THE INTERFACE BETWEEN PUBLIC POLICY AND THE PRIVATE SECTOR

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An old friend of mine once said that if you're going to talk to a group of people, you should tell them what you're going to tell them; then you tell them; then you tell them what you told them. So this is the part of my talk where I tell you what I'm going to tell you.

I'm going to do six things.

- I'm going to first talk about the rise of market forces in health care. What is this "private sector" that everybody's talking about?
- I'm then going to say something about the declining policy expertise in government.
- Next: The double-edged sword of policy.
- Something about the conventional wisdom (which those of you who know me know I will probably trash when I get to that part of the talk).
- I want to emphasize that all of us are different in a little bit, and that we all have to go, to some extent, our own individual ways as foundations.
- And lastly, I'd like to leave those of you who are new at this with a few parting shots of advice.

A disclaimer here: some of you in this room have been doing this a lot longer and a lot better than I. So to those of you who put yourself in that category, I'm not really speaking to you. There are other people in the room who are either from new foundations like ours or are new to the foundation world.

So I'll have the temerity to say something to those of you who are new. Those of you who are grizzled vets of philanthropy can sleep, doze, doodle, whatever -- because the advice part particularly is probably more directed at those of you who, like us for the last two years, have been trying to figure out what to do with this money.

The rise of market forces in health care

I'd like to try to prove to you that health care is now increasingly part of a market economy. For proof, let me urge you to consider some of the things that we normally anticipate occurring in markets:

- price competition;
- use of market power for leverage (which is to say if you buy 30 windshield wiper units from me I'll sell them to you for a lower price than I would if you were only buying two.)
- advertising (if you've got a new product, a new service or innovation, the only way people will know about it is if you tell them); and
- new entrants and exit of unsuccessful firms.

The point I'd like to make is that all four of these phenomena of markets, and others that I didn't have time to name, are now expected and normal health care in a way that was unheard of in the health care system of 20 years ago.

As recently as 25 years ago it was against the canon of medical ethics for physicians to advertise. As recently as 15 years ago, doctors and other providers would be up in arms at the notion that they should actually have to offer a price, let alone publish that price, *let alone compete on price*. Even today there are many structural and cultural barriers against the exit from the market of unsuccessful firms in health care, particularly hospitals. And let me point out to you that, in many ways, the use of market power for leverage is thought to be “unethical” to this day, by many players in health care.

Increasingly, we find these phenomenon and others that are part of market economies

part of the normal course of business in health care. They are, in part, the cause for the clinical insanity of most health care providers today. Those of you who are physicians or who talk to them regularly know that the vast majority of them are demonstrably clinically insane.

The reason is that for their entire professional lives (and the entire professional lives of their fathers,) health care was always a bull market. This is true, by the way, of hospital administrators and health services researchers, as well. It is the only industry for which it could be said for three generations there was always more money this year than last, there were always more jobs next year than this, there was never a bad year. There was never shrinkage. There was never down-sizing. There were rarely, frankly, any serious constraints.

Well, markets contain constraints. Part of why everybody in health care is so dyspeptic these days is that for the first time in their professional lives they're having to deal with constraints.

So what are the potential responses to these developments? I suggest that there are three. (All of you who are in foundations know that you present to your board always three options. There's "jump off a bridge", "walk into traffic", or *my* proposal.)

The first potential response to the development of market dynamics in health care is to oppose and condemn them. That is the response of the "grave reservations" school of health policy.

A second, equally ideological, approach is to rejoice in these market phenomena and to engage in what the psychiatrists call "magical thinking". Magical thinking means believing that "it's all going to be okay." "Now that markets are here, price competition will do everything." (That's, by the way, the "walk into traffic" option.)

A third, more reasonable, response is to accept that these phenomena are going to

happen, frankly whether you or I like it or not, and to be curious and vigilant about the limitations, imperfections, failures and victims of the growing market economy in health.

Let me point out here that for those of you who have “grave reservations” about the health care market and want to point to ways in which it is imperfect - all markets are imperfect. The market in housing is imperfect. The market in food is imperfect. The market in automobiles is imperfect. There is no such thing as a perfect market and there is no market without market failures.

The reason I make this point is that our foundation has chosen to make the theme of “market failure” part of our central mission, which is to say we've taken the approach of saying health care is increasingly a market economy. It will, like all markets, have market failures. Our job is to recognize those market failures and try to play a role in plugging them where we can.

Why do I go on and on about this market thing? It's because it has consequences. One consequence is this: markets have winners and losers. In general, losers do not like losing and they mount a mighty effort against that loss. That is much of what, in my opinion, we see in the policy debate today, always in the name of “patient rights” or “patient care” or sometimes “quality”.

No one has ever introduced the Orthopedists’ Boat Payment Protection Act. No one has ever introduced the HMO Executive Bonus Guarantee bill. No one has ever introduced the Unnecessary Hospital Job Maintenance Act. What gets introduced is always in the name of “rational policy,” “the health of the poor”, the “safety net”, “quality of care”, or some other such slogan, which is at least half of the time is actually a cover for the economic interests of one set of stakeholders or another.

The subtlety here is that it is not conscious deception. When the ophthalmologists say that they must be included in the panel of every HMO and must be paid a certain payment to take out a cataract in order to ensure “high quality care” for their patients, they really believe that.

So you can't just dismiss it, because if you're going to interact with that culture you have to understand that people rarely get up in the morning and think of themselves as self-serving economic animals, and no one in health care is *entirely* an economic animal. But the fact of the matter is that this market will have winners and losers and winners tend to gloat and losers tend to yell.

Second, there will be instability. The path and trajectory of health care executives today, is a little like free agency in baseball. Last week a leading executive was announced to be the new CEO of a major California plan. She was traded from Prudential where she had been previously acquired from Kaiser for two players to be named later and a first round draft pick.

So not only in personnel, but in an organization, one finds HMOs and so-called “integrated systems” (what we call hospitals in drag), going into being and coming out of being. It's a chaotic situation. But because many of us are actually closet health planners and regulators at heart and love order, we must resist the tendency to want to bring order to the chaos of health care.

I can't tell you how many times I've heard policy people say “this thing is not organized”. “We need to pass a bill and organize this damn thing out here”! Be careful of that tendency. No one would dare suggest that we want to “organize” the software industry or “organize” the barbershop industry.

But it's an almost irresistible impulse for most of us because many of us are refugees from our health planning background. We want to organize this thing. We want to make it predictable. We'd like “rational” use of resources (rational defined by us.) But among

the consequences of markets are instability, chaos and unpredictability. That's what markets are.

Thirdly, markets will have excesses. I am aware that there are people in health care who are not nice people, who are probably making egregious profits doing things that probably ought not be done. And I suggest to you that the same thing is true for newspaper reporters and agriculturalists, Members of Congress, foundation officers and almost any other profession I can think of.

There is, however, a tendency for some of us to think that because we see an example of an excess, that therefore means that either the market must fail or must be reeled in. And I would suggest to you that's probably not going to happen for one-sixth of the economy.

Many of the excesses of markets, particularly volatile ones and immature ones, are self-correcting ones. And for those of you who were concerned three years ago about the "astronomical profits" that health plans were making and wanted to pass a law to keep them from making these excessive profits, well guess what? Most of them are now non-profit -- even those that don't want to be.

We should expect that this will be a period of some excesses and change. That's the way young markets work.

This is also a time of declining policy expertise in government. Term limits, like med flies, are <u>from</u> California, but no longer limited to California; some 20 states have now passed term limit laws.

We all, then, are experiencing is "devolution" of government -- that is decisions that used to be made in Washington are now made in Sacramento and Albany. But decisions that used to be made in Sacramento and Albany by career professional politicians are now being made by amateurs.

I don't mean amateurs in a disparaging way. What I mean is that Medicaid is an incredibly arcane, complex program. The people who run it don't fully understand it. The people who have been making policy for it for years have difficulty understanding it. How then, can we expect someone who a year ago was selling insurance and is now the chairman of the health committee of a state senate to understand Medicaid? Let alone when the professional staff of that body has been reduced by 70 percent by the same taxpayer revolt that established term limits.

So one of the challenges that we are facing is that the policy expertise in government in the elected sector is, I think, decreasing. Paradoxically, this actually puts more power in the hands of trade associations, lobbyists, and others with financial interests because they're the people who know Medicaid for a living. That's what they do.

So my suggestion to you is that something happens when market forces meet inexperience in the government sector, given the complexity of these programs. And I think that what happens is a policy opportunity for foundations to help play a role in supply unbiased, objective information.

The double-edged sword of policy

Now, let's talk about the double-edged sword of policy. On the one hand, it is important to recognize that if you are a health foundation in, say Akron, Ohio, your $300,000 for children's health care doesn't mean a lot compared to the budget that the federal government and state can mount. So what the government does in funding and regulation sets the environment for everything we do.

The California HealthCare Foundation and the California Endowment together will next year be giving out something like $200 million. Now $200 million is a lot of money, don't

get me wrong. But the health care economy in California is now $100 billion a year. So if we spent our entire endowment in one year, we'd be less than 3 percent of the action and we'd be gone forever.

So I certainly understand that we've got to be involved in policy work because it sets the context for what we do. But it's also important to be careful about the potential downside to a focus on policy.

We are policy wonks. If you look at where we come from, we come from public health schools and public policy schools and the legislature and think tanks and, occasionally, from medicine or health administration. And we and our boards have a set of backgrounds and culture and rewards system that tends to move us towards policy and away from the "mere" delivery of health care.

Have you ever been in a meeting where "policy" people sort of sneer about doctors and hospitals, like "What do they know? Those are providers, that's delivery. We're foundation executives. We do policy."

In my view, there are really two ways to view policy, depending on where you sit. Some of us who are policy wonks view policy as the top of the food chain. Once a week I get a resume from a French major from Wellesley who wants to "do health policy". (It could as easily be an English major from UCLA, but you know the phenomenon I mean, right?) They want to "do policy" and they want to get paid $90,000 a year to "do" it. I sometimes want to say to people, "Who was it that appointed you to do this exactly? I mean, where does this life goal come from, to 'do' policy?"

On the other hand, I have heard health care policy described as fruit flies. Health care policy is to health care as fruit flies are to fruit. Fruit is in the name, but it's an entirely different phylum, you see? And basically, what people do is buzz around the sweet stuff (the actual delivery of health care) rather disdainful of it but making a pretty good living doing so.

The point I'm trying to make here is not that policy is a bad thing -- not that leverage is bad, but we ought to drop back and remember that we -- the people who work in this policy world and our boards -- have a set of biases about what's important, about what rewards us, about what we value. And that to some extent, those of us whose philanthropic assets are concerned with health care live in a world quite divorced from that of the people who are actually providing that care.

I think that those providers and the public have a right to expect that we have a little better connection to the world of care than some of us do. I know that's a heretical point, but I'm supposed to be provocative.

Foundation focus: different strokes

Foundations are all different. And I want to argue that there is no “right” path for all foundations. How are we different? We have different mandates, we have different origins, we have different asset levels. We have different staff, we have differing activities of the other foundations in our environment to consider.

When our foundation was getting started, the first thing we did was go out and figure out what Sierra and California Wellness, Robert Wood Johnson and Irvine and Kaiser and Pew and others were doing -- and then not do that.

Each of us has got to come up with our own answer to what it is we do. We've been involved in an exciting and interesting, though sometimes painful struggle, to come up with our own answer for that. I would argue that it's important not to necessarily accept anyone else's definition of what's important, least of all what's most important, because what's most important for your foundation will vary depending on where you are on these points.

Conventional wisdom

“Don't substitute for government activity.” How many times have you heard that? “Be careful. They'll try to leverage you. They'll try to make you step in where they should be doing it”. “Don't substitute for government activity.” Well, maybe yes; maybe no.

Our foundation just issued an RFP for a vendor to come up with an automated, hand-held, wireless Medi-Cal/Healthy Families Application and Enrollment Device. The last time you went to Hertz and turned your car in, what happened? Somebody walked up to the car with that thing hanging from their belt, pushed some buttons, waited 15 seconds, gave you a receipt on the spot. Goodbye, end of story.

If I showed you the trail of what happens to the new joint application for Medi-Cal and Healthy Families, you would be amazed. If you are in Tulare County and you're sitting at the desk of the welfare department’s Medicaid eligibility workers or with an application assistor in a community-based organization, you fill out the application, sign it, put it in an envelope, turn it over and check off one of 59 boxes for which county you are from. The envelope is then sent to a mail house in San Bernardino and then forwarded again to the county you checked. (Hopefully you get it right, because if you don't, it gets forwarded again until it lands in the right welfare office in the right county.)

Check off Tulare County, put it in the mail. It is sent to Los Angeles, where *unopened* it is put in the “Tulare County” box and sent back to Tulare County, where it rattles around the mailroom in the Tulare County welfare office and several days later winds up on the very desk where it started. If you were trying to design a work process that is error-prone, expensive, and exasperating, you would take a snapshot of Medicaid application and be done.

Now should the government change this? Yes. Has the government done it? No. *Can* the government do it? I don’t know.

So our view is not, "We're not going to do this because that's something that the government should do." It is "Perhaps we are nimble enough and know people at Silicon Valley companies, and for whatever reason -- maybe we can get this done." And if we get it done, it will be a fantastic boon for the Medicaid program in California, and perhaps elsewhere. But let me tell you, if we started with the notion that we wouldn't do anything the government "should" do, we would not do this.

Conventional wisdom, number two. "Don't fund direct services or clinical research."

We made a grant that last year to fund the development of a vaccine against a fungus called coccidioidomycosis - Valley Fever. When we made this grant it was the lead story on every TV station in the San Joaquin Valley because about 70 people a year in California die of Valley Fever and several thousand get ill, but they're all around Bakersfield and Fresno and down there where foundation people never go, because there's no "policy" going on down there.

So it turns out that there are six or seven people in the whole world who know anything about Valley Fever vaccines and they've all agreed to work together in a kind of a Manhattan Project. We've got an advisory committee with the CDC, the FDA, NIH and private vaccine companies, and if the researchers are successful, in four years they'll have a vaccine to go to wide scale trials, and we might actually make a grant that would save somebody's life. Imagine that.

Now I've got to tell you this is not high health policy. Senator Daschle's office isn't going to call. Ted Koppel isn't waiting to interview anybody on this one. But we think it's an appropriate expenditure of our money, in part because the people of California expect us to try to help solve the health problems of Californians. And this is an example of market failure, because it's a big problem for part of California, but not big enough to interest a big vaccine company. No one is going to move 30 million units of cocci vaccine every year.

Five years ago I would never have made this grant because I'd have said, “you can't fund basic science research. What can you know about that? We can't do that. We've got to have leverage. This is something the NIH can do. We can't substitute for government.”

I don't know if this will work out or not, but I think it's a good grant. I think it's an appropriate investment of our money given where we came from, what the public's expectation is of us, what other foundations in our area are doing, what our board and staff are like, what our asset level is. It is, I say, a useful application of those axes as they relate to our funding strategy now.

The last piece of conventional wisdom I want to challenge will not come with an example for, for obvious reasons. A lot of people will tell you that broadly collaborating with other foundations is a good thing. “Do things with six foundations, eight foundations. Let's all get together and do a collaborative.” I've got to tell you folks, it's a nice idea, but in my experience it rarely works well.

It's not because people are evil -- it's because we all are a little bit different. We all have slightly different takes on why we want to do something. We all have our own competitive needs, or our board has its own needs for visibility. So I would argue that those things that two, or maybe at most, three foundations do together tend, in my experience, to be far more successful than when you've got eight people around a room and you're trying to make a stew.

It's a nice idea and one will hear grantees and others saying, “Why are each of these foundations doing things separately? Why don't they all get together?” And every now and then we'll have a spasm and say, “Yeah, why don't we all work together?” Then a year later we say, “What could we have been thinking about?” So I'd argue that this notion of collaboration, while it sounds good, is something to be taken with a grain of salt.

Words of advice

So quickly to the end, some parting advice for the new folks in the room. First, you've got to choose what's right for your foundation. I'm not suggesting that our choices are right for you with regard to policy, or what kind of policy, or what level of policy. But there is a right choice for you.

Second, having made that choice, you've got to stick to it and be disciplined. And in my experience, it is harder to say what you are not going to fund than what you are.

Third, you have to recruit staff with backgrounds appropriate to what you're trying to do. And that's difficult because there is a world of professional philanthropists, which probably includes most of us in here. In our case, we're trying to play a particular role at the interface of the private sector and foundation world and government. And frankly, what that means is recruiting somebody who's been a medical director who's got no foundation experience, and recruiting some people who have foundation experience but don't know health, and trying to let them teach each other how to do this. But that's our strategy, and so it's our recruitment task. I would argue for each of us, we've got to think about who we want to work here based on what skills they need to have, based on what strategy we've chosen. And lastly, communicate what you're doing.

In conclusion

So what I've told you is, one, health care is increasingly a market phenomenon. That market phenomenon has consequences that we need to recognize. Not all though will be pleasant. Certainly, they'll not all be controllable, but they are, I believe, inevitable and we might as well recognize it and figure out what we do in that circumstance.

Second, we're in an era where the policy expertise on these complicated problems is increasingly vanishing, particularly from the legislative branch of government, and that presents opportunities for us.

Third, this policy interest of ours derives in part because it's right and in part because it's easy. That is, it's easy *for us because it's what we do*. And we've got to distinguish what's easy for us from what needs to be done.

Fourth, the conventional wisdom needs to at least be questioned, if not defied. Particularly for those of us who have assets that came from a local hospital or a health plan, a knee-jerk “we don't fund direct services,” attitude needs to be seriously examined.

I think that we probably fund services. So be careful, you new folks, not to be swayed by the blandishments of these grizzled foundation policy vets, that there's something somehow ignoble or lesser about funding a “mere” home health nurse, because that's what we should be doing in some circumstances.

Fifth, those circumstances are dependent on our staff, our asset level, where we came from, what people expect from us.

I’ve given you a set of highly idiosyncratic and personal advice for those of you who are trying to figure out where you fit in this complex world. The disclaimer is that not everybody at my foundation would agree with all, or maybe even any of these points, but I’m the one with the mike so I get to make them.