



VOICE EXPEDITION INTERVIEW TRANSCRIPT
The Oral History of Nephrology
Philip J. Held
Interviewed by Dugan W. Maddux, MD
November 2, 2012

DWM: (0:02 - 0:15)

So, good morning and here we are on November the 2nd, 2012, in San Diego, California. And I'm talking with Dr. Philip Held. Thank you so much for being willing to talk to me about the nephrology.

PH: (0:15 - 0:21)

I'm thrilled and honored. Thank you. And so I hope I can be helpful.

DWM: (0:21 - 0:33)

Very helpful, I'm sure. So I want to start with, I know this is going to sound a little crazy, but I want to start with where you were born and raised, which will just give us a little bit of context for this life that we're going to talk about.

PH: (0:33 - 1:32)

I was born and raised in Philadelphia, Pennsylvania, actually a suburban town, Willow Grove, which is to the north of Philadelphia. I was from a Catholic family, eight children. I was the seventh child in the family.

I was the only member of the family that went to college. I was kind of a Sputnik child. 1957, the first Sputnik, you know.

At any rate, I wound up going to it. I had a lot of Catholic education. And when it came time to go to college, I applied for a naval ROTC scholarship, which at the time was a big thing.

And I won it.

DWM: (1:34 - 1:40)

Why did you decide to go to college when your siblings had not gone? And what made you think about it?

PH: (1:40 - 3:07)

I was a Sputnik child in the sense that when the Sputnik occurred, it was this kind of a big, America was behind in some ways, you know. And there was a need for science and education and that sort of thing. All my family, certainly my immediate siblings, were in construction.

And I spent my summers banging nails. In my family, you had an eight-penny nail. You had to be able to drive an eight-penny nail in two hits, one to start it and one to drive it home.

And now, of course, they don't even use it. I mean, it's all electric or pneumatic. But anyway, so I don't know.

I don't know how I wound up. I wound up at Villanova University, a Catholic school. A friend of mine was there and said, why did we go to school here?

Because we were second generation American Catholics that didn't know any better. And then, at any rate, in the Navy, I was a statistics major, undergraduate. And then I was obligated to four years in the Navy, and I wound up five.

DWM: (3:09 - 3:16)

So tell me about when you were in the Navy, where you were stationed, and what was your duty in the Navy?

PH: (3:16 - 4:45)

Well, I was originally scheduled to be a naval aviator, as they called it. And it turns out I had had a bad automobile accident, which my head went through the front windshield. At any rate, they ruled me out of that as a pilot.

And then I wound up as a navigator, technical coordinator, on a long-range anti-submarine aircraft, which was actually, I did a lot of my training right across this little bay here at North Island Naval Air Station, which was on Coronado. I wound up from there being stationed in Okinawa, and we were part of this big patrol force, which was, we were to be the early warning force for the invasion of Taiwan from China. And so I navigated, spent a lot of time in the Pacific, and I knew we actually flew reconnaissance missions from Shanghai to Hong Kong on a pretty regular basis.

So I spent my time there. Then I was transferred back to Hawaii, and spent about a year in Hawaii. And then my final year in the Navy, I was here at North Island as an instructor.

DWM: (4:46 - 4:49)

What years would those have been that you remember?

PH: (4:49 - 5:28)

I graduated from Villanova in 1961, and I got out of the Navy in 66. I was extended a year because of Vietnam, and I wound up after the Navy. Well, I loved California from the time I came here.

In 1962, I drove through Sacramento. It was 115 degrees. Came down to San Francisco, and it was 55 degrees.

Same day. Ended up at an hour and a half apart. And at any rate, I'm in California.

I loved California from the moment.

DWM: (5:30 - 5:34)

What was it about California? You had this very entrenched East Coast family.

PH: (5:35 - 9:19)

Oh, yeah. I am one of the few members of the family that did flee. I don't know.

It was, as a young naval officer, it was very, very exciting. It's only my old age that I've really come to realize how much I learned in the Navy. And I guess one of the best things I learned looking back is, you know, when you really have a lot of power, it's important to exercise that power very judiciously.

And, you know, in my whole professional career, I don't think I knew two or three other people that had been in the armed forces. And the images that in the military you tell somebody to do it, and they do it. I mean, that's just ridiculous.

I mean, you have to lead. And one of the most important management tools I learned in the Navy is you can fool people over you, but you can't fool people under you. And so I think as we talk about our career, if anything, I think my success was really based on building large research staffs and tying people together.

And I think it was my Navy experience that taught me how to really, you know, praise people in public, criticize in private, and that sort of thing. So anyway, California. I'm in California, and I'm getting out of the Navy, 1965 or 6, and I had a good friend from undergraduate who was also Navy.

He was nuclear-powered Navy, which was a very exclusive club at that time, you know. And he was an instructor in his latter years at the Mare Island Naval Air Station, Mare Island Nuclear Submarine Base, which is north of San Francisco. And he was living in Berkeley and teaching at Mare Island, but he was also going to school at night.

Now, he was a physics major as was I, and he had been into nuclear power. And this was the big time of John Kennedy and the emphasis on economics and getting the economy going and growth in the economy. Here we are, 1972.

I mean, 2012, three or four days before an election, and the big issue is, how do you get the economy growing? So anyway, he said, why don't you think of coming to Berkeley? And I said, well, you know, that sounded all right, but I wondered if I'd be able to make, you know.

And so I applied, and Berkeley at that time was in turmoil all over the Vietnam War for protestants and so forth. And what I did, I applied to the B school.

DWM: (9:21 - 9:22)

Like the business school.

PH: (9:22 - 10:22)

The business school. It turns out that they just loved vets. I think they were trying to leaven out the campus or something like that.

And at any rate, I was absolutely amazed. I was accepted, and I went to, I was in the B school for two quarters. I did very well, and I switched over to the econ department, which was considered to be a bit more, I don't know, purist.

Although, I think to this day, I mean, the B school at Berkeley has become very, very campaigned. You know, I felt in a lot of ways very much out of sync with all these young

kids, most of whom had studied economics undergraduate. It was very, it was, I mean, the fact that I got into the economics department at all is amazing.

DWM: (10:22 - 10:28)

Why? Why, having had this physics science background, were you thinking or working on economics?

PH: (10:30 - 19:05)

Well, first of all, I wasn't that good as a physicist. And, but I did have a fairly good quantitative background. You know, in physics, it's important to study mathematics and so forth.

I hated chemistry. And of course, there was a big emphasis at that time on quantitative methods in economics. And of course, it's gone totally wild since that time.

And there was a, it was interesting, there was a very stressful period in the first year of graduate school in which they had these theory courses. And the, in general, I mean, what a small world, what it, in general, the intention was to cut the class in half. And so you had to do a certain amount in this certain grade level in this theory.

But the irony of it is the theory course was taught, well, by two people. One of them, Dan McFadden, went on to win the Nobel Prize, which I was always very honored to think that I was one of his students. But the other was a young man named Steve Goldman, who had just come to Berkeley from Harvard.

Steve Goldman, in 1990, this was like 35 years later, loses his kidneys. And Steve Goldman, he's back on dialysis now, he had a transplant for a while. So a couple years ago when I was running the USRDS, I asked Steve Goldman, who was a very top-notch theoretical economist, to serve on a national committee.

And it was interesting, coming from this absolutely terrified status as a new graduate student with these two professors whose job is to make your life pretty miserable, and then wind up working 35 years later with one of these fellows who's on dialysis. So anyway, at Berkeley, though, I studied more traditional economics, monetary theory, which probably doesn't mean much to most people, but you probably heard the name Milton Friedman and so forth. And this, of course, is extremely relevant to today in terms of the economy and so forth.

But subsequent to that, comes the thesis time. What are you going to write on? And I found this obscure office on the university which was run by a fellow named Mark Blumberg who had a medical degree and a dental degree from Harvard.

And he was very fascinated with quantitative economics and methods. And at that time, California was trying to float a bond issue to build more medical schools. California has always received most of its medical students from outside of California.

But the big issue was, oh, if we don't build more medical schools, we won't have enough doctors and all this stuff. So I wind up looking into this question about if you build more medical schools, do you get more doctors? And, of course, as an economist, we'd say, well, you know, the market evens all this out and so forth.

So I wind up working with the AMA and they, of course, had a huge database. I mean, you have no idea how primitive data processing was. This is 1966-67.

And so I decide to buy this big data file on all physicians who graduated from American medical schools in 10 years of them, from 1916 to 1970 or something like that. But, of course, this cost money. And lo and behold, I had a nice angel of...

I had a guardian angel, I guess. And I wind up... There's a public health grant, big project at UCLA.

I'm at the Berkeley. Very rival, big rival to the two. And this public health guy in the southern California has his grant expires in two weeks and he has like a half million dollars to spend.

So, first thing you know, I get this account to pay off the AMA to get their data. I get this huge data file and, of course, he's like, can you spend any more? And, so anyway, so I read a thesis on migration of doctors across the US.

And the question was, if you think about it, you know, well, I mean, sort of like headline stories. There's more graduates of the University of Nebraska practicing in California than practicing in Nebraska. So you see that there are these very big flows of people, physicians, doctors from here to there.

And so the question I focused on was, well, what determines the out... Why do physicians leave Nebraska? Why do physicians come into California?

Well, if Nebraska expands their medical schools, do they get more physicians? If California expands their medical school output, does the flow of physicians into California, which they mostly come in in graduate programs like the fellowships and that sort of thing, does the flow, is the flow of physicians into California sensitive to local production of physicians? And the truth is, yes.

However, quantitatively, it's not such a bad deal that California could expand and they would reduce the inflow, but not on a one-to-one basis. And so it was kind of... The public forces at the time liked it because it was about...

They were trying to build... See, at that time, there was only Stanford, UCLA, UC San Francisco, Loma Linda. They were the only medical schools in California.

Huge city. New York City had more medical schools than the whole state of California. But I was never able to prove this, but I really found out that why California wanted to build more medical schools had to do with the upper class of California wanted to put their children in medical school.

And medical schools, especially state-funded medical schools are very territorial. And so that's why they really wanted to build more medical schools. But I didn't...

I wasn't able to prove that, but I was absolutely convinced of it. And anyway, that's how it got there.

DWM: (19:05 - 19:12)

But your answer was that they should build more medical schools. It wouldn't hurt. They'd still have...

They'd have a net gain.

PH: (19:12 - 20:01)

They'd have a net gain. And of course, I produced the estimates for all the states. It was a very...

It was... You know, for its time, it was... I guess I've always been able to dazzle the medical community by fairly...

I mean, you understand, in the field I was working in, this was a small time. But the fact that I was able to find money to fund this, and at that time, for example, computer costs were very, very expensive. I mean, it was...

That alone was a big, big problem. Anyway, it turned out that I was good at that, at finding money and applying quantitative things to medical issues.

DWM: (20:02 - 20:06)

Well, so you were paying... Paying... As a graduate student, you were paying for your computer?

PH: (20:06 - 22:02)

Well, yeah. I mean, you had to find somebody. I wound up...

I landed a Ford Career Specialist Fellowship, which I hate to say... This is cruel, but I think part of it was a lot of students were being drafted. I was a veteran, of course, and I was coming back, and so some of the scholarship money became available.

And I... Anyway, so no, I had... But even then, it was computer money was...

It was a big issue. And then... I mean, just as an example, though, of how you learn and maybe in a lot of ways influenced my career.

So I assembled this big prize. I forget how many. At that time, a typical medical school had 100 students, graduates per year, and then there was...

There were about 100 medical schools in the United States at the time. I think that number has gone up by a factor of two now. But anyway, so I had to look at histories of all these people, but I had to do this huge editing job to put it all into one form.

And the estimates I came up with is this was going to cost me or cost Peter about \$10,000 or \$15,000. It was more than that. It was \$25,000 to run this big program.

So I found a computer specialist over at the University of California Medical School who specialized in making programs efficient. And I paid him out of my pocket, by the way, and he managed to reduce the cost of this \$25,000 program it would run, and it ran for like \$1,200.

DWM: (22:03 - 22:03)

Wow.

PH: (22:04 - 24:57)

I think I had to pay him about five grand. But at any rate, it was worth it. So I spent all this time...

I certainly was using... I had the biggest files of any of the students in my class and so forth. And it was...

looking back, it was fun. And as you say, it was irrelevant. It was very...

I mean, very, very focused. And there were certainly a lot of people who were interested in the results. And it turns out, later in my career, I would always tell my staff, you know, you can be rest assured when we finish this paper, it's not going to be something sitting on a shelf collecting dust.

There's going to be two groups of people. Half of them are going to hate it and half are going to like it. But you're not doing obscure work that collects dust, which is, of course, true of a lot of academic work.

So... And that was... that was the start.

And of course, then it comes for looking for a job. And the truth is, I just... I didn't fit the traditional model of an economic student.

I mean, you know, maybe I was too much onto this practical policy stuff. So, it turns out that a firm in Princeton, New Jersey named Mathematica, which was a spin-off from Princeton Economics Department. It was a commercial firm.

They were doing work on what was very, very important work at the time called the National Health Insurance Experiment. And it was really the first, maybe the only, randomized controlled trial of people in America who were assigned to different health insurance plans. And so, you would put somebody on this very generous plan that had no co-insurance and you would put somebody on this other plan that had a very high co-insurance.

It was very, very sophisticated work. The principal investigator was still at Harvard, Joe Newhouse, one of the grand, grand persons in whole of health economics.

DWM: (24:57 - 25:09)

How did they ever get permission to do a randomized controlled trial for health insurance? That's fascinating. How did they recruit people to be part of that?

PH: (25:10 - 26:26)

Well, that was a long story and it's fundamentally they basically compensated them with cash so that if in a sense the person may have had a big co-insurance on their policy but they would receive cash and then the person would choose, well, do I want to buy this operation or do I want to put the money in my pocket? So it really gave them choice and nobody was worth off in a sense. It's to this day, to this day, I mean, you've got, this is in the 70s, 72 to 75, something like that.

And it was, it is to this day one of the most fundamental pieces of research when people talk about Obamacare or talk about health insurance or how you're going to model health insurance and what impact is it going to have not only on cost, what's the impact on quality of care, on outcomes?

DWM: (26:27 - 26:27)

Utilization?

PH: (26:28 - 29:19)

I mean, this was, this was a gigantic experiment. We're not talking small beer here. There were three sites.

I wound up, my task was to choose the locations they were going to have three sites. One was in Seattle, Dayton, Ohio was one and there were three different sites. Anyway, so I wound up again, I guess you'd call it practical data work of choosing these different sites.

And one of the things I did, of course, was we were trying to look at how tight was the medical market where they were. And so, I'm about to make a confession of something that I'm, you know, we all have in our history some job you're not exactly proud of. But, so I designed this and implemented a national telephone survey to measure waiting times for an appointment.

And this was asking, you know, we focused on GP, they were called GPs at the time, not family practice, internist and pediatricians. And so basically, I came up with a scheme in which we were able to measure waiting times for an appointment in like, I don't know, 100 or 200 cities in the United States. And the reason, I mean, it's kind of like I hate telephone surveys, you know, but the organization and the AMA, everybody picked up on my study and now it's standard practice.

My organization, Mathematica, grew into Mathematica Policy Research. I'm sure they have a huge survey division that just does telephone surveys. And all came out of my work in the 70s.

And of course, I went to Mathematica because I had done this quantitative piece. I mean, I understand at that time, to say you were a health economist, there might have been five people in the United States who would have said they were a health economist.

DWM: (29:20 - 29:26)

And was that a specialty area or did you just based on your say that you were a health economist?

PH: (29:26 - 30:03)

It was based on your say. So, again, you know, it was like me getting out of the Navy. I mean, think of getting out of the Navy.

Understand, I come from a working class family. All my family built things. What am I doing?

Research. 10, 15 years after I was out of graduate school, my brothers would quite regularly say, now what is it you do?

DWM: (30:06 - 30:08)

And they pay you for this?

PH: (30:14 - 30:46)

I'm kidding. I'm not kidding you. So, because I had done this very quantitative thing focused on the physician migration in the United States, Mathematica got latched.

I mean, they were kind of interesting. And then looking back, these were all kind of maverick guys too who they had done unusual things. I was the first Ph.D. that they hired at this group.

DWM: (30:52 - 30:59)

And that was How big was Mathematica?

PH: (30:59 - 32:01)

At that time, as I say, I was well, there was two groups there. One was the traditional Mathematica which had started as a consulting firm. And anyway, the total employment must have been less than a hundred.

I think Mathematica Policy Research, which is really big time today, they now have offices in Ann Arbor, in Boston, San Francisco, New Jersey's home, and Washington, D.C.

Mathematica Policy Research must have a thousand people or more. At any rate, so that's what I did. And then I wound up taking a job at Northwestern, which was probably the one very bad choice in my life.

DWM: (32:01 - 32:03)

So how long were you at Mathematica?

PH: (32:04 - 32:09)

I was there about six or seven years, I guess.

DWM: (32:09 - 32:15)

So what year did you go to Northwestern then? I may have it.

PH: (32:16 - 32:20)

No, I doubt it. I generally suppress that in my resume.

DWM: (32:20 - 32:21)

Why was it bad?

PH: (32:25 - 32:45)

I guess I was young and immature. I mean, I don't know. I just didn't fit in the traditional academic model.

But while I'm there, I'm doing some work for the CMS, which is called HCFA. It was called HCFA at the time. Healthcare Financing Administration.

DWM: (32:45 - 32:48)

How did you get into doing work for HCFA?

PH: (32:48 - 34:58)

Well, they, this Northwestern Center, had a grant from the government to do policy research. And that's when I got hooked up with Mark Pauly, who is really one of the great world health economists. And a woman at CMS named Martha Blacksall asked me to write a two-page memo.

So this must be about 1977, 78. Medicare has funded all ESRD patients about 1972. So she asked me to write a memo on how should the government pay for that is the physician portion of the dialysis treatment.

And from its beginning, dialysis was both a unpopular thing and a very popular thing within CMS. It was very popular, people felt, the government officials felt very crusader-like. Because this was the first national health insurance. Here was a program that was offering coverage for nearly everybody.

Small print, there were a number of people who were excluded from this coverage. And those were farmers and government workers. Because they weren't in the social security system.

See, the government program, all the government program said, I mean, you've heard the story of the guy who dialyses before Congress.

DWM: (34:59 - 35:02)

Well, do you recall that story? I mean, did you look at that at the time you were working there?

PH: (35:02 - 37:40)

No, I mean, that was the folklore. Everybody spoke about it. But technically, what the government said in 1972, I think it was, is anyone who has irreversible kidney failure and

lives for three months with irreversible kidney failure is considered eligible under the Social Security Act.

But they had to be in social security. They had to pay. And there were actually groups of people who were not in social security.

And there's still groups of people that, the groups have gotten smaller. I think at that time it was about seven or eight percent of the population did not have, they weren't in social security. And if you weren't in social security then you didn't get this Medicare coverage.

And that's not well known. But it's, it's, you know, I would say, if you want to know if people really understand the mechanics of this, there's two questions you can ask. How many people are not, how many people with kidney failure, Americans as citizens, who are not covered by Medicare?

Now there's a separate issue about Medicare secondary payer, so forth, which we could get into. That's another complicated story. My point is, when Medicare passed the law, well, the Medicare didn't pass the law, Congress passed the law, which extended Medicare coverage to about 93 percent of the U.S. population who would develop kidney failure. How did they come up with this notion of waiting three months? I don't really know. It's, I think, and the truth is, it has shaped, it has shaped the program in a lot of ways.

DWM: (37:45 - 37:47)

Why would that have been that, every month?

PH: (37:47 - 42:30)

The notion is, I'm sure it was, I'm speculating. Certainly, general sound principles about insurance, which gets extended over to health insurance, is, there's a notion called moral hazard. And my friend and colleague, Mark Pauly, of course, he was the first to bring the notion of moral hazard over to health care.

And the issue is that, put simply, if you make the price of something zero, people will buy a lot more of it than if the price is greater than zero. And this, in a sense, is almost principle one of health economics. So, you're always trying to prevent moral hazard.

That is, I mean, in a lot of ways it sounds crazy. I mean, are you telling me this patient's going to go get extra dialysis treatments because their price is zero? I mean, it's a crazy concept, apply ESRD.

And by the way, the whole notion in, you know, all ESRD, most all, all dialysis outpatient services and so forth is covered under Medicare Part B. And as a result, there's a very large copayment, 20%. I said, how many patients ask this question, how many patients are not covered with dialysis under Medicare?

The second question you want to ask them is all these numbers we see up here about cost, are they what the government pays or is that the approved charge for a dialysis patient, for example, in this day and age in which their dialysis care, most of their visits to a physician,

their treatments by a physician, all their laboratory services and so forth is outside, it's in Medicare Part B. There's a 20% co-insurance on that. So for the typical dialysis patient, this could be \$10,000 to \$15,000 a year.

And as we go into Obamacare and there's these various demonstrations, a big question in my mind is how this co-insurance is going to be treated. Because there's a lot of money involved. Now there's not a lot of knowledge publicly available as to how much the community, the business, both the hospitals and dialysis units and physicians collect of that 20%.

The common wisdom is that they collect most of it. And I based that just recently, I spoke to a fellow who I won't mention his name, but he's certainly a recognized billing specialist. And he says most of it is paid.

It's paid by private insurance, Blue Cross Blue Shield or something like that. Or it's paid by Medicaid. Or it's paid by state kidney programs.

And that which is not paid apparently winds up as a tax advantage under bad debts. So this sliver of 20% co-pay is a big issue. And it's clearly grandfathered in terms of general health insurance, well general insurance, you have a deductible on your auto insurance and so forth.

Why do they do that? Well to avoid this moral hazard idea that you don't take your car down to get your oil changed.

DWM: (42:30 - 42:32)

Just willy nilly because it costs you nothing.

PH: (42:34 - 47:02)

But the direct applicability to ESRD and dialysis is very it's a big stretch. And the three months waiting time if you listen to Ray Hakim I heard part of his talk yesterday, I wish I could have heard the whole thing, but he's very focused on this mortality rate in the first 90 days. I think he'll credit me with having put him on that topic.

The truth is we have very low knowledge in America of that first 90 days. It's clear the mortality rate is very high. And one of the problems is of course we don't know a lot about in fact I would suggest there's a big vacuum in our knowledge about what happens between chronic kidney disease let's say stage 5 there's a big gap in our knowledge between what happens when a patient approaches kidney failure and then goes on to kidney failure.

Now as you know I founded and ran the USR DDS so it was certainly always an issue. It's a big issue about cost, but it's a big issue even about simple practical clinical matters. What was the patient's creatinine the day before he started dialysis?

Even the DOPPS program which doesn't rely on claims and so forth goes to the medical record. They have a hard time getting that information. Why?

Because often these patients are starting dialysis at this dialysis facility and there isn't a medical record for the pre-dialysis period. By the way, one of the big advantages of the Kaiser system, which I don't think has gotten the recognition it deserves they are about the only full service provider you might say in America in which you have this stream of patients and you're on to them from in some cases birth maybe pre-birth and prenatal right through death. But anyway, get back.

We were on Northwestern. Someone asked me, a woman who was director of research at CMS at the time and Martha if you look at this I want to say thank you or hear this it was a great gift you gave me. So she and I flew into Washington.

She lived in Washington but of course CMS is out in Baltimore so she drove us out to Baltimore and kind of threw us into the pit. But like I say CMS has always had a special place in its heart for the dialysis because they realized one it was very expensive two it was this some form of national health insurance it was in the 70's if I remember when it started and all ages and so they've always given the data collection and so forth special attention. That was good and bad.

The good is of course as a society we have a very good research database to work with and I think by the way the nephrology community was extremely hostile to using data from CMS. I don't know if you're aware of that.

DWM: (47:02 - 47:02)

Why?

PH: (47:09 - 48:57)

I don't have a full explanation but there was this you know at the time everybody liked to point to Europe where they did these surveys. I mean I tell you one of the most interesting things about the dialysis in my mind to the dialysis credit is from the earliest days they recognized that this dialysis unit this hundred patients 150 patients is not big enough to do anything substantial research. So from the earliest days and I don't think it started in America as much as it did in Europe.

This idea that we had to collect data broader, wider. So back to the question CMS is there collecting all these data there isn't much coming out. The leaders in nephrology are extremely hostile to the CMS database.

Why I don't know but I could give you, I mean you may you mentioned John Sadler earlier. Okay. When I had my first grant to look at CMS data I actually got a letter from John Sadler saying how could you be so stupid to think you're going to learn something from this CMS database.

And he had a lot of support in this. I mean certainly Chris Blagg and all these guys. John Bower.

DWM: (48:58 - 49:33)

Well one of the things that I think they talk a little bit about is their concern that CMS was going to take this data, these data and use it to make policy changes or treatment, you know, limit treatment instead of that CMS was just looking for ways to try to stem the tide of the services they were trying to provide. And so they were worried. I think they were worried about what CMS would do with their knowledge.

PH: (49:34 - 57:53)

And they certainly had right reason to be worried like that. But I will say in all my years I mean I'm probably a person who has spent more time in CMS than anybody you know. I never heard anyone say well let's see if we can cancel the number of patients being treated or reduce that.

And I will say that I had always I have always found them to be speaking quite forcefully for patient care. Now I said within CMS there is a division you know and it extends to Congress. You mentioned the we mentioned earlier the Medicare Secondary Payer Program.

What's the Medicare Secondary Payer Program? It's an effort to shift the cost off the federal budget onto private insurance. And you know when they first started it was 12 months then it was 24 months I think it's 36 or 40 months now.

And of course fortunately speaking either from CMS or the society I don't know as a whole but the provider community has loved this because these private insurance by and large pay a much higher price. I mean I've had more than one executive tell me that their decision whether to open a dialysis unit here or there is contingent upon whether the patient population they withdraw has private insurance because they claim they can't make it on Medicare alone. And I think there's a lot of evidence for that.

so we were talking about so within CMS you have this small group that was very focused on the ESRD program. And they were very protective in times of trying to get data and collect data. And the truth is they did a good job.

Not perfect by any means. But within the restraints and so forth that they had. Now this other force which exists not only within CMS but also within certain Congress in fact when I first went to the Urban Institute in Washington D.C. which is after Northwestern I get a phone call from a staffer who was working for a not widely known although he ultimately became very well known Congressman Stockman who became Reagan's hatchet man. And this young staffer says well you know we're having hearings on the Hill and we're looking to identify these places in the healthcare system which is a big weight. Now could you come up to the Hill and testify on this ESRD program and how it's you know it wasn't quite that blunt but it was pretty close. And I said well I don't know about that.

I said it seems to me the ESRD program first of all has had a record I mean fantastic experience in terms of controlling costs compared to Medicare in general. And you know most medical care it's very hard to measure what the outcome is. In ESRD there's no question you've got a real good outcome measure and there's no question about when the patient's dead.

So I don't think you're going to want me to come testify. And that was the last time I heard from them. But the point is that thinking is very prevalent in Washington.

And I think there are a couple reasons for it. Number one I think is in some way there's just hostility to for profit companies. And I you know I'm a traditional market economist.

I mean I've always said you know it's not my job to say whether we should be treating these patients or not. That is a real political societal moral question. And I don't have any particular expertise.

I mean I have certainly an opinion on the value of life and so forth. But my job is to ask the question if you do this then what? And on that I would suggest that the for profit community has been wonderful in terms of providing access to care in every nook and cranny in the United States to all populations.

I think I've told you before I got called in as a consultant for a short time in a case in Gary, Indiana which had no dialysis unit. I found that unbelievable. All black population as you know blacks have a rate of kidney failure four to five times that of whites.

Gary's a poor black community by and large. A lot of patients. But they were being bused out of the city to a Catholic hospital in Hammond.

And this group of kidney docs in Chicago which we know borders on Gary, Indiana want to open a dialysis unit in downtown Gary. And not only that they're still radical. They want to employ a black nephrologist.

Anyway the for-profit community these people did open a dialysis unit in downtown Gary. And I understand, this is seven years ago, the Catholic hospital in Hammond actually came into town and opened a unit right next door. So those patients really had choice.

I use that as an example of one of the many benefits of the for-profit community. I mean where else in American healthcare system can you point to, especially in this period, 70s 80s, 90s where people were fighting to provide care to poor minority populations. I don't think there's another example.

Why did it work? The government created incentives, but part of the consequence of that was this huge hostility that developed about for-profits.

DWM: (57:54 - 58:07)

I want to go back to where you are at Northwestern and Martha calls you and you go so what do you start doing for CMS? What is your work that you do?

PH: (58:07 - 58:10)

Well, we wrote a 30-page paper.

DWM: (58:10 - 58:12)

She wanted you to write a memo.

PH: (58:12 - 58:13)

A two-page memo.

DWM: (58:13 - 58:16)

How did it end up being a 30-page paper?

PH: (58:16 - 1:02:26)

Well, understand, Mark Pauly Mark Pauly is Mark Pauly is one of the great minds at health economics. Understand, he had been he wrote his PhD thesis on moral hazard which became by the way, Mark Pauly he's a conservative as you can be. Mark Pauly is the author of the concept of individual mandate.

He wrote that in 1994 and he wrote it for Republicans. So you can imagine the turmoil with Obamacare when the Republicans were running away from this idea of the individual mandate. The individual mandate makes a lot of sense from an economic viewpoint called free rider.

The free riders in our society are the people who don't have health insurance they show up at the ER we don't throw them out, we spend a lot of money. So in a sense they're free riding on the healthcare system. Now avoiding politics, I mean the question is it's not unreasonable to say that those people in a sense are getting health insurance but they're not paying for it.

So that's where it came from. It of course became political a nightmare. Very interesting interview with Mark Pauly in the Wall Street Journal in the midst of the Obamacare debate in which they're trying to get him to say oh those hypocritical Republicans they've abandoned your ideas you know.

He sticks those guns in even though he's certainly a well known conservative and says that the individual mandate is still a good idea. So anyway, Mark Pauly he's been working on designing health insurance schemes for years when Martha asked to write this memo. And I actually had gone to Northwestern to work with Mark Pauly.

He's now at Wharton at Penn. And so you know we wrote which was a paper which was really on kind of trying to think about how would you design a reimbursement system in which the principal actor, the physician is collecting about 10% of the pot. But affects 90% of the pot in a big way.

Now the people who are asking us to write they all want something like how can we screw these guys you know. You probably didn't go to a session yesterday on and it was this issue about Medicare requiring nephrologists to see their patients more than twice a week or something like that. And so we wrote this and said you know what you want to do is to structure this reimbursement system that this physician who himself is only getting 10% of the pot but is incentivized to make efficient social choices about the rest of the healthcare system.

Not earth shattering brain science. It certainly wasn't a popular idea at the time. And as I said so we then start doing site visits and we visited NMC headquarters with what was his name?

Guy who founded. Quite respected Harvard guy. Less nephrology.

DWM: (1:02:26 - 1:02:28)

Hampers. Gus Hampers.

PH: (1:02:30 - 1:05:44)

One of the most the first time I think I really made an impact on the nephrology community is we were invited I'm still at Urban Institute of Science. And we were invited I was invited to an RPA meeting in Arizona and of course living in the mid winter you always take an opportunity to go to Arizona in the winter. And I devised this plan which quite frankly I got from Flip Wilson.

And you know, I've been to a couple meetings and there are all these nephrologists who stand up and they're supposed to be asking a question and they make a long blabbering statement about this and that. So this guy and I, we constructed this consultant panel which was basically an overhead projector. And we had these different doctors' names and then he and I alternated playing the doctors.

So one of the doctors was Dr. Hampers of Make-A-Buck Inc. John, what did we call Sadler? We called Sadler I forget.

Allen Dull from Allen Hall Allen Dull from from Monopoly Dialysis Inc. And Chris Bragg from Utopia Dialysis on the Sound. John Rattler we called him.

John Rattler. I forget what we called where we placed him. So then we had this dialogue of all these consultants you know, and what they would say about designing a health care system.

And the reason I say Flipp Wilson is Flipp Wilson once explained the reason he had, who was the he had the Gertrude or something a woman that he Right, right. He says, you know I could say things in that role that I could never say as Flipp Wilson. So that's what we did.

So we played these guys and to the RPA Association My wife was sitting in the back of the room listening. Understand we're really green green new to this field. But it was they took more we got a lot more respect after that.

And my wife says that they were the guys, they were jealous that they didn't make the the cast.

DWM: (1:05:45 - 1:05:48)

And what was the idea of this dialogue?

PH: (1:05:48 - 1:06:43)

Well we were designing a we wrote the first big grant from CMS and we also had one coincident with it from the Federal Trade Commission on how would you design a healthcare system for dialysis for patients. It was a big, big picture. And what we were doing is kind of I was trying to mimic this was a big time this is Urban Institute it's either the late 70's or early 80's.

And the Reagan I guess the Reagan folks would come in and it was all this talk about a new healthcare system and so forth.

DWM: (1:06:44 - 1:07:36)

Well we're sort of where you got the, you and Mark are working on the memo. But before we leave the Flip Wilson story it's clear that by this time where you're on this sort of panel with John and Alan and Chris that you've come a ways from where you're beginning to work on this memo and John Sadler sending you letters that are hostile saying why are you trying to work on this data to actually being a part of this group at the RPA that are concerned about policy change and dialysis in the United States. So how did you go from being somebody that was sending hostile letters to being part of this As I say it was a combination, first of all I've always been doing empirical work.

PH: (1:07:36 - 1:07:53)

So like my colleague Randy Boberg at that time and even somewhat Mark Pauly these were always big thinker ideas you know. I did all the empirical work. So I'm working with the claims data.

Does Lou Diamond's name come up?

DWM: (1:07:53 - 1:07:54)

Yes, yeah I know Lou.

PH: (1:07:54 - 1:08:37)

Alright, so my first nephrologist that I worked with was Lou Diamond and Lou Diamond who is a very good friend of mine by the way but I don't know him at this point as I say we have two projects but they're both really the same thing. One from the FTC and one from the FTC CMS on how would you design if you were to start from scratch how would you design, I mean how would you pay the physicians, how would you pay the hospitals and so forth.

DWM: (1:08:38 - 1:08:59)

Which may be a big issue because I think one of the concerns that people like John Sadler and Chris Blagg have about the payment for dialysis is that when a medicare needed to design a payment system they almost were willy nilly. I mean they went and looked at what was happening at the time and they said oh okay well three times a week dialysis well that's what we'll pay for.

PH: (1:08:59 - 1:10:29)

I was saying earlier about you know this notion of putting a 20% copay practically makes no sense for a patient who is, I mean you're going to keep the patient out of the dialysis unit, I mean the patient is going to although John Newman at one point was trying to achieve it, he

was doing hemo and CAPD, he was running a KT over V of three or something like that. But the point is that one of the complications and this is when I get back to what I wrote for Frank, but this is not news to Frank I'm sure, but one of the complications is because this part A part B division and so you're going to be doing services under part B like in the dialysis unit which may be saving money on part A in the hospital. So you're absolutely right, I mean it is a it's a mess in a way and so the Medicare Advantage program or these prospective payment programs do have a lot to be said for them because they consolidate this into one payment and I mentioned Kaiser before and integrated care ultimately hopefully.

Yes, that's right.

DWM: (1:10:31 - 1:10:49)

So you come together with this group of physicians who at one point would have been hostile with you but now you all sort of have this common purpose in the sense that they know clinically that the payment system doesn't really make any sense and you know economically.

PH: (1:10:49 - 1:13:44)

Well I think that there was a recognition that in a sense we didn't have an axe to grind in the sense we weren't running a dialysis unit we were always I mean I will say that we tried if there was an overarching principle of what we would say a good payment system is is if people spend the money and all this combinations of this and this and this, if they were spending the money as if it were their money coming out of their checkbook I mean if you were to talk about the golden goose that you'd want to kind of set up and so that's what we wrote about now how much respect did we get on the practical side of that?

I don't know I think maybe like I said we're doing empirical work and by the way one of the reasons why Nathan and I are so close is Nathan never doubted that I was going to do good things. I mean I'm very serious and that's to me when I'm dealing with all these hostile guys and many of them were hostile Nathan knew or I don't know why he had so much confidence in me but he knew from day one I mean I can't somewhere in this period he's president of RPA he's very cordial and I mean he's a wonderful guy but his behavior was different than everybody else I mean through all these Allen Hall he was Dallas Bower was Mississippi and Hampers he had his own image of things although he was I think Hampers was in ways the most candid I mean I think Hampers he certainly has a bad name but I think he did a lot of good you know I mean I come from before we moved to Walnut Creek we lived in Ann Arbor automobile country you know Henry Ford is a unpopular guy in a lot of places anti-semi Henry Ford did a lot of good things and we didn't have an axe to grind

DWM: (1:13:45 - 1:13:53)

well this 32 page this memo this short memo that turned into your long paper what was that what was that about

PH: (1:13:54 - 1:14:10)

I can't remember the details I couldn't even find a copy I told you though I was flattered when we went around and we did some interviews then with the big players Hamper I make that mistake with Allen Hall

DWM: (1:14:10 - 1:14:11)
all the time

PH: (1:14:12 - 1:16:51)
Allen Dull you can see the link to Cliff Wilson yeah Allen Hall would say that that was the most influential talk I ever gave he'll speak very highly of that we went up and we interviewed Scrib and Scribner and we interviewed Chris Blagg of course now here's an example it was a huge debate going on between home dialysis run out of Seattle and the for profit Hamper's group and they were actually sending they were in some battle in the literature calling each other killers and things like that and of course we as an economist we talk about social cost what's the real cost across the society for things you know well we saw home dialysis as fundamentally it's not lowering the cost of that it's lowering the cost of what the government pays but it's only doing that by shifting the social cost onto the family and that wasn't a popular thing to say but it was the truth I've never looked at the divorce rates for male and female hemodialysis patients who went home dialysis that's a big burden to put on the family but anyway it wasn't our position to say that that was right or wrong our position was that you know you're not really lowering cost you're just shifting the incidence of the cost from the taxpayer to the family and so I think maybe I mean for example when we're up at visiting Hampers we wound up spending a good bit of time with Ed Lowry and I think Ed somewhere in there I'm asked to give a talk a small talk at ASN it was probably my first and there was a lot of hostility in the audience and Ed Lowry stood up and defended me at great length and

DWM: (1:16:52 - 1:16:55)
Why did he defend you? Do you recall what his point was?

PH: (1:16:56 - 1:17:59)
I think in his talking with Mark and I and maybe reading our paper he saw that we weren't fooling around you know we weren't um in the midst of this whole thing maybe this is there's a sociologist that evolves on the scene in Boston and he comes out with a paper which I first saw in draft form which was very hostile to NMC and he claimed he was I mean he didn't know what he was talking about technically but he claimed that this methodology is used by the for profits to measure time to death or something and it's biased and so forth but he was going from interviewing me in Washington to interviewing Ed and I called Ed and I said be careful with this guy he is not a friend and maybe that was it

DWM: (1:17:59 - 1:18:09)
Well and Ed also and when I talked to him he was a big believer in data very dedicated to data and that was part of our

PH: (1:18:09 - 1:22:30)

union you know maybe I really made it to the big this sounds like bragging I'm not trying to but talking about where I impacted the system Alan Hull in 1987 Alan Hull and Tom Parker put on the mortality conference now I had some connection with Alan I forget how it started anyway Alan invites I mean I'm a total unknown Alan invites me I'm a Michigan at that point is it? No I'm still at Urban Institute but I invite Bob Wolfe biostatistician to join me to go to this mortality conference now I understand all a lot of other big names like my colleague Fritz Port the mortality conference in Dallas in 87 was one of the most influential meetings in the history of dialysis in America I don't know if you're aware of that but it really really was now Bob Wolfe who was a first class biostatistician good guy fantastic would be a great guy for you to talk to he presents a paper on the Michigan kidney registry remember I said all these little empires Michigan when I said you know from the earliest days the dialysis community really believed in huge data sets, multiple data sets, well Michigan and they weren't the only ones Michigan, a couple other states had kidney dialysis history programs and they collected these data at great length and Bob Wolfe presented first class report on measuring I mean you have to understand at this time the people in the field they had no knowledge of how do you measure I mean how do you estimate these proportional hazards I mean I can remember when I explained in fact John Sadler complimented at an RPA meeting I explained relative risk and I had an example of you know 10 patients in this unit die and there's 100 patients in the unit this other facility had 3 patients die well the relative risk between the two is 3 over 10 I mean as simple as that but my point is how did it go about doing a scientifically acceptable I mean Blagg and Hampers they didn't know any of this Lowry was very much in a learning mode at that point he knew he didn't know but you know he worked they did the famous randomized trial and he employed a very good biostatistician Nan something Nancy Lew was an A staff person this was a biostatistician from Harvard first class she wasn't any light weight and Ed listened to her Ed learned from her Ed was always learning seriously Ed was an interesting interesting guy didn't always have friends but anyway so I present this paper at the Dallas conference which has to be my most quoted paper which I compared mortality of US Europe and Japan

DWM: (1:22:31 - 1:22:49)

yeah how did you get in that gap of 10 years between the late 70s and 1987 how is it you came to begin to pull together not only beginning to look at US data which I guess began with your CMS work but you're beginning to look at global data

PH: (1:22:50 - 1:22:51)

how did I do that

DWM: (1:22:51 - 1:22:53)

why were you beginning to do that

PH: (1:22:53 - 1:27:55)

part of it was so I go to the RPA for I just want them to endorse this survey they end up being heard talking to economists and Louie Diamond is assigned liaison or he's at Washington what's Washington he was really spent his time over at the public hospital Washington General so this lawyer friend and I were on this grant we go to breakfast with Louie Diamond in southeast Washington and the truth was I think in fact Louie will say this

today when I first dealt with these Urban Institute guys I was very hostile to for profit firms and I was very hostile to these guys at Urban Institute which is me and this other fellow and I he says you know I learned there isn't much difference between for profit and for profit I mean you can talk to Louie and anybody so that was the beginning of a connection and I think Louie was I think he was quite impressed by our knowledge of the field and the fact that we really were taking this broad view and I think ever since then he was an advocate in fact the first really serious paper I published in JAMA Louie Diamond was the third author Louie always loved that paper and looking back that paper was a breakthrough because here it was in JAMA and it was about it was really a mortality model and I think one of the big outcomes of that paper was we showed that reused dialysers had lower mortality and that was very popular with a lot of people including the CDC because the CDC is charged with regulating reused processes and so forth it's interesting later in my career I'm sued by Mintec over a paper we did which showed higher mortality which I made a switch from formaldehyde the greenies had regulated out from formaldehyde and they switched it as acetic acid but anyway so this JAMA paper must have been in that period and that was the JAMA paper and the international mortality now how did I get hooked up with the Japanese I know how so we go to the conference and I present US data and Hull and Parker had found this guy named Odaka who brought data from Japan and there was this Swiss guy who was very instrumental in the European registry and he was brought and he spoke of European data and I will credit Allan Hull after the conference Allan says why don't you write this up as a paper it would take too much time he says well this will get published immediately not in New England Journal but the American Journal of Kidney Disease will take this and of course what we showed was the Japanese lived forever but nobody believed that it's true one of the first things I mean the Japan DOPPS people loved me because we brought Japan DOPPS out of the closet if you ever attended a Japanese conference you know right away one of the things we would the Japanese feel very proud of their data and their institutions but the West is really they'll tell you you guys don't take us seriously anyways that paper and so I put that paper together who was the Swiss guy it would be in my resume

DWM: (1:27:55 - 1:27:57)

I'm sure I've got it right here

PH: (1:27:58 - 1:27:59)

so

DWM: (1:27:59 - 1:28:06)

first of all I've got to back up here a minute so in 1987 when this mortality conference happens where are you working?

PH: (1:28:07 - 1:28:44)

The Urban Institute in Washington DC. Still the Urban Institute ok and it was subsequent to that that I you know the powers that be Chris Blagg was always a big player in the government and of course the reason was he was not for profit etc you know his motives were considered pure am I being recorded? I don't know

DWM: (1:28:46 - 1:28:47)
and

PH: (1:28:58 - 1:37:47)

after I understand this is all hearsay but Hampers leaves the office of this Stockman who was Reagan's hatchet man in which he was complaining about something Stockman allegedly believed in the marketplace and all this and he says let's get a bidding process in for this dialysis stuff and he passes the mandate I mean you understand he is about as high in the administration to CMS and CMS uses a convenient grant they have running with me and say would you look into this?

No I mean more effectively would you do this? So we wound up I mean maybe alright so this meeting is called for and RPA sends two reps Chris Blagg, John Bower and the government invites me and my colleague Randy Bovert and we sit around this table to discuss this competitive bidding which has a lot to be said for it but that's a long story so we wind up choosing two cities to try Denver and Denver and some city in California and oh the community the community was furious we did site visits mostly in Denver this is where John Newman worked with me you know I said I always had a good patient on my side so there's a shogun in Denver I forget his name boy what a smart aleck he was and I'm laughing because he is so he actually has his lawyers write the government letters about how this is illegal and so forth and all it was to ask dialysis units to submit bids and half the price between what the composite rate was and the bid price would go to the patient you want to see anger from a nephrology community giving patients that kind of power at any rate that meeting I think Bower and Blagg sitting across from Randy Boberg and Phil Held with government moderators I mean the government was supposedly running the meeting we were giving the theoretical pluses and minuses and how you might go about this and so forth and what the advantages of it would be I subsequently became good friends with both Blagg and Bower but if you ever saw I really felt sorry for him in a way because I'm this jerk economist what do I know about treating a dialysis patient and so forth. Here are these guys in there and they've got 35 years of experience and they're clearly committed, dedicated physicians and they're treated on a par with this moralic economist I'm serious I've never asked them what they thought of that meeting it was out of that meeting and so I started to think about John so we got this guy in Denver who has a couple dialysis units and he's the shogun very difficult guy and of course John is going with me to interview these people and of course while he's there he'll dialyze well that changes the whole center of how John was a well known patient he was very active in his own care and so forth and they may bullshit me but they weren't going to bullshit John so I'm sitting in the dialysis unit feeding John while he's dialyzing surrounded by pretty hostile dialysis people I think in that experience I ultimately I must say it did not endear me to some of these for profit shoguns and the reason is this guy who was all the trouble this is the guy this whole thing is illegal and so forth and we actually had a working conference in Washington D.C. where we had Eli Friedman and this wise guy and maybe there were two nephrologists the wise guy thought he was going to come in and just tell us kids we didn't know what the hell we were talking

about and he was one of these guys that I would like to have had in the Flip Wilson talk I mean he was so dumb and stupid I mean the thing is how do you the question that we were we were trying to assist the government in trying it's not an unreasonable thing about asking these dialysis units to bid a price you know I mean you can the program went down in flames by the way it didn't go anywhere I think by the way who was Davita before they became Davita there was only one dialysis company that submitted a bid and I think it was the predecessor of Davita I was at a Davita reception last night anyway so this dang wise guy who comes to the he described our work as the black hand of the urban institute he he steps to command I don't know if he did it in writing you know what I'd like for competitive bidding this is the guy who thinks this whole notion is illegal has his lawyer write the government a letter what I'd like I'd like to submit a bid to take over all Denver how would you react but anyway that was

DWM: (1:37:48 - 1:37:51)
what did John Newman think about all that

PH: (1:37:52 - 1:38:05)
I've told you on the phone before well John was very much in support of it because you know he had been president one of the founders of the patient association and so forth

DWM: (1:38:05 - 1:38:06)
and

PH: (1:38:07 - 1:38:11)
John was an economist by training

DWM: (1:38:11 - 1:38:13)
he had a PhD in the econ

PH: (1:38:14 - 1:39:16)
John had a masters in public health from Harvard and a PhD in economics from Tufts and John was big on the world bank and he actually lost his kidney John had been born with just one functioning kidney and that went out when he was working for the Ford Foundation in Indonesia anyway John was very supportive of this because you know kind of our operating mode was something about competition and how do you make competition work well there are a lot of ways you can make it work but if you could inform patients and give patients power we smile but that really is a question

DWM: (1:39:16 - 1:39:19)
I agree

PH: (1:39:19 - 1:40:02)
just the other day with Nathan a conversation on this line he said to me well you don't really think that an individual patient can affect what dialysis units do and I said well you're making the first mistake that liberals always make which is they assume that every patient has to be a shopper when it's really the marginal patient it's the last patient in the unit or

the first patient that leaves it was interesting we had conversations with this children in Denver I like that word children

DWM: (1:40:03 - 1:40:06)

he gives a very specific image yeah

PH: (1:40:08 - 1:47:18)

the community has improved tremendously and I would say in a lot of ways because of the change not all good that the change has become so big for the competition Nathan says you don't expect the individual patient to and I had to explain to him that you know not every patient is a shopper but there's enough shoppers out there that drive suppliers to behave in certain ways I used to always use I used to buy backward film when I was a student I would buy film from 47th street photo in New York City 47th street photo used to go to your pickup Kodak film which included pre-processing payment and they'd pick it up at a low price we call that arbitrage in economics and they would bring it to New York and they would sell it on the mail order well I didn't have to be this hard driving consumer to go to 47th street photo and get a deal all those other marginal shoppers have driven 47th street photo to behave in a certain way and I benefit from it and that's no different than a dialysis unit the rousing patients who's pushing the dialysis unit to do this and do that he's or she's being the representative of all patients and when I was telling this story about the shopping in Denver I remember asking him about by the way there was a big price change in dialysis which is another maybe if you want I'll try to write the big events one of the big events about 1987 around in there the government reduced the approved charge from 148 to 132 and we as economists quantitative economists man this is a wonderful opportunity this is a natural experiment how did the dialysis units react well the government of course in fact I would say one of the most important things that I think we try to teach the government and we're mildly successful only mildly is how costs are determined is what the government pays the government has always thought let's go find out what costs are and that's what we'll pay and going back to this big multi-million dollar medical director by the way there's now a policy that says this thing they can't pay a medical director more than 35,000 or something like that it's not even fair but anyway where was I so they decreased payment and again I think one of the most important papers I ever wrote not the most widely said was how providers change to that price change they basically got rid of all RNs a lot of them shortened dialysis and I think that's where Ed Lowry got himself in that wasn't a pre-chapter for national medical care I don't know if you're aware of that shortened dialysis for treatment the dialysis units reacted to this price change I don't know if you know but around the world everybody uses almost all RNs except for the US and the point is what costs are is pretty much what the government pays. So if the government reduces the price dialysis units can either say well we're going to adapt or we're going to go out of business that simple notion is very difficult to convince people on the Potomac. The people on the Potomac think in fact I think there's a very famous graphic out of Obama describing this float it's a we call a SAM chart which is all health care and there's part of it is hospital costs and physician costs and drugs and so forth and then there's profit and Obama apparently points to the profit see we're not going to pay that we're not going to pay that and that's kind of predominant thinking and that's what it was I mean when these guys did this audit and they see this medical director part of this they took this pot of money very cheeky

statistical procedures they used I mean they should have used the median you know you have a hundred dialysis units you've got these three guys paying themselves three million bucks or something I don't know well when something is so skewed as that normal statistical procedures would be to take the median they took the median which means all those big bucks get thrown in there no they don't get thrown in they get they say okay this is what these guys claim their cost is but we're going to throw out this nine million bucks and use the average and so that was part of bringing it down.

That was the first composite rate by the way. There's this new composite rate going on but that was the first so the paper like I say we looked at showed that the dialysis units reacted to this price change in big ways and in our paper in fact there's something Pauly and I were writing back from that first paper is the government has to decide how good do they want to make it for dialysis patients now nobody wants to make that decision and they want to call you nephrologist bad guys and all this stuff but the truth is that price you set is what makes the community respond.

DWM: (1:47:19 - 1:47:56)

Well that is one of the things Nathan and I have been talking a lot about which is that I think people like to think that medicine is about the science and about medicine and that we're providing medicine based on scientific information clinical information only but in in real life public policy and government reimbursement significantly impact the way care is delivered.

PH: (1:47:56 - 1:48:54)

Let me give you a little history Marty Feldstein you've probably never heard of the name he was he's probably one of the world's most famous macroeconomist he was Reagan's top man. First term second term I think my colleague from Berkeley. At any rate Marty Feldstein he's an old man maybe an old man but still very powerful and important.

He's a Brit his Ph.D. thesis looks at the national health insurance scheme and you know what he did? He showed that very point that when the government sets a price the medical providers respond to that price the direction of causation is from setting a price to what makes people do things. That was his Ph.D. thesis.

DWM: (1:48:54 - 1:49:26)

He was the original health economist Marty Feldstein and all he showed was the direction of causation is from Right and it leads to things and I guess the national health service in Britain is one example that leads to things where there's you know decisions like clinical decisions well patients over the age of 55 shouldn't be on dialysis you know because they're clinically they're too old. But the real reason is that there's a scarcity of resources.

PH: (1:49:26 - 1:49:43)

There's not enough resources and so the really the public policy The point is you someday have to limit I mean you cannot you cannot spend everything on healthcare.

DWM: (1:49:44 - 1:50:01)

So we begin to make clinical decisions and even moral decisions based on public policy which is an interesting sort of thing and I think one of the issues for medicine is medicine tends to get sort of as if it's all a medical issue.

PH: (1:50:01 - 1:50:25)

It's a clinical decision when it's definitely got a component of the public public moral The only time this is the reason I was ultimately accepted in nephrology was because I brought what was underlying and assumed that there is an economic component to this.

DWM: (1:50:25 - 1:51:39)

Which is the data. So all of a sudden there's all this clinical you know whether people like somebody like campers or they don't like campers or you know the perception is John Sorry. But I know we'll remember.

De Palma But whether you move away once you have the data and you're looking at it from an economic standpoint you're just a prime example of that. You're not you don't have any skin in the game. You know this is just this is your economic background, your data driven fundamental look at this situation then you take out of it the moral ethical division that people have about what's right or what's not right morally or whether they like somebody like Gus Hampers or they don't like somebody like Gus Hampers or is the doctor making too much money or not making too much money You can bring the data to the picture it allows the beginning at least of an objective assessment of why are we doing certain things?

PH: (1:51:40 - 1:58:00)

And you asked me what was this transition for me? We used to say data are by the way data is plural now data are power and it was in this period. I still remember Louis Diamond coming over to my office after we had this breakfast you know and he said well what are you trying to do?

And I said I'm trying to estimate how much more expensive it is to treat a diabetic dialysis patient than a non-diabetic patient and he looked at me and he said you're going to do that with these data from CMS? He was totally incredulous. I don't know if he admits that but I remember he was very impressed Yes Because at this point there's not much recognition of the CMS data in the community and that was our first paper I don't think I only published one paper with Louis Diamond You've got a lot here with Louis Diamond So how do you get from the Urban Institute to Michigan and the USRDS?

At the Urban Institute okay so I'm in great advantage to being in Washington I lived 200 yards from the NIH There's a guy named Gary Stryker he comes from Seattle he's a pathologist renal pathologist his wife his French wife is a much more famous renal pathologist Chris Blagg and the Seattle crew they had been they wanted something like the EDTA for years and years and Stryker comes to Washington I won't put all the personal background in there anyway he comes to Washington he's at NIH now before him there was a woman, he's the head of NIDDK the main institute for kid kidney stuff and I asked for a meeting with him now at that time my the Urban Institute which is the think tank type of place now they had never had a grant or project from the NIH so I asked to see Chris I mean

Gary Stryker and I sent him a few papers in advance along here I published a paper on transplantation which I showed that transplants were going to rich white males and I remember oh boy I remember the surgeons they wanted to castrate me I mean they basically said I don't believe it even though I had the national data anyway I go out there and Gary I was talking to Nathan about this the other day and I wrote a letter of recommendation for a fellow at Michigan who is doing something on patient education and chronic kidney disease a woman I don't know how my heart does that she was very successful in the business world before she went to medical school anyway she's a fellow so I wrote a letter and I expected to be reviewed by others you know and I said in the letter that this work she was doing would be really advantageous to NIH when they get down the Capitol Hill to talk about next year's appropriations and they don't have to talk about what one kidney cell is saying to another kidney cell well I thought the people I'd ask to review this letter would throw this out you know oh they loved it you know and the story is of course NIH they don't like to be touched well it depends on the institute but until that time they didn't want to be near the are you scheduled to talk to Bob Rubin do you know Bob Rubin he's a very influential man who was in Washington D.C. nephrologist he's with Lewin one of the he's a smart guy he's unfortunately on the Republican side so he's kind of out of power at the moment but certainly anyway he's a good guy anyway so I got to see Stryker and quite frankly he's shocked he never he had never heard of me he had never heard of I'd done these papers in JAMA on survival in Europe and the U.N. and I'd done this transplant paper you know and he says I need this kind of stuff in Washington and he recognizes first of all the power of the CMS data and two the fact that I'd been working with it for quite a while and that I was good at it actually so there was a national competition there were nine submissions and I won

DWM: (1:58:01 - 1:58:03)
what year would that have been

PH: (1:58:04 - 1:58:36)
must have been mid 80's and anyway we were off to the races and I had given a subcontract to the University of Michigan and actually Nathan was the matchmaker Nathan hooked me up with Fritz Port Nathan's at Henry Ford at the time Nathan and I had a long association and

DWM: (1:58:36 - 1:58:38)
so Nathan gets you together with Fritz Port

PH: (1:58:38 - 1:59:32)
Fritz Port comes in from Michigan and I give a subcontract to Michigan and fundamentally I get Bob Wolf and Fritz Port in and I had I had all the data people Randy Webb who's now on dialysis and Jose Garcia who was a man wonderful Cuban and anyway it was very successful we had the first five years but we had awful relations with the project we had awful relations with the contracting officer at NIH he was convinced that we were thieves

DWM: (1:59:33 - 1:59:35)
why was he convinced you were thieves

PH: (1:59:35 - 2:05:25)

well one of the reasons was one of the things until this time until I really got on the scene the standard medical community was I collect the data and I bring it to my chest and I share it with no one and what I did quite broadly was to make data available to everybody so this whole notion of I don't see where you go to the USRDS you get the data files and everything that's mined 100% and but what's the general principle I mean I will give it to Stryker Stryker pushed this and of course he immediately made Blagg chairman of the scientific advisory committee and we did a lot of good things with Blagg and I think he was I think he'd speak quite highly of me I I was up and running with this project on day one and the first thing we did was we launched five special studies and this is where we went out and actually collected the first one was data validation study and the second one I mention this guy Bob Rubin because Congress had passed this law that said written by some lobbyist I'm sure that the US government the US government or the executive branch will develop a national data registry for end stage renal disease very simple word well Stryker just is absolutely catatonic about any notion that there would be economics in this they just wanted clinical well where Bob Rubin comes in Bob Rubin if ever there was a guy you'd like to keep on your side and you wouldn't want him only opposing you so Bob Rubin who is an old Washingtonian he was former president of the DRB for a while he's a smart smart he's a smart guy so somehow there's this committee appointed to look at this question I forget what this committee was who was Bob Schreier from Colorado Schreier from Colorado Rubin and one other guy and there on this they have this committee which is questioning various things about NIDDK so Rubin says to Stryker I mean it really was a knife to the heart by the way this USRDS contract you collect is this the administration's response to the congressional mandate to establish a national the registry the law this law said including economic analysis Stryker I mean he sees hand writing I mean if he says no there's a lot of people down in Washington he's at the NIH at the time he's NIDDK so he's basically blabbering while he's trying to think of an answer because he can't possibly say no I mean this was a big issue to him it wasn't a big issue to Rubin I think Rubin was playing with Stryker in a way anyway so Stryker's in the position where economic analysis has to be part of this new project he's commissioned and of course it turned out to be wonderfully beneficial I mean at that time NID I used to NIDDK used to put out a hundred million a year on basic science kidney research we're talking 20 years ago 200 million and I'll be honest with you I could never see any output and I used to always think the worst job in Washington would be have to get down to Capitol Hill and defend NIDDK's budget now's the case the US I mean this is their oh boy they get down there and shoot fireworks off about this thing you know so anyway the president of the Urban Institute says five years this contracting officer just was absolute I mean I understand the Urban Institute's quite competent at dealing with contracting I felt so sorry that George Chow this poor old Chinese guy he just I mean everything worked out that we planned the database

DWM: (2:05:27 - 2:05:44)

just how you thought so were you happy to go to Michigan? yeah I was and so you were saying you were in the nephrology department I was a full professor of internal medicine a full professor of internal medicine the only one without an MD degree who created that job?

PH: (2:05:44 - 2:06:06)

uh Roger Wiggins what a creative thought well part of it was which I guess he got a lot of points was I was willing to take the job without tenure and did you have other responsibilities besides the USRDS?

DWM: (2:06:07 - 2:06:08)

in the department of medicine?

PH: (2:06:09 - 2:06:11)

I had a big grin I mean I was doing

DWM: (2:06:11 - 2:06:12)

don't forget

PH: (2:06:12 - 2:06:15)

my clinical publication record isn't so bad

DWM: (2:06:15 - 2:06:23)

as a nephrologist for me the USRDS has been a very influential and powerful tool

PH: (2:06:23 - 2:06:26)

sure including the economics side

DWM: (2:06:27 - 2:06:36)

absolutely because as we're talking about there is really truly no separation from health care and economics

PH: (2:06:37 - 2:08:11)

absolutely I mean in economics we have a term called free good a free good is something that is so plentiful that the price is zero bay water out here is a free good everything else has cost greater than zero and medical care costs and you know the government's at conflict with it in some way I mean you've got the NIH producing all sorts of new things that are costly it's back to that question of who's going to decide are we going to buy this or are we going to buy this we can't buy both and that I suggest is a I mean when I get back one of those fundamental issues I think of what I try to do with the NIH with CMS is to convey to them what you were just talking about with NASA that price influences a lot Gary Stryker was very determined to keep economics out of USR I mean you might find that hard to believe but he was very very determined why don't we take some big take some issues

DWM: (2:08:12 - 2:09:45)

ways I distinguish myself

PH: (2:09:52 - 2:16:33)

sampling is once every five years and that's not three of us Bob Trio and Bob and I both tell everybody he was asked to speak at Scribner's retirement and I show the abysmal I mean as you know I was a patient in America lived around four for four and a half years now that's somewhat age dependent and so forth but when I I'm sorry yeah that's what I'm telling you

medications anyway so how do you inform and I'll never forget one of the first dialysis patients and at that time and this gets back to this idea the government has to decide how much do they want to spend so we were asking the question we asked this panel of dialysis patients clearly this was not a random sampling if the government were to spend more money what would you have them do and you know what almost universally said they would want more psychological help for their family that they always had all their family anyway

DWM: (2:16:33 – 2:16:38)

Thank you very much for spending your time with me today.

PH: (2:16:38 – 2:16:40)

I must say it was fun.