AcademyHealth
25th Annual Research Meeting
Reflections on the Field of HSR: Where We've Been & What Questions We Left Unanswered
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Uwe E. Reinhardt: All right. Why do we not get started? This is the 25th anniversary, of course, of AcademyHealth, the former AHSR, and we have this session on "Reflections on the Field of Health Services Research: Where We've Been and What Questions We Left Unanswered". And that, of course, will be done in two sessions. First of all - the old guards, so to speak - those of us, who when we entered the field, there was not that much a field. There certainly was not an AHSR, and there was not that much health services research. Certainly, it was almost none in economics. So the panelists, we have Stuart Altman of Brandeis; Ron Andersen, University of California, L.A.; Bob Brook, RAND Corporation; Karen Davis, the Commonwealth Fund; and Joe Newhouse, Harvard.

I'm Uwe Reinhardt, and I moderate this thing.

In those days, when I started, people often ask me, "How did you become a health economist?" And it was, actually, because I was told to be one. I wanted to write on a far more interesting topic, and it was "Optimal Tolls on the Connecticut Turnpike." And I already sank a half a year's reading into it because I was always bothered -- when it came out of New York

at midnight, I had to pay tolls when there was no congestion, and that offends an economist. And to me, that was a serious topic, but Richard Ruggles, whom some of you may remember, said, "It is the most ridiculous thing I ever heard. Six years of college and that is all you can think of." So I asked him, "What interests you?" He said, "Health," and I said, "All right. I will write in health, I do not care." So I went and read some more and wrote a thesis on what the practice of physicians had to do with workforce forecasting. Everyone said we had a shortage, and I came out - you have to be opposed, of course - saying we did not, and I had nice equation to show that.

Now, I view health services research as, basically, an attempt to limit the folklore and lies on which health policy is made, and we have done that, I think, quite successfully. For example, when we started out in our field, the health economics, people really believed the demand for health care is totally price inelastic. Certainly, people go to the hospital or not could not have anything to do with price. Well, I think Joe Newhouse's work shot that one out of the water very quickly. There was the theory that every time you take a dollar of health care out of health care, quality of care will fall. And I think that is being completely demolished

initially by Jack Wennberg, but then Bob Brook went far more beneath the Wennberg data and looked at it.

There was the theory that there could not be a quality problem in the United States because we were the best health system in the world. I think Karen Davis' recent work has pretty much killed that idea. We believe that there is an optimal physician population ratio. We destroyed that idea. So there was a thought every American had access to good health care. Well, Ron Andersen and his colleagues destroyed that idea, and there are many of you out there, our vintage - Mitch Greenlick; I see, Dorothy Rice; Clif Gaus -- we did quite a bit of work that actually did limit the range of folklore. It is a little bit like legal cases. They have precedents; we have papers and data. And I think it does improve the policy process, although there is still a lot of faith-based analysis as in recent years we have particularly seen.

Now, my first panelist is Stu Altman, who got his - what did you say - PhD in a Chicago farm school called UCLA. In economics, that was then the Chicago farm school. He is the Sol Chaikin Professor of National Health Policy, was the dean of the Heller School from '77 to '93. I thought you still were.

Stuart H. Altman: I am again.

Uwe E. Reinhardt: I think -- yes. So it never ends with him. He just does not get paid for it now. He was president of Brandeis when I became a major Jewish philanthropist, remember?

Stuart H. Altman: Yes, I do.

Uwe E. Reinhardt: He was the chair of the politburo called ProPac, the Prospective Payment Assessment Committee that introduced Soviet pricing in America; on the Clinton transition health team; a great friend of [indiscernible], who fired him the minute he looked at him. And so Stuart was instrumental in keeping me in health economics. We met in Detroit in some defunct coffee shop, and I was going to quit and go into finance. I thought more of a future there, and I realized it would have been -- you can actually sell garbage and get paid for it. But Stuart told me to stay, and how could I not when he told me that. And he has been very helpful to me when you are in a little rural economy. I live in rural New Jersey. We do not really keep up with what is happening. And I can tell what is happening, and I showed that to you a couple of years ago when we got the prize from AcademyHealth. And people pleaded to see those pictures again - I'll show you - how you can tell what is happening.

This is '70s, the era of regulation when Stu dressed like this, like a communist commissar. He regulated everything in

sight. If it moved, he would regulate it. Price controls, ProPac - that was his life. Then came Ronald Reagan, and Stu retooled, and he became like a snake oil salesman, looking, selling pro-competition as the new approach. And then he heard of consumer-directed health care, and that is him now, totally wired into the latest data on where to get cheap, cost-effective health care. So with that splendid introduction, I turn it over to Stu Altman.

Today, by the way, he wears his bar mitzvah suit, which means he is in a holding pattern. We do not know what is happening.

Stuart H. Altman: I left my hat home. So the moral of the story is that you cannot be a successful entrepreneur in health services research unless you have a hat. So feel free to get your own hat.

So I'm glad Uwe told you the truth because it is. The story he did tell at the end was true. He had given up. He did his dissertation on health care, and we met in Detroit. I think there was a group of the early health economists that really set the stage, Herb Klarman, and even though Paul Feldstein is not much older than we are, he was much earlier. But it was a very small, little group, and I do not know if everybody remembers "The Graduate". Remember plastics?

Well, my background is similar to Uwe's. We were trained in economics. There was no such thing as health care economics. I have always had an interest in women. I have three daughters, five granddaughters. I have female guppies. And so I wrote my dissertation on unemployed married women, and that made me uniquely qualified to go into the Pentagon to create a -- I anticipated the fact that the military now has a lot of women in it, and so I got there and -- economists, in the '60s was a wonderful time. All of a sudden, this town thought, "Oh, my God. We need to understand economics," and there was this great war on poverty and the OEO and the Pentagon. And then, all my friends went over to what was then HEW and I went to play academics for a while at Brown.

And I was there about - I do not know - six months, and they called me up and said, "I have a problem with nurses. You know about women in labor force. Why do you not come and help us?" I knew absolutely nothing about nurses. I knew nothing about health care, but it turns out economists, next to surgeons, are the most arrogant people you are ever going to meet. We can do anything, and for those of you who were trained in economics, you know what I'm talking about.

So I went down, and being a good academic, I said, "Well, I need a grant to do this." So I got money, and I eventually wrote a book on nursing. And that got me into health care, but

then I ran into his young guy. It turns out we are a month apart in age, and we compared our childhood. And he was hunkered down in the middle of Germany, and I was hunkered down in the middle of the Bronx. And our lives have been the same ever since. Anyway, we met and he said, "This health care stuff, there is no future in it." So I said, "Health care - this is going to be the field." And there were two people that I feel the most proud of convincing to come into our field. And one is Uwe, and the other is Gail Walinsky, who was my almost next door at the Urban Institute. And she was into welfare economics, and I said health care.

And so now, of course, we have this wonderful field that you are all part of, and for those of us who helped start this organization, it cannot bring but really warm, good feelings. It is a group that has prospered and grown and not only in terms of numbers but in terms of influence. As a matter of fact, it has gotten to the point that I get a little worried. The good news is that no -- since I live in the world that transcends research and policy so much in my life, I like to think of myself like a bee. I go back and suck up the honey of all the smarts that are in this room and in this meeting. And then I go to the Hill and around any place that will listen, and I give them the little words of wisdom.

The good news is that health policy cannot and does not function without a whole research aura around it. The problem is that every side is well surrounded by research, and sometimes, I think we do ourselves a disservice in the sense that we are - I do not know if it is intentional or unintentional - on every side of every issue. I do not care what piece of legislation is up there, but it is surrounded by some level of research. Now, how good the research is and where it comes from is up for grabs.

One of the things that I said yesterday at our meeting of the founders of this organization is that what is so important is that this organization, AcademyHealth, while it strives for decent funding and for decent standards, must maintain the quality of the product. I do not know how we do it, but we need to stand for things that say standards mean something; quality, in terms of research, means something. We are busy criticizing the health care community for its lack of quality. We criticize it for using too many services. We criticize it for not covering the uninsured. But we should criticize ourselves in terms of some of the research findings that find their way into the policy arena that are less than -- let's say they are not always complete, if not false.

So as I think about where we were, there is no question -- I go back. And this is a long story I do not tell sober, but

there I was, the good kid from the Bronx in the middle of the Nixon administration - and many of you remember, I had the job of -- for those of you who have great desire to have the federal government run the health care system, I'm living proof on why you should be nervous because there I was in 1971 as the chief health policy person for this country. And if it was not for Clif Gaus and Dorothy Rice, I had to write on my sleeve the difference between Medicare and Medicaid. And then my sleeve would get dirty, and I would screw them up. So they would come and help me out.

But the point was that I did find myself in the middle of a health policy debate. We were debating something that you probably never heard of like national health insurance. In 1971, we almost passed that, actually, and we were very concerned about rising health care cost. And I was told by the powers in the White House that if America had eight percent of GDP, our whole health care system was not going to die, and so I went out to regulate health care cost. And for those of you who enjoy the trappings or the droppings from the health care system, you should be very proud of the fact that I failed personally, from eight percent to 16 1/2.

But the point was that we were sitting there in the beginning of the 1970s with really no information whatsoever, and I remember we were debating this issue, as Uwe said - what

is the elasticity of demand? And we actually spent $100 million and made this young health economist from Harvard into a household name. The idea that we would spend $100 million on a number that we all knew before we started this study -- so I almost apologized because I realized that economists are really not allowed to talk about quality of care. It is not in our union contract, and physicians get very mad. So I said, "While we are spending $100 million on it, should we not know a little about the quality of care?" And I said to Joe, "I want to approve the continuation of --" - remember this one, Joe? I want this to go on because for some reason, it wound up in my office.

The people above me did not know anything about research, and I made believe I did. And I said, "I want it to go on, but we need to justify it a little more than just what the elasticity of demand is. You think you could learn and maybe put some things in the RAND experiment that would look at quality of care?" He said, "Well, we have this young, aggressive, energetic physician who thinks he knows about quality of care, and I'll bring him at the next meeting," and that is how I met Bob Brook. And of course, Bob was a nobody then, and of course, now, look at him [sounds like]. So we are very fortunate that health services research got that shot. I wish we could get it today.

So the point here I'm going to finish is that we have made tremendous strides. Health service research is not taken for granted. It is not a back order section anymore. It is not appropriately funded, of course, but it is much better funded than it was then. But we do need to guard against allowing our research findings to be used in inappropriate ways, and David and AcademyHealth need to maintain those standards as we go forward because our -- unfortunately, the problems we face today are the same problems we faced then. We still have a system which, of course, we know, does not cover nearly enough people. The numbers grow too fast. Our health care cost could, in fact, lead to a meltdown in our system. And now, we have created a third problem, which we did not think we had in the '70s, and that is, that we do have quality problems. So there were real problems out there for you to do research on, but we do need to maintain our standards. So let me thank you all for making this such an exciting 25th anniversary for those of us who got this organization started, and it is a pleasure to be here.

And I'm sorry I did not wear a hat.

Uwe E. Reinhardt: Thank you, Stu. I should mention that Stuart is the father of Altman's law, which is more lasting than $e=mc^2$ will ever be, because that will be disproved someday. But Altman's law is, in the United States, everyone's second

best health reform plan is the status quo, and that will never change. They will change $e=mc^2$ long before that law.

Our next panelist is Ron Andersen, who, again, needs, basically, no introduction. I think sociologists started to work on health care earlier than economists did, because there was this thought that health care was not amenable to economic analysis. Ron is the Fred W. and Pamela Wasserman Professor of Health Services and Sociology at UCLA. He got his PhD in Sociology from Purdue University, and he has a huge CV and many, many studies. But the thing that comes to mind when you hear Ron Andersen is studying access; really worrying about who in America gets access to health care, on what terms, developed a behavioral model of health services used, which is the analytic framework he uses to study access and that, in our days, we did not actually really know much about, and now we know a whole lot about it. And Ron is certainly the dean and one of the leaders in that field. Ron.

Ronald M. Andersen: There was a tradition related to health services research before Academy and before many of our distinguished economists got into the field. We did have some early economists - and I want to mention Dorothy Rice here - but they were relatively few and far between. On the other hand, I was a doctoral student in, probably, the first formal training program in medical sociology at Purdue. It was funded

by the National Heart Institute, so NIH was involved early on before we think of it being so. Under Dr. Eichhorn - Bob Eichhorn there -- and I chose that program, not having a clear concept of what medical sociology might be, but my adviser - I went to Santa Clara University - had been an engineer at Purdue before he became a sociologist, actually, at UCLA. So he said that was, for a straight semi-rule kid, this might be a good place to go.

The project at Purdue was associated with a study called the Purdue Farm Cardiac study, and my dad had died of a massive heart attack the year before. So I thought maybe this would be a good place to go. And frankly, Purdue gave me the best offer with a fellowship. I got $200 a month; it was the best one in the department. And I also applied, ironically, to Chicago where I ended up spending 28 years. In UCLA where I have spent 18 years -- but they were not so enamored, and the offers were not so good. So that is how I ended up at Purdue.

As I reached the dissertation stage at Purdue, there was a project at the HIF at that time and NORC at the University of Chicago. They had a grant from NCHSR, now AHRQ, to do what was the third in a series of National Studies of Medical Care Use and Expenditures. We did not have a lot of economists involved, but we still tried to study medical care expenditures. They had no study director. Odin Anderson was

the research director at the center, and they were really scratching for a study director. There were not so many people trained in doing health surveys, and it turned out that was a major component of the training program in medical sociology at Purdue.

So Anderson talked to Eichhorn, looking for somebody to run the project. And I think Bob greatly exaggerated my skills and certainly my experiences, but after some hard interviews and discussions - and they had no alternatives - they offered me the job. And I thought I was a researcher, and I even thought, maybe of health services research by then, that I was going to researcher haven because here was Odin Anderson, who - I had read about - was proposed as the "father of medical sociology" and I believe the coiner of the phrase and the initial concept of the health services system, and an array of talented, well-known sociologists at NORC, including a Peter Rossi, Jim Coleman, Jim Davis and Jack Feldman, who was the methodologist for the series of national health studies at NORC.

So I took the job. I took the job and went there, and I worked for five years with these marvelous mentors, designing a study, collecting the data and doing the analysis. I had experienced that project and was told, "You write the final report, and then we will pay you to do your dissertation along

with it." And so we wrote the final report; Odin and I were the authors. It was published by the University of Chicago Press in 1967, and it was called *A Decade of Health Services* because that was the third in the series of studies, "Trends and Use and Expenditure". And then I was struck when I got into this project at the tremendous discrepancies in the use of services across income and ethnic classes and also discrepancies in health status as far as we could measure it. And I was really troubled. I did not understand why some people seemed to have pretty good access and other people did not.

So for my dissertation, I tried to develop an approach to better understand these discrepancies, and I completed this dissertation, which was a behavioral model for health services, in 1968. And I have continued to work on issues of access and versions of the behavioral model for my entire career. The initial model was not the first or only model of health services developed at the time, but it was an early effort to assist in understanding why families use services and to define and measure equitable access and to assist in developing policies to promote equitable access.

Now, the behavioral model evolved over time. Some people still cite that '68 publication as if maybe I had been deceased or had not done anything since, but I have wrested on and used

the behavioral model all my life, but it has emerged somewhat. Additions occurred in response to emerging issues in health policy and health services delivery, an input from an array of colleagues and students at both Chicago and UCLA and elsewhere.

I want to stop just a moment to say something about students and the importance of students and trainees. I felt sometimes overwhelmed in students, both at Chicago and at UCLA, and complained about being inundated with those students. But the fact of the matter is I realize, in retrospect now, I courted those students. They were my colleagues. They were my resources. And I used them, and I hope they used me. That was the kind of relationship it was, and that is the kind of relationship that we need to have with our younger colleagues. I think of these folks as they are always my students, but I treat them the same way as I taught them as students, as colleagues. And that is the kind of interaction that, I think, is important to bring along the young folks in the field today.

So the model emerged in response to criticisms of early versions and what was happening in the field. So in phase two, with colleagues at Chicago - I want to mention particularly Luanne O'Day [phonetic] - we added to the model, the formal concept of the health care system and its effect and also satisfaction of consumers as an outcome of health services. This was in the '70s. In the '80s and '90s, we recognized, in

addition to the use of health services, the importance of personal health practices - such as diet and exercise and self-care - that interact with the use of health services to influence health outcomes.

Phase four was in the '90s, and I tried to explicitly recognize the dynamics and recursive nature of the health services use model and emphasize not only that health services use as well as the predisposing, enabling unique characteristics of individuals influenced health outcomes, but those outcomes, in turn, influenced patient needs and health care utilization. And the last phase in 2000's stresses the fact that health services use is best understood by focusing not only on those individual characteristics but cultural and environmental factors as well, which are very, very important.

Now, the fact that many of the problems of health and health care disparities have remained through all of the phases of the model and before, of course as well, may give us cause to criticize the value of the studies and the models, seeking to understand and improve equity, effectiveness and efficiency of health services. I prefer to emphasize the real progress in access to care that we have made, and I suggest that we need to redouble our efforts with new generations, some people represented here now of health services researchers, to better conceptualize and analyze health services utilization. And the

new generation has improved skills, creative ideas and, I think, youthful enthusiasm, and there are good opportunities to build on what has gone before and go much further to understand and assist in reducing the major healthcare disparities we still face.

Thank you.

Uwe E. Reinhardt: Well, thank you very much, Ron. By the way, is Luanne here? Luanne O'Day?

Male Voice: No, I think she --

Uwe E. Reinhardt: You had heard Stuart mention Bob Brook who is well known to you as the dean of quality research on health care. When I first met him 25 years ago - I think it was around - he was very distressed, and he said, "The world will go to hell in a hand basket soon." And I bet you, if you ask him today, he will still say that. We know a lot more about quality, but I think there is still a lot more to be done. Now, Bob got his medical degree and a doctor of science from Johns Hopkins University. Was your mentor Kier White [phonetic]?

Robert Brook: Yes.

Uwe E. Reinhardt: I recall. And he has devoted his life since then, primarily - not totally but primarily - to research on the quality of health care and of course, stimulated an awful lot of further research and is a world-known figure in

this field. He is vice president of the RAND Corporation and the director of the RAND Corporation's healthcare initiative. He got the prestigious Gustav Lienhard Award in 2005. And I must say, some years ago -- I asked him this morning. I was in a peevish mood. We had these very heavy meetings in the evenings to give awards, and I gave Bob -- Alice Hersh almost died. It was not on the program, and she liked to have control of stuff. I gave him an award for the most distressed health services researcher. I remember it was an expensive $20 wood frame, and it said, "[Latin words]." It is Latin for "Shit happens." And it was a bumper sticker our daughter had brought from New Orleans. And I thought that is what Bob had to learn. Look, the world is never going to be perfect, and I think he has cheered up in the meantime. This morning, he was in a euphoric mood. I think he is going to, hopefully, not do a number on me, but, Bob, please.

Robert H. Brook: I'm going to begin by saying we should declare victory and that we have succeeded, and I really do believe that the missing person here who made this all possible is Alice Hersh. And I do not mean from the standpoint of the organization; I tend to mean from the standpoint of the field. And we do not tend to reward people who are non-PhDs or MDs as much as we should, and Alice really made this organization function but really brought life to this field. I would take a

minute of silence, but Ron used up that minute, so I better go on. But I think we ought to declare victory. Now, there is a downside to that, which what I'm going to try to do in my few minutes to suggest that we have to fundamentally change who we are and that we no longer can go on doing what we have been doing.

And why I will say that we ought to declare victory is all the things that we could not do. If you go back to the 1996 reports in Milbank and read them - and all of you should as new people, for those of you that are new in the field - of what needed to be done. And you look at what is in them, we have done them all. You can measure access. You can measure quality. You can do surveys. You can do econometrics. You even could do analyses that statisticians and economists do not understand each other, what they are doing and never will. We have developed the methods. We have developed the tools. We have done all of this kind of stuff. There is not a lot left to be done, except at the margin, so we know a tremendous amount. And therefore, we need to change what we are doing.

And why I want to say this is -- I'm going to use a couple of examples to show that. The first study I ever did was a study that John Williamson [phonetic] and Paul Sanosero [phonetic] were the PIs on, and they had collected 25,000 critical incidences from people around the United States

professors on what was good or bad about quality. And the first thing I learned is that professors never read raw data, and so they wanted to hire medical students to actually read and code these 25,000 sheets. And the medical students that I went with did not need money enough to actually want to do that job, so I learned about economics at that moment. And I coded them all, and I was a second-year medical student. And my belief structure was that I did not know enough to do this, and that these would be esoteric problems in quality. I did not know there are seven years of training left. And what I found out is that 99 percent of everything that was said was something like, "I did not read the X-ray. And the person had a tumor and I did not get to it for a year," or "I did not get the potassium result back, and the patient died because I did not take corrective action." I did not need to open a single medical textbook beyond a year to a medical student to read these 25,000 incidents from presumably the best people in medicine, and if I did the same thing today, it would be the exact same result today.

Now, I want to spend a word talking about the health insurance experiment because I want to distinguish facts from values. Joe Newhouse really does not get distressed very often. If I get distressed, Joe does not get distressed. And one day, Joe and I were trying to sell this health insurance

experiment, and we flew to Dayton, Ohio, met with the Dayton Medical Society. And at the end of the meeting, we were labeled communists. We were the stalking horse for Kennedy because if you did a health insurance experiment, that meant you were going to have Stu Altman regulating the world, and therefore, the bottom line is we were communists. On those days, you could have a luncheon meeting and then fly to Seattle, and we were trying to get Group Health Cooperative of Seattle to join in to this experiment. And the two of us were there again, and at that dinner meeting, we were labeled communists, not communist-fascists. And we were fascists because instead of actually implementing health insurance, the government was collecting data to find out how it would work, and therefore, we were preventing people from getting health care, and we must, therefore, be fascists. So on the plane back - and you could still fly back in one day - Joe consumed more liquor on that plane than I had seen him ever consumed before in his whole life. And I want to distinguish facts from values because I think that is one of the things that we have to deal with in this field.

So let me just go directly to some of these ideas that I think. We have a field right now that is consumed by extraordinarily small studies that produce a lot of small data that are not used to make a difference. Somehow, if we are

going to do small studies, the least we can do is coordinate them. And the least we can do is try to figure out a strategy to make sure that as we design these studies, actually do them in a way that actually builds them into something that is big enough that might be used to make a difference.

We have to deal with this whole question of work in the area of rights versus responsibility. There are not any philosophers in this audience or any religious people in this audience. Somehow health services research has not included them. What is my right and what is my responsibility? What is researchable in that area? Would the American people buy into something that says that if I'm going to have health insurance which is subsidized and the economists have taught me that that means we are going to use more than we would use if we did not have somebody else paying for it? Do I have the responsibility of actually producing data of saying that my data can be used for the common good, whether that is to determine whether a specific medical intervention works or whether that is to determine whether a former financing is better than another form of financing? We spend most of the money in this field eating rubber chicken dinners to try to convince people to do the studies that we want them to do. Most of the money goes there. Very little goes to analysis.

The next question is -- I bet if I asked your political preference in this audience that 99.8 percent would be Democrats, and therefore, the knee-jerk response of this audience is to reject anything that a Republican proposes. Somehow, we have to work on balancing this field of researchers so that people who have different political philosophies believe the facts, not the values but the facts.

Third - there is now a new movement that is overtaking this movement. It is not so new, but it is, at least, becoming - more put together - better. Instead of solving the problem of how to deliver health care, there is now a group of people that are talking about the determinants of health. And we now have two camps - one that is interested in the determinants of health and one that is interested in improving the health care system. And what we are doing is shooting each other in the foot so that neither of us wins. These two models have to be put together and integrated into something that makes more sense. All of this is stuff that we have not done.

Implementation research - if we wanted to implement health care policy tomorrow, we do not know how to do it. If we wanted to eliminate for-profit HMOs, how would we do it? Would we just throw everybody out of work? How would we phase out Medicare, phase in Medicaid or do whatever we want to do? The amount of implementation work that is actually done is so

little that it is very, very hard to imagine a major change in health policy in the United States because of the lack of knowledge in this area.

Now, I wanted to say two last things. The first is, when we reminisced around the board last night, to my somewhat disquiet, I realized that a large number of my colleagues have had serious medical illnesses in the last few years - a number of heart attacks, a lot of stents, a number of these kinds of things. We published a study in the *Annals of Internal Medicine* a number of years ago that said that 40 percent of men in the state of New York who underwent surgery for coronary artery bypass surgery did not have the lesion that required them to get the surgery, not because of any disagreement over guidelines but because the angiogram was not read reliably.

I have another institution that I'm a professor at, namely UCLA. Well, I think I know that the vast majority of doctors do not wash their hands when they see patients. Florence Nightingale determined 150 years ago that that was true in military hospitals. The kinds of stuff that we have not acted on are now becoming personal to this field as we get older. Maybe we will take more interest in implementation research in trying to figure out how to make a difference.

In terms of this organization, I think the focus of this meeting ought to be is - what kind of information is needed to

make a difference? And how do you change values from facts? The fact is we are spending 16 percent of the GDP on health care. What Stuart said was a value decision that he failed. His value decision was that that is too much. I do not believe that. My value differs from him. I do not believe he believes that. But we have to be able to talk about facts and distinguish them from values. There are a large number of people that believe that we will live through or you will live through spending 30 percent of the GDP on health care, and that will be good.

And finally, it is possible to make a difference and change what you are doing. There is a military site at RAND, so when the question occurred when we were sending U2 planes over Russia; the question was, how do you read these photographs in a way that increases reliability because pilots' lives were at stake? And we developed a mechanism for identifying people who would be the ones that actually could be trained to teach them how to read a photograph, to teach how to test visual acuity and increase reliability. You can make a difference if we want to do it and with the statement about we eventually are going to need to re-change the entire structure of medicine.

Imagine a world where the people that read mammograms are high school dropouts, and they get trained because they have

wonderful eyesight to actually read mammograms. Imagine a world where the person that does cataract surgery is the person that gets the highest score on the latest Sony PlayStation and could actually look there and do here, and we train them to do that as opposed to being an ophthalmologist. Imagine a world where we actually use disruptive technology to change what we are doing, and then we can convince the American people that we will spend the money that we spend wisely. And if we do that, maybe 30 percent of the economy will be spent on health care and the board members that I have come to love so much will stay alive because they get effective, reliable medical care.

Uwe E. Reinhardt: Thank you, Bob. This dichotomy between the health researchers - most of my colleagues at Princeton do that - and health care researchers. There is a potential danger because they generally showed that health care for large populations is not that important a determinant of health. But I have observed with them when they get sick. They do rediscover the virtue of health care, so there is hope, Bob, with these people. I think when you talk to them, they do not deny the importance of health care. I think it is just good to know all the other factors that drive -- education being the major driver of health status, and there is another angle where we could improve the quality of life, which brings me to Karen Davis who is a champion of that.

I think I have known Karen longer than anyone else on this panel. First time I met her, it was in what I believe was a broom closet of the Hilton Hotel in New York. Marty Feldstein had rented it to gather the American Economic Association, young people writing their dissertation. And we were in mid-PhD dissertation, and we were supposed to talk about what we were doing. I think Mark Pauley [phonetic] was there. I think, Joe, you already were done or behind us. I do not think you were at that meeting, but it was very interesting. I remember distinctly Karen's dissertation was in hospital cost functions or something like in that nature. Well, she, like a rock star, progressed very, very quickly. She got her PhD at Rice University, then worked at the Brookings Institution, taught at Harvard for some time, then became the Deputy Assistant Secretary of Planning and Evaluation. Did she take over? Stuart held that. And that is interesting.

And no, Stuart, I do not know what you are politically - but I would imagine you in Bob Brook's category - but you worked for Nixon. I do believe we should be nonpartisan. I think that we should break bread with anyone. It distresses me that there are Republican and Democratic macroeconomists. I think that should not be in our field. So in those days, it was much less partisan.

After serving as Deputy Assistant Secretary in '77 to '80, Karen then became chair of the Department of Health Policy and Management at the Hopkins, really dean of that very distinguished school. There are so many distinguished health services researchers that are actually your students - Diane Rowland - this town is full of your students who rose very quickly - and is in my view, the dean of the international health care study. She revived that field through the Commonwealth Fund. Once, I was asked what to think of Karen, and I said, "Well, if we were in Korea, she would be a national treasure," because they designate people formally like that. They get first-class seating and stuff. It is good when they do this. But what I mean by that, when I did my thesis, I did it because this professor said, "That is what you should do." Yes, sir, and I did. I did not have a philosophy about it, but I think -- imagine Karen decided she is going to be a champion of the vulnerable in society even before she started her thesis. Maybe I'm wrong, but I think that is what happened, and that is what makes her so precious. Thank you. Karen.

Karen Davis: Thank you for that very generous and lovely introduction. Uwe asked us to talk about how we picked our dissertation and how that formed the foundation of our careers in the field of health services research. And I heard the word foundation, so I decided to talk about how the private

foundations contribute to health services research. One of my mottoes in life is if you do not know much about the subject they have asked you to talk about, talk about a subject you know something about, and I do know, obviously, about health services research. But it is such a vast topic, I thought I would like to talk at least toward the end about private foundations.

But to be a bit compliant and to respond to Uwe's last comment about why I work at what I do, it really was the influence of the 1960s and particularly being in Houston - so to see Civil Rights and to hear President Kennedy talking about the war on poverty and hearing President Johnson talk about a great society. I was a graduate student from 1965 to 1968. Those were the first years of Medicare and Medicaid. And so I went into economics because at that time, economics was about helping people achieving full employment, achieving opportunities in life. And while at that point, health economics was not really a field - and so my training and economics was general training, focus [audio glitch] economics - I, too, like others on the panel, picked health care because my chairman said, "Why do you not think about health care?" But it really resonated and certainly is the biggest favor that anyone ever did to me because it has just been an

intellectually exciting and professionally rewarding field to be in.

As Uwe mentioned, I did my dissertation on pricing and investment behavior of nonprofit hospitals, building on some of my training in the industrial organization, but then I had a wonderful opportunity from the Ford Foundation to become a Brookings economic policy fellow - wonderful opportunity to work with Dorothy Rice, who headed the Medicare research division and access to hospital cost reports, pre-imposed Medicare, and a real opportunity to look at the interrelationship between Medicare and health spending and rising health care cost. And Dorothy's brother, Joe Pechman, ran the economic studies program at Brookings, and Brookings did offer me a staff position at the end of that fellowship where I had an opportunity to really look then at what difference Medicare, Medicaid and other government programs like community health centers made on access to care for the most vulnerable. So that is how I got to where I am with the focus and interest in health care.

But I think the field of health services research has made extraordinary contributions over the last 40 years. We have heard it from Ron Andersen and the behavioral model of access and the research on the consequences of being uninsured, the

research on disparities in care that come as a result of the way that we finance and deliver health services.

Certainly, the Robert Wood Johnson Foundation was very instrumental in my own career, funding me to do work on health and poverty, and particularly a 10-year appraisal at the Medicare, Medicaid community health center, maternal and child health programs and the difference they made in improving access to care and financial protection. When I can find a free minute, I'm trying to write testimony for a Senate finance committee retreat next week or June 16th on the role of public programs and health reform. It was really great to be looking back over this body of research of the difference that public programs have made and how they could be a building block for health reform.

I think those of us who have looked at state programs and analyzed those experiences are making a contribution to this field. I particularly like the growth in simulation models that give us a better sense about the cost and coverage implications at different reform proposals. Having served in the Carter administration as head of health policy, we scrambled for the first year to just building a micro simulation model to know what the implications were of different proposals so to see that capacity today. Certainly, a lot of work on cost - Dorothy Rice's classic work - just

building a national health expenditure accounting system so we know what we are spending and –

[audio abruptly cut]

Karen Davis: -- starting to really have the National Committee for Quality Assurance reported every year on the state of the nation's health. And we know whether quality is better this year than last year and we do have Jack Wennberg and his Dartmouth colleagues' wonderful work on the variation in quality across geographic areas. So I agree we ought to declare victory, just tremendous contributions that have been made.

We have also designed good research that has led to policy change. Certainly, the Thompson-Feder work developing the diagnosis-related group methodology for prospective payment of hospitals under Medicare bill shows wonderful work on the resource-based relative value schedule that underlines the Medicare; fee schedule, Mitch Greenlick; Harold Luft's work on health maintenance organizations and managed care.

We have come to understand what are the potential implications of having integrated health care delivery systems, more recent work looking at new payment methods that might better reward excellence and efficiency in the health care

system, plus just a wealth of research which Uwe certainly contributed to on comparative health system performance.

So those are certainly some things that stand out for me. I run the risk in a large room [sounds like] like this that I have forgotten some of the seminal work but I think we are where we are today because of giants, not only on the stage like Joe Newhouse's work with the RAND Health Insurance Experiment, but the whole contributions at the field and particularly the vision that the founders and Alice Hersh had in the very beginning.

So having said that, I would like to focus, just to give you a sense of the richness of the most recent kind of research on things specifically that The Commonwealth Fund has done. We have put a lot of emphasis on performance measurement. We particularly historically cared about patient-centered care. And starting in the 1980s certainly before I went to The Commonwealth Fund, the Picker-Commonwealth surveys of patients' experiences in hospitals has really made the patients' experience a key measure of performance of providers.

That started in 1986 with a gift of Harvey Picker at the assets of the Picker Foundation to The Commonwealth Fund. He died at the age of 92 in March, at the week that Medicare announced their release of public data on what is called

Hospital CAHPS, the Hospital Consumer Assessment Health Provider Survey.

Certainly the work on patient-centered medical homes has built on that history; a lot of the work on racial and ethnic disparities has built on that work. We funded early on Don Berwick and Sheila Leatherman to look at the business case for quality.

And what they found is there were many innovations that places like Henry Ford, HealthPartners, Group Health Cooperative were doing and they had a return to the patient into society but not a return to the hospital that was making those innovations in care delivery, so that they did not have a business case.

And now, all of that work really led to this movement that is sometimes called Pay-for-Performance, it will probably evolve to become pay for results or something else. But the basic notion is to reward providers for making the kinds of changes in care design and care delivery that we would like to see. Uwe has mentioned the international work and certainly I think we have made a lot of progress there and opening our eyes about what we can learn from other countries.

Universal coverage - certainly a number of ideas that are out there that we have helped support including a recent *Health Affairs* article called Building Blocks, how to have a mixed

private-public system building on public programs but also employer, group health insurance, ways of achieving savings while enhancing value in the health care system with the report of bending the curve, and in general, the work of our commission on a high performance health system.

Grantees like Marsha Gold, Brian Biles and Bruce Stuart have really done important work that led to the Medicare prescription drug legislation and that have evaluated some of the needed changes in both the Medicare advantage and the Part D program.

One of the issues we are devoting a lot of attention to right now is patterns of hospital readmissions. Our state scorecard on health system performance found wide variations at the rate of which patients are rehospitalized in 30 days. So we are supporting a lot of work on effective strategies for reducing avoidable hospitalization. Less familiar maybe to folks but we are also supporting a lot of work on what I think of as patient-centered care or residents-centered care in long-term care facilities particularly nursing homes, a lot of work on family-centered care trying to see that families with young children get the kind of help they need from the health system on preventive and developmental screening and services.

In the last few years, we have supported a lot of work looking at the gap between the rhetoric and the reality of

private markets whether that is consumer-directed health plans, Medicare advantage, but really furthering our understanding about the instability and inadequacy of insurance. I'll walk out of this into a teleconference on the release of our new underinsured update which will come out in *Health Affairs'* web exclusive in the morning, just showing the rapid deterioration in the quality of insurance coverage even for those with insurance.

But finally, I would say the thing that gives me the greatest satisfaction at The Commonwealth Fund is what we have contributed in the way of developing future leaders. Certainly The Commonwealth Fund-Harvard Minority Health Policy Program, our international Harkness fellows, the early work through Academy Health supporting Picker-Commonwealth scholars.

But particularly as I went through the list of Young Investigator Award, first of all I'm just delighted that this year's awardee, Ashish Jha, we funded his research at an early stage of his career. Arnie Epstein brought him into The Commonwealth Fund for a project Arnie was doing and Ashish presented it, we said, "Arnie, why is Ashish not the PI on this?" He is clearly the one doing the work and Arnie said, "Fine." So it is great to discover that kind of talent early on and we have supported at least half of the young

investigators and at least half of the article of the year award authors.

Well, let me wrap by just talking about future challenges. I think already we have talked about how we have a terrific track record of health services research. In fact, our international fellows say, "You have the best health services research in the world. Why is it you do not have the best health system in the world?" And I really think they are onto something there and whether it is that we have not done implementation research or I would say, we have not done actionable research and put enough emphasis on the translation of that research into policy.

And in fact, I really think we need almost a different mode of research. It does not mean that we would not continue to do formal demonstrations, but I think we need to talk about learning systems, pilots with rapid feedback, rollout and spread. And I look at the way corporations develop new products. They often test them in three or five markets and then, they get quick information how well that works and they tweak it, revise it, and roll it out to more markets. Follow that, revise it and roll it out to more markets.

And we do not really have this model in health policy and I think we would be better served by having this. We talked about states' learning laboratories and certainly the

Massachusetts' health reform is paving the way for national reform, but I think we need a more systematic approach to what I call pilot rapid feedback and then roll out to more and more settings.

But finally, we need to communicate our research more effectively and particularly, reach the audiences who are in the position to effect change whether those are policy leaders or those on the front line of care running health systems. So thank you very much for your attention and obviously to all of my colleagues at The Commonwealth Fund.

Uwe Reinhardt: Well, thank you very much, Karen. By the way, when students come at Princeton, they must write a senior thesis and say, "I want to write in health." I always tell them spend the weekend with The Commonwealth Fund website and see me next week. You start there and some others, but that one in particular because it is so rich in content.

Our final speaker, simply because his name starts with N is Joe Newhouse, probably the most distinguished health economist worldwide, in my view, best known. He is the John MacArthur professor of Health Policy and Management at Harvard and the head of the Interfaculty Institute of Health Policy. Harvard is very difficult; it is not a regular university, it is a whole lot of feudal systems somehow and this is one knight

who was allowed to go from castle to castle. Is that how that works?

Joseph Newhouse: It is something like that.

Uwe Reinhardt: -- without getting clobbered, yes.

Joseph Newhouse: Most of the time.

Uwe Reinhardt: As you heard from Bob Brook he started his career, I think, in major ways at the RAND Corporation as the principal investigator of the classic study never been replicated again on health insurance, then returned to Harvard.

He has been, since its founding, the editor of the *Journal of Health Economics* and Stuart mentioned rigor, certainly in our field, Joe is the guardian of rigor in many, many ways of analytic rigor in that field. He was the coeditor of the *Handbook of Health Economics*. It is a two-volume tome, which, for any graduate student in Economics, it is the first thing you tell them, "Read that book and then come and tell me what grabs you there." There must be eventually a volume three with updates. Is it coming?

Joseph Newhouse: Probably.

Uwe Reinhardt: Probably. Okay. Anyone wants to fund it. I happened to have the privilege of overlapping on Physician Payment Review Commission with Joe, and also Karen was there. And Joe and I were the neoclassical bad boys with all these weird ideas for example, that graduate medical education

subsidies really cannot be justified and it was always Karen with her Oklahoma charm putting us down gently, the naughty boys, saying, "Oh, this is one of your more flaky ideas." I remember that was one of those and that was usually the end of the discussion at that time. So Joe, will you come up or do it from there?

Joseph Newhouse: So I feel a little odd not having slides. This is the first talk I have given in a long time without them. But Karen's story about why do we have such good health services research and such a health care system - I will not put an adjective in that - since reminds me of one of my first doctoral students at Harvard who was Canadian, and when he was coming across one time from having gone home coming back to the U.S., the INS wanted to know what he was doing in this country and he said he was coming to study Health Policy. And the INS agent did not believe him.

I got the title for this session, "Where has health services research been and where is it going?" And I did not realize that there was a has-been panel and we are going panel, and I have been assigned to the has-been panel. So I thought I would say a little about both topics and since I cannot conceivably cover the whole field or even health economics, I would like to say a little about a piece of health economics.

Oscar Wilde is well-known for having said that economists know the price of everything and the value of nothing; and that was how Stuart characterized me when I came into his office, so I thought I should say a little about prices and what we know. People have talked about the RAND experiment and I noticed looking at the panel that actually all of them had a hand in making that a success. Stuart and Karen helped provide the money. I was there working out on my elliptical one night, a couple of years ago, and there was Karen on the News Hour saying, "And I was the project officer of that project." And Ron actually sent me the data from the survey that he discussed.

We had to provide power calculations and those were the data I used to provide the power calculations. And many years later, I was giving a talk to some students about the design of the experiment, and I had never gone back and looked at how well we did in those power calculations.

It turned out we are right on, I mean the standard errors at the end of the day were right what we said in our proposal. You would be glad to know that Stuart, that is what we said, and of course Bob was central to making the whole health status and quality of care piece work. In fact, little did Stuart know that what Stuart did by his remark was to give Bob an entitlement to come into my office - it would seemed like

everyday but probably it was only every week - to say he needed more money for the health status and quality of care work which most of the time he got, although he never got enough to satisfy him. But anyway --

In terms of prices I want to distinguish demand prices, that is what people pay for care, and supply prices, that is what providers get for care, the difference being of course insurance. On the demand side, the usual or first side anyway, is to the RAND experiment. But where the field is going I think, is how to write a better set of demand prices or better insurance contract than we had in those days when we simply ramped the coinsurance up or down subject to a stop loss.

My colleague, Mike Chernew, has talked about value-based insurance design. Other people talked about -- like Cass Sunstein and Richard Thaler about nudging consumers, when does it pay to actually lower prices to get consumers to do things that they should be doing? The extreme is directly observed, therapy for TB where we actually pay people, but I do not think we know very much about that domain. And I think over the next few years, there is an opportunity for a lot of studies to figure out where it makes sense to raise and lower selected prices on services that people are underconsuming.

The supply side when I came out of graduate school was something of a mystery to me. There were these models where

one wrote down P or something called P on the y axis, and P just sort of magically descended from the sky. When I started running the RAND experiment, I suddenly realized that I had a hand in studying P and that that was not something that was in the model. So what do we know about supply prices?

Uwe alluded to the fact that he and Karen and I did some mischief with physician prices, and Stuart and I actually had a hand in hospital prices too. There are several dimensions to the prices. There is the level of prices, how much you pay, Tom Rice [indiscernible] and some of the PPRC work showed that levels matter; if you pay physicians less, they do more. And that is efficiently well-established that the CMS actuaries actually account for it when they do formal scoring.

We know the degree of bundling matters. When Stuart introduced DRGs for hospitals, length of stay fell about 10 percent. And we know that hospitals later unbundled services to post acute care in the early '90s that was rising fast and now, we have also a new dimension - pay for performance.

Again, to go back to where Stuart was with his question, I do not think we know a lot about what all of these do for quality and outcomes. The RAND group certainly did the definitive study on PPS for quality and outcomes, but there are a lot of dimensions to supply prices and there is a lot of work for what can happen to what economists would call welfare

effects on supply price. So there is a lot of work left to be done and maybe even the next panel will talk in more detail about some of that.

Uwe Reinhardt: Well, thank you very much. Joe's remarks have been -- that was perhaps careless. We should have called it the panel of seasoned adults relative to everyone else present. Everyone here is still active and working which is one of the great things about this country, that you can do that. In other countries they would put you out to pasture at age 60 or 55 and here you can keep going.

I think the consensus on the panel was basically we feel our cohort has done quite a bit. We do not have to apologize even for the succeeding cohorts to do. There is a lot to be done and always will be. Health care by the way is now the economic locomotive of the American economy. It created the only jobs between 2001 and 2006; the only metric creator of jobs, one million jobs was health care. The entire rest of the private sector, nada, zilch, they created jobs and killed just as many.

So health care is in some way from a macroeconomic point of view -- I have always felt if you really want to play Keynesian economics and stimulate the economy by injecting money into it, tax cuts are not a safer thing because they may go into offshore mutual funds or Ferraris. But if you put it

in health care, every dollar stays home and creates jobs overnight.

We do not do research on that but macroeconomists might have a look at health care as the economic locomotive now. So you will always be employed for years to come. We now have some time for questions from the floor. Always ask the second question, the first one people are always shy, so the second questioner, please.

If not, we will talk some more. We have somebody.

Larry Kleinman [phonetic]: Larry Kleinman from New York City, Mount Sinai. I would be interested in hearing the economists' respond to Bob Brook's suggestion that we really need to think not only about the value proposition but the values proposition and how in your discipline you might think about incorporating that.

Male Voice: I do not know how these things --

Uwe Reinhardt: No, you are okay.

Male Voice: Okay, I'm okay. Well, I agree with Bob. I think there is a significant body of economists, usually not strictly health economists, that have developed an alternative model about how our health care system should function which is really at odds with - I would suspect - a great majority of what we are talking about here at this meeting and stuff like that.

I mean we all know what it looks like. And you see it in one of the candidates which will go unnamed right now, but it really has a whole fundamental basic microeconomic theory foundation and then has all the pieces of it. One is consumer directed health plans doing away with employer-based insurance, giving people a dollar and a half and telling them to go buy private insurance, especially hospitals run by physicians, breaking up of regional cooperatives, the opposite of what we are talking about in terms of large delivery systems - so economics is really, I mean once you separate -- there is a big chunk of economists that have a very different view about what the health care system should look like.

And if they have their drivers [sounds like] will look like which is, if all due respect, quite different than the results that you hear from Commonwealth or from Kaiser or from most of us, that battle is not over. Quite the opposite, I think it is really center stage on where our health care system is going. And every once in a while, those of us who sneer at it and then we wake up the next morning and we have more of it.

So for those of us who are fighting whether it is -- I think it is based on research, I think my side of the knowledge base is much stronger, but the ideology that runs the other side is very powerful and it does have resonance outside. So

Bob is right, there is a group out there that believes the truth is totally on their side.

Karen Davis: This is a bit not directly touching on the values question, but I think economics often gets a bad name because in recent years it is focused on the only way to control cost is for people to have skin in the game, it has to pinch, it has to hurt, high deductible health plans which obviously are beyond the means of most uninsured, most low-income working people to afford.

But when I go back to my economics training, I think it is all grounded in utility theory, that goods and services ought to be provided in a way that maximizes patient satisfaction - the good that they get from goods and services. So I feel like if we would really have patient-centered care, and I have weighed the consumer driven since that is kind of a distortion of what it was really about, but if we really designed the health care system so that it worked for patients and delivered the kind of care that they valued in a way that works for them and a way that they deserve.

So that is why I have just a lot of enthusiasm for the whole field of patient-centered care, surveying patients' experiences, designing health system around that. So whether it is all the public views work that Bob Blendon has done so well to kind of find out what people want, particularly from

their elected officials or whether it is more directly what patients want; that if we will just ground ourselves in listening to the patient, listening to the public, then we will be able to help contribute toward moving the health system both in policy and practice toward a system that is high performance.

Uwe Reinhardt: Bob Brook --

Robert Brook: I actually interpreted the question a little differently so economists - at least of my era - have been trained to distinguish sharply between efficiency or how to make everyone better off at least in principle and equity, and the tools of economics on the whole focus on efficiency. There are some economists that have crossed the two. Richard Musgrave early on did pioneering work in public finance and talked about the distribution branch as well as the allocation branch.

And today, Amartya Sen has a Ph.D. in Philosophy and in Economics had won the Nobel Prize and talks about this. I think actually you, as health services researchers, to the degree you are trained in a multi-disciplinary fashion, have some advantage over straight economists in this domain because you can in principle take both economics and courses in ethics. You can read somebody like Norman Daniels as well as economists

and they would not normally appear in a standard Economics Ph.D. program.

Male Voice: I was going to try to clarify two seconds what I wanted to say, maybe I did not say it well. Let's take the health insurance experiment. A fact of the health insurance experiment is that for the average employed person did not change health or health status even though use changed dramatically. It is a value judgment to say that that holds true for today's health care system.

I have no idea whether that would be true given the advances that have occurred in medicine. I'll give you an example for medicine. It is a fact that coronary artery bypass surgery was better than medical treatment for people with certain kinds of lesions in the arteries. That study was done 30 years ago. Medical therapy is different. Surgery is different.

It is a value judgment whether you want to decide that you want to extrapolate that today. On a little bit even more difference, we are all health services researchers, when we are confronted by people that look at the determinants of health, where should we invest the next dollar to produce health in this country? Do we improve intercity schools or do we give health care coverage to people that do not have it in the intercity?

What is the fact and what is the value here in terms of what is going on? We have a value that believes that we ought to have a medical home for people and that home ought to be run by some team that has a primary care doctor in it. That is a value; there may be some facts to support it but that is a value.

There is a fact that says that is not going to occur in our lifetime because there can be no doctors trained to be primary care physicians anymore, unless these characters that control the economics actually really do something radical with the reimbursement for primary care physicians or a mandate that medical schools - that is the regulator approach, we got Stuart back the hats - actually regulate that doctors being trained have to be primary care doctors or they cannot practice in the United States, they can go to Germany.

The bottom line is that we really need to be careful between distinguishing what we know - we know a heck of a lot - versus the values we believe in. And we really need to answer the question as a group in making a difference. Is the difference about differences in values or is the difference about differences in facts? And for each of the important issues that we address, we really need to be clear what we are doing because it gets very confused when you go out to try to interact with the policy process.

Stuart Altman: I want to address this issue. When I made the comment about it, I failed, that was part in jest but I think, Bob, two things I would say about how much money we are spending on health care. You are absolutely right, given the fact that I'm falling apart, 30 percent sounds just fine for me. My concern though is what I call the meltdown.

And I do not think we are doing enough research on that. You can say what you want, but if I add up all the dollars that many of our research findings suggest that we need to spend more on X and more on Y, and oh, yeah, well, we can take it all out of insurance administrative costs, it is nonsense. The issue is that there is a meltdown potential out there and I do not know when it is going to happen, but we are actually losing coverage.

We have been fortified by our Medicaid program during the '90s and part of the 2000 so that it did not result in numbers of uninsured. I'm very worried about this recession that we are in, that we are going to pass 50 million like a shot. So my comment, Bob, was not in disagreement with you.

I do not have a number anymore. I knew it when I was 32 and of course then, we were spending too much. But at my age now, we are not spending much. But I am concerned about our health care system and I am concerned about the people that are uninsured and partially insured. I think the work that Karen

is doing, it is wonderful, but we need to do more things on trying to figure out a way to get a growth curve that our country can sustain. I do not think we are doing enough research on that and we are leaving it at the ideologues to make those calls.

Robert Brook: By the way, Stuart, I agree that the facts of this need to absolutely done. I absolutely agree. And we are all doing it. The confusion that occurs is when there is a value decision that is made with that fact as well. I mean, I am a geriatrician. I can tell you that the most expensive technology is a very caring person and a fork, because you can keep elderly women alive with a fork and a very caring person for seven to 10 years to die a slow terminal death from either their bones rotting away or their heads rotting away.

And the fact is that we can do that. Now, how much you want to invest in that and the value of whether we want to do that or not, it has to become a value judgment. But the fact, I as a geriatrician can tell you that there is a fact that we can spend an enormous amount of money here.

The value of doing this is something that -- and I would love this organization to begin to have ethicists, religious people and others in here to really begin to figure out how you debate values regarding these facts. But I could not agree

with you more that we need an enormous amount of information about some of these questions that you are talking about.

Uwe Reinhardt: Well, it is interesting, this morning we had a session on some international work. And you could, in theory, if we did everything cost effectively in this country, think of generating a quality of life, quality supply curve, some quality of life years are cheap to buy and others, when you get into Erbitux, Avastin - some of the specialty drugs - it gets very, very pricy to rest another quality life year from nature.

And most societies somehow implicitly or explicitly say there is a maximum price we are willing to pay for another life year. And Americans not even implicitly, explicitly refuse to confront that question because it was mentioned in the latest drug bill, the Medicare Modernization Act, it was explicitly mentioned that costs cannot be considered in effectiveness analysis.

So Americans have their head in the sand which brings you to Stuart's point at current trends. Think of a family with a $50,000 income, if that grows at three percent per year for the next decade; let it grow at three percent. Now for a family like that according to the Milliman Data, it costs $15,500 for a family of four to keep them in American health care as we know it.

Run that out at about eight percent which is what is likely the growth rate, that means 10 years from now, 53 percent of that wage base will be chewed up just by health care and then you still have social security contributions, FICA, income tax, rent, gasoline - all of that to come out of that. And this will not compute which is what Stuart is talking about.

We are facing a major moral question in this country and no one is talking about it. You cannot even get an Op-Ed piece published on it because Americans simply do not want to hear about it. They do not want bad news. But we are facing in the coming, you ask, I do not know, when it will happen; I'm telling you it will happen in the coming decade.

I think we do have to come to a close. There are more questions but you cannot come up, but I do not want other people to miss the wonderful offerings that follow us. Thank you. Would you join me in thanking the panel? And thank you for joining us.