn't played out the way he thought, but it's a classic book, well worth reading. One of his central points was that you sort of you would like the entity that is providing health care to get a capitated payment, with performance measures.

In other words, you want someone to sort of own

that expensive patient and make, in conjunction, obviously, with the patient, and we're talking about physician assistants and so on, but to make the decision that says what we're going to do is double the number of drugs you take because otherwise you're going to be in the hospital, or we're going to do this radical kind of surgery or we're not, with the intent of, A, preserving the patient's life and, B, keeping costs down, because there's an element of capitation and you can make more money to keep costs down.

But you have to have control. That's what I meant earlier by internalizing the externalities. You have to have a budget, in effect, for the patient that lets you have those right incentives.

There are organizations that would like to do that for various kinds of chronic diseases, which is a whole raft, ranging from congestive heart failure to diabetes, you name it, in this elderly population.

Medicare will -- CMS is going to experiment, I think, with paying some of these kinds of organizations, but that's just going to be piddling around for years and years and years.

One would like to have a system in which those kinds of organizations could compete for business for those patients and it is -- unless there is something much

more radical that anyone is even talking about, it ain't going to happen.

But, I mean, yes, that is -- and I think that is what Jeff was basically proposing, as well. We are nowhere on that front compared to the -- you know, the current Medicare program is the antithesis of that.

MR. ANTOS: I'd like to take only a slightly more optimistic view than Dan. Just to remind ourselves that you don't get to the hospital suddenly. Rarely, some people do, but mostly, our big spenders were small spenders. Mostly there is a process of disease. There is a history of disease and except in rare cases, clinicians will recognize kind of what the next steps are going to be.

That being the case, then I think it is still true -- I mean, you're right. Once you are deathly ill and in the hospital, you're not making anymore decisions, although your relatives are, if you have any. But before you got there, you have decisions that you can make and you should make.

You owe it to yourself, from a quality of life standpoint and a quality of death standpoint, and, bluntly, you owe it to everybody else, because they are paying for your care.

So I would be a little more optimistic. I'm not

saying I know how to do it, but I think there are some greater potentials to deal with this problem in a market-based way.

MR. HYMAN: Well, it is quite clear that the problem of coming up with good performance measures for health care and implementing them is a daunting one, both in public and private sectors.

Here we have somewhat more straightforward performance measures. The enthusiasm and intellectual content of the panel and finishing early and on both scores, we did exceptionally well.

So I would like to thank the panel for their hard work, and I hope the report will match the level of discussion that we have heard here today.

So thank you.

(Whereupon, at 4:49 p.m., the hearing was concluded.)

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C E R T I F I C A T I O N O F R E P O R T E R

DOCKET/FILE NUMBER: P022106

CASE TITLE: HEALTH CARE AND COMPETITION LAW AND POLICY

DATE: SEPTEMBER 30, 2003

I HEREBY CERTIFY that the transcript contained herein is a full and accurate transcript of the tapes transcribed by me on the above cause before the FEDERAL TRADE COMMISSION to the best of my knowledge and belief.

DATED: OCTOBER 16, 2003

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LISA SIRARD

C E R T I F I C A T I O N O F P R O O F R E A D E R

I HEREBY CERTIFY that I proofread the transcript for accuracy in spelling, hyphenation, punctuation and format.

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SARA J. VANCE