NATIONAL PRESS CLUB LUNCHEON SUBJECT: THE STATE OF THE UNITED STATES' HEALTHCARE SYSTEM SPEAKER: DR. DENIS CORTESE, PRESIDENT AND CEO, THE MAYO CLINIC MODERATOR: SYLVIA SMITH, PRESIDENT, NATIONAL PRESS CLUB LOCATION: THE NATIONAL PRESS CLUB, WASHINGTON, D.C. TIME: 1:00 P.M. EDT DATE: FRIDAY, MARCH 21, 2008

MS. SMITH: Good afternoon, and welcome to the National Press Club. My name is Sylvia Smith; I'm the Washington editor of The Fort Wayne Journal Gazette and President of the National Pres Club.

I'd like to welcome Club members and their guests, as well as those of you who are watching on C-SPAN. We're looking forward to today's speech, and afterwards, I'll ask as many questions from the audience as time permits.

I'd now like to introduce our head table guests and ask them to stand briefly while their names are called. Larry Lipman of Cox Newspapers and a former Press Club president; Peggy Eastman, President of Medical Publishing Enterprises; Brenda Crane, the director of Washington Media Relations of the American Medical Association; Donna Jones, a guest of our speaker; and skipping over the podium, Angela Greiling-Keane, chairwoman of the Speakers Committee and she works for Bloomberg News and skipping over our speaker for just a minute; Ira Allen of Congress Daily and Speakers Committee member who organized today's event -- thanks, Ira; Marcy Ross, a guest of the speaker, Ed Selker of The Rochester, Minnesota Post-Bulletin; and Barbara Siebuhar (sp) of the Centers for Medicare and Medicaid Services.

Welcome. (Applause.)

Whether it's the presidential primaries causing Americans to focus on the issues of healthcare and health insurance or the other way around, there's no debate that the topics are on voters' minds. Polls regularly show that healthcare is in the top four or five issues in the list of national concerns. There's not, however, agreement on what to do about it. For instance, a Harvard School of Public Health poll released this month found that the majority of Americans think that U.S. private healthcare may not be better than the national systems in Canada, France and the U.K. But there were sharp disagreements when the findings were dissected according to political affiliation. Among Republicans, for instance, 68 percent said the U.S. system is best, compared to 32 percent of Democrats and 40 percent of Independents. Yet a majority of Americans report they are very or moderately worried they will not be able to pay their medical costs if they got seriously ill. And about 47 million people in our country of 300 million have no health insurance, either private or government provided. So what to do about it?

Last spring, Mayo Clinic leaders joined the nation's healthcare debate outlining their position on what was needed to fix the system. They spent nearly

a year traveling the country convening industry officials and academics to refine those positions, which include a transition to individual insurance plans that are fully or partially paid by employers or the government.

Today, Dr. Denis Cortese, the president and CEO of the Mayo Clinic, has come to tell us the results of that fact-finding and amplify the proposal. Dr. Cortese heads an institution of more than 3,300 physicians, scientists and researchers and 46,000 other staff at three locations. More than half a million people are treated each year at the Mayo Clinic. Besides heading the clinic, Dr. Cortese is a professor of medicine at the Clinic and was the director of the Pulmonary Disease Training Program.

Please help me welcome Dr. Denis Cortese to the National Press Club podium. (Applause.)

DR. CORTESE: Well, good afternoon. It's a real pleasure to have the chance to talk with all of you. Look around at the audience and there's so many people I recognize who have participated this past year, and I hope I can carry the message as well as all of you have helped create it for us. We're here to talk a little bit about how to create a healthcare system that really works for all Americans. And I want to start by taking the approach that Mayo Clinic takes to all of our discussions and all of our planning, and that is looking at it from the patient's viewpoint; we try to think about the patient first and put them in the middle.

We have two folks with us who we've asked to join us. Donna Jones -- and each one of them have given me permission to just make a couple of comments about their own situation. Donna over here was born with spina bifida and she's had over her lifetime multiple operations, probably close to 20 or in that ballpark, for various reasons. She's had a major health event occur to her roughly about every three years. It's been very hard for her to maintain a job, and, therefore, continuous health insurance. There've been problems getting into the public system, the private system, as you can imagine.

The issues that her situation raise fall into really three categories. One is an issue of insurance; the other is an issue of the cost of medical care; and the third, and most important one from my viewpoint, is that she is only comfortable and feel that she's getting focused attention and care to herself when she's being seen by an integrated, coordinated system, which in this case was Duke University. So that's an important point that I'd like to leave you with.

We have also with us another patient advocate, she's also a patient herself, but she comes from a position -- Marcia Roth (sp), comes from a position of a mother. She's the mother of two children. She gave me a picture of them; they're now getting ready to go school, one graduating high school and the other in college. But the story behind these two children are amazing. The young girl had a stroke when she was 12, and had a long prolonged recovery, as you can imagine, and now she does quite well. And her son has suffered from rather severe attention deficit disorder and is getting special schooling and is also doing quite well over time.

Now, these children at various times were on up to 19 medications at a given time. She has had to call in providers herself and collect them together to conduct the orchestra of the care for her own kids. Now, how many of you have been in that situation? We've all been in that situation one time or another, and this idea of getting care coordination in an integrated way, focused on what

the patient needs, not on what the insurance company needs or what the government needs, but on what the actual patient really needs. And it will be different from patient to patient as we'll talk about. And there are also issues with the multiple medications, the issues of safety and quality and the kind of care that she and her children are receiving.

So our discussion today is going to be focused with the idea of what can we do as a population for our grandchildren? What we can do for my two daughters, for instance, and my two grandchildren? We have to create something better and -- better than what we had before and in a whole new light -- at least that's how a few of us feel about this. And why do I say that? I say it because most people in this country today are talking about the system as being broken -- the healthcare system is being broken. I think that's a fatal way to think of this problem because it gives you the impression that you can maybe fix it, that you can actually go out and do something that will improve it, and even worse, you might be able to tweak it in one spot or another. And I would submit you can't do that. It's like trying to fix a car but you find out when you go into the garage that you don't own one. It's kind of hard to do that if you don't actually have it.

So we have a situation here where we don't actually have a healthcare system. Now, I know the technical people will tell me, well, we have a healthcare system because it's -- it's we are where we are and all this. Forget that. If we really had a system of healthcare, who were the system engineers that designed it so we can blame them?

There really never was a conscious effort to get where we are today. Now, that is a liberating thought because now we can take a step back and say, okay, let's design one now. Let's think about what we might really want. And I'm going to take you through a -- just a two question exercise that we always do at the Mayo Clinic and try to boil the things down pretty simple. I'm going to ask you two questions. All of you in this audience here who would like to be hospitalized in a hospital tomorrow, even if it's the best one in the country, raise your hand? Okay, there's one hand that goes up, that's number three of thousands. (Scattered laughter.

) Now, you're probably raising it by saying -- and I've asked this question to thousands of people and this is the third person -- who probably will say when you ask him, he says, yeah, but I would go -- if I'm sick, I want to get the best care I can. Yes, that's the second question. Who in this audience wants to be sick tomorrow? Nobody's hands go up.

You have just done the strategic planning for healthcare in the United States for this century. You've just designed what we really need to be thinking about as we move to the future. Hospitals are not the center of the universe for healthcare. Who wants to really be sick enough to have to go into one?

A measurement of success of a new health care system for the future would be closing of hospitals or reducing the number of hospital beds that are needed. How do we take care of people so they can function well?

Now, this was stated, not in those exact terms, by Will Mayo in 1910 at the graduating class of Rush Medical School in Chicago, when Will Mayo -- he's one of our founders -- said two important concepts in one sentence. One, the best interest of the patient is the only interest to be considered. That is

translated now to Mayo Clinic's core value of "the needs of the patient come first."

The second part of that sentence -- there is a comma -- and the sentence goes on and says, "in order that the sick may benefit from advancing medical knowledge, a union of forces is necessary." The concept of teamwork is extremely crucial. They were talking about that a century ago. It's been a core principle of the Mayo Clinic for a long time, and it's really what this country needs now. I've already alluded to two examples of where -- teamwork and coordinated care.

So if we are all agreeing that we've just answered two strategic questions and we're thinking that we ought to focus on the patient, for the rest of the discussion now today I want all of you to forget what you actually do and who you represent and what your jobs are. Just picture yourself as a patient. An individual person.

And a patient, by the way, the definition of patient is one who suffers, one who endures. And I would also ask the question then that, given that definition, who wants to be a patient? So you're a person. Picture yourself as a person, and what would you like to have from health care, as we look to the future? Well, I'll list a few things that you may want to add to or detract.

But we may want to have pretty good prediction of risk of illness. Now, with new biology, we might be able to predict some of those things. If you have risk for an illness, you may want to get engaged in prevention to stay as healthy as you can. If we can't prevent it, we'd maybe like to have accurate, timely, precise diagnosis -- at the right time, the first time. A cure, if possible. If not a cure, maybe we can control the chronic illness; turn it into a chronic illness and control it.

You may like to have wellness in the concept of what you're actually getting. Quality of life, as you move forward. And speaking for myself, I'd like to stay out of a hospital, if we possibly can. So those may be a few things that we can actually list that are measurable that we would like to see happen.

How do we want it? How do we want that care to be delivered? Well, I would submit that you probably wanted to have it with excellent quality. And the components of quality would be, number one, to have the right thing done the first time, the right time, every time, and the right way.

You'd like to have really good outcomes of whatever occurs -- however you measure outcomes as a patient, not how other people measure it, but how you measure it as your own person. Remember, that's how we're talking now.

You'd like to have it done safely. You'd like to have it done timely. You'd like to have it in a coordinated way. And maybe, most importantly, you'd like to have it done with compassion, coming from the heart, by the people who provide that care. You'd like it to be affordable.

So if you'd like to have all the good quality stuff and you'd like to have it be affordable, what you're really talking about is you want personal, high-value health care. Value means the relationship of the quality to the cost to provide that quality. Those may be some concepts.

Okay, if we're moving along now, we might say to accomplish some of those goals that I've just listed, what might be some components of a learning health care organization? We'd like the country to think about the concepts of learning health care systems in the United States. How can we construct something like that? And we'll talk about the details I'm about to list in a moment, but I'm just going to list the details.

First, within this learning system we should have learning organizations. They could be real structural organizations like a Mayo Clinic, other clinics in this country. We have some superb ones. Some academic centers in this country; we have superb academic centers. But also, virtual organizations where physicians, providers, nurses, are linked together -- hospitals, all linked together.

And that could be done virtually. They don't have to be structurally put together like other organizations. We have to begin to think about how do we structure something in the country that will allow them to be learning organizations? I'll define what I mean by learning organizations in a minute.

That system that comprises a series of learning organizations should produce value -- best outcomes, best safety, best service, with affordable costs over time. That's one of the goals that we should be focusing on. That should be the thrust of what the whole system is generating.

It should be doing it in an integrated, coordinated fashion, so you're getting integrated and coordinated care. In addition, there are some pillars that are needed to really produce the value in an integrative way. One pillar is the concept of focusing on the individual and understanding the role of the new biology -- genetics, proteomics -- what can we do to predict disease, prevent disease, be more precise in our treatment?

This is an exciting era that's coming upon us in this century. We have to build this into our thinking, and we can, by -- that will support individualized medicine. It's a concept we call, that whole thing is what we call individualized medicine.

Then there's another component. If you want to have a system and connect all these interdependent parts, you need to have system engineers involved. We need to get engaged with system engineering -- like all of you that run businesses know exactly what I'm talking about -- system engineers to help us provide the connectivity and the needed connection of the dots of all the people in that system together.

Okay, if the learning system and the organizations are producing value, another component we should be doing is a very simple one. It's actually so simple it's -- almost begs the question why haven't we been doing this all these years? We should pay for value. If you want value, you want that high-value care we talked about, then why don't we just doggone pay for it? And the last one is everybody should have insurance. And I'm going to address that, too, as we get into it. So those would be the kinds of components we're talking about.

Now, I'm going to break it into two parts -- the role for the delivery system on these -- this picture I was just describing, and the role perhaps for private and public players. Let's talk about the delivery system. First, I'll define what I mean by the delivery system. I mean the people who are involved in providing health care, and I'll just list a few of those key people. One, the patients -- the people, all of you. Two, physicians. Three, nurses. Four,

other providers that help integrate and coordinate the care. Five would be hospitals. You know we're not going to have no hospitals. Hospitals are needed. Pharmaceutical and device companies are part of this delivery system. And the entire research enterprise is a resource to help us accomplish what we're talking about. That's what I mean by the delivery system, and the delivery system has some responsibilities.

All of those sectors that I just listed have the responsibilities of coming together to work, build the learning system and those learning organizations I talked about; to create the value; to bring it in a way that's integrated and coordinated; to make sure we're focusing on the role and the value of individualized medicine and what incremental value it brings to caring for people,; and the science of health care delivery that is engineering science. We call it the science of health care delivery. Let's take each one in turn now.

What's a learning organization? If you believe the Institute of Medicine's report that about 90,000 people a year have preventable problems that may occur in hospital and other settings and that they die from that, that's the equivalent of a 747 airplane crashing about every two and a half days. Every two and a half days. Would this country tolerate this in the airline industry?

Do you know we don't even have a way to report near misses and report errors in this country to any central body that systematically looks at it and reviews it and tries to get ahead of these problems and tries to distribute the learning throughout the whole organization?

So if a hospital in Seattle finds a new way to eliminate a complication of a drug, every other hospital in the country should learn about it the same day, with the click of a button. That should be a goal. That's what I mean by a learning organization. Other concepts: That everybody knows what everybody knows in the system. Patients and people know also what is known within that system. And that we get the right advice when we see the doctor. When you go to a physician today, there are thoughts that if it's a woman with a breast cancer problem, given what we know about breast cancer, a person will get the right advice about 85 percent of the time. That's about as good as we do in this country, and it's -- it may sound pretty good to some people, but that means 15 women out of 100 are getting the wrong advice.

If you have a problem like I have, which is intermittent, mild atrial fibrillation and you go into the system, you get the right advice about 15 (percent) to 20 percent of the time. On average, it's about 50-50 for everything we do in the country. We need to improve that.

A way to do that is you get all the information and knowledge connected. Information technology has a huge role that it can bring to bear. And that we use medical evidence to help make decisions on how to treat patients on what is the right academic or scientific decision for that patient, or options for that patient.

Now, how you treat the patient subsequently will pretty much depend on what the patient wants to do. They may not want to take what is the most likely thing that's recommended, but that's when physicians and nurses should become real caregivers and practice the art of medicine. But knowledge should drive the science of medicine. There's two components here.

And we need to have transparency with regard to outcomes, safety, service, and the cost. That's what the underlying -- overlying learning organization might look like.

Value. What do I mean by value? I do not mean cheap. Example of a value would be when I was about to go in the military back in the '70s, I bought a pair of shoes. Leather shoes. Greatest shoes I ever had. Spent $300 for them. Very expensive leather shoes.

About 10 years later I was making rounds one day and one of my fellow -- friends said, you know, you're wearing the same shoes all the time. You always wear -- They were comfortable, just delightful. Great shoes. And he said, how much did you pay for those? And I said, I don't know -- I'm not done with them yet. (Laughter.) Still using them. They lasted me another five to six years. That's value. I haven't had a pair of shoes that have lasted that long since, and I've been looking everywhere for a good pair.

That's what I mean by value. It's the cost over time. It's the outcomes, the safety, and the service -- all of which are measurable. Many people will disagree with me on that statement, that -- you can't measure outcomes and safety and service. I disagree 100 percent. They'll also -- you can't measure quality. And I say yeah, I don't know what quality is, but I know what outcomes are and I know what safety is and I know what service is, and they're measurable and we should be measuring them in this country.

And then you look at cost over the span of care, not the line- item cost. You can get a really cheap product that'll get you nowhere. We've got to think of that long-term in this country.

And really, it's when patients -- you all -- start to really buy or consume health care, looking at value, that you now turn into people who are controlling your own destiny. You turn into the CEO of your own health care. You turn into -- you take charge of your own health care when you begin to think along those lines.

Integrated and coordinated care. What do I mean by that? Well, it's teamwork working collectively to get it right the first time. It's teamwork in making the right diagnosis. Not every physician knows everything, and they should be working together and, indeed, many places they do collaborate to try to work together to really take care of the patient and to make that right diagnosis.

But then to provide the care. The care needed for each patient is frequently a little different than what might be needed for that diagnosis. What do I mean by that?

Take a group of patients that have diabetes. If you develop diabetes when you're in your 50s or something, well, that treatment for that kind of a person is going to be entirely different than if a child develops diabetes when they're five to 12 years old. It's entirely different than somebody who's on an insulin pump. It's different than somebody who's on oral anti-diabetic agents. It's different if somebody's waiting a transplant.

It has to be individually designed so that the care of a population of people with diabetes is designed so that each individual has their own bin -- or at least groups of individuals fit into the bins within that diagnosis. And you coordinate the care. Somebody needs to help create that orchestra that will

take care of that particular patient, or take care of you. And at a given time you may need a big orchestra. Another time you may need a little chamber orchestra and sometimes you just need a duo. It'll vary from month to month, week to week. And we have to have that integrated, coordinated thinking.

Medical schools need to change the way they train physicians, therefore. Physicians are trained to sort of know everything; they're supposed to memorize everything. And one of the ways they protect themselves in the future to be able to make sure that they're still pretty expert is they begin to become more and more specialized, because you cannot keep up with all the exploding knowledge as an individual practitioner.

We have to teach people to realize that that's okay to not to know everything. What's not okay is to not to know how to find the answer for the patient. And when I go to medical schools and I ask them does your class take an examination, a clinical examination, a clinical test -- do they take that test collectively, to get it 100 percent right for the patient? The answer to that question is that's called cheating in medical schools, because we don't take tests like that in almost anything.

But once you finish medical school, if you're really going to be a good doctor, you end up having to cheat the rest of your career. You've got to work with nurses; you've got to work with home aides; you've got to work with other colleagues; you've got to work with the patient's family; you have to review the literature and stay current. You've got to accumulate the knowledge when you need it at the right time and pull teams together.

We need to recognize the value of that and begin to train people to think that way, not to memorize stuff. But to think on how do they orchestrate and coordinate care as we go forward.

The other concept was individualized medicine. That's pretty straightforward. Focusing on the patient, number one. Number two, how do we evaluate the role of the new biology and the potential for genes and protein markers to help us be more accurate in prediction, prevention, precise diagnosis, personalized treatment?

This is an ongoing activity that should be built into the system that we do it and it comes out as an output of the system. New knowledge is generated as an output of the way we take care of people.

The issue of science and health care delivery. What am I talking about there? I'll describe it in terms that were given to us at Mayo Clinic, where one of our real strong supporters was an individual who ran a company that invented -- that was making an insect spray, a mosquito spray.

In that bottle, the container, was an active ingredient. That active ingredient was about 0.001 percent of what was in the bottle. Might have been DEET; I don't even know what it was. That active ingredient was dissolved in a petroleum-based solvent, that when you sprayed it on the skin was somewhat toxic to some people, kind of greasy, kind of oily. It was toxic. It was also the most expensive component of the product.

So the point he was making is that the delivery system was the most toxic and expensive component of the product. They already had the active ingredient. All the competitors were doing more and more basic research to find

better active ingredients. Active ingredient worked fine; it just wasn't getting delivered well.

They changed the delivery system. They came up with an aqueous solution, eliminated the toxicity, and drove the cost down to one- tenth the cost. That's engineering, looking at the way we change the way we provide care. And engineering can help us reduce, in a systematic way, medical errors, the way we examine what happens in this country, and it helps us establish new roles, new models of practice as we look forward.

So those are just some components of the delivery system, to give you a snapshot of the potential that we've got in this country. Now let's turn for the roles of the private and government payers. And I would say there are two roles for them -- that is the pay-for-value issue, and insurance for all. And let's take them in turn.

Pay-for-value I've already defined. It should be viewed, in our opinion, looking at a numerator and a denominator and that ratio. And the numerator should include outcomes, safety, and service. And we can define all of those.

The most important one, in my viewpoint, from your perspective and my perspective as an individual, is the service. So we can respond and tell people are we satisfied. Wish somebody would listen.

Maybe the next is safety, because you like to have it safe, and you probably really want outcomes. So that whole numerator is important to you. And then, of course, the cost component and what we look at as the cost over time.

Our position is that payments ought to be focused on -- and reward -- those providers and those patients -- it takes two to tango, here. Patients have to be participating. We should be rewarding both of those groups for the results, for the outcomes, for the value, not reward based on compliance with process measures. Pay for performance that Medicare's talking about is pretty heavily oriented towards process measures. Paying for process is not going to guarantee that you're getting the outcomes. We've got to measure the outcomes. So that's one of the thrusts.

Right now, actually, the more we make mistakes on patients, the more, sometimes, we make. If we don't make the accurate diagnosis right away, well, we get paid for the next round of tests and things. It's a little backwards, from the patient's viewpoint, in my opinion. We ought to be rewarding folks for getting it right the first time somehow.

An example of a Medicare -- of a payment reform that could lead towards paying for value would be what Medicare might be able to do -- Medicare as the largest insurance company -- and that is if they were to be allowed to pay for value, it's basically just the opposite of what they've been doing for the last many years. It's been a process of the way Medicare is structured and the way its board of directors, Congress, interferes with Medicare's ability to do what it needs to do.

The outcome of that whole business structure -- Medicare and its board of directors, been in business for more than 30 years. We have good measures for the last 18 years or more, with the Jack Wennberg data that comes out of Dartmouth. We can say without any question that that insurance company and its

board of directors pays the most dollars to the regions of the country that provide the worst outcomes, the worst safety, the worst service, and the worst integrative coordinated care. I think that's backwards, from what we've just been talking about. So we need to change.

We think Medicare should expand its program of really providing coverage for new ideas, techniques, and devices, but the quid pro quo is you do that while you're developing the evidence. In other words, we're examining the value of that technology. And they've done that a couple of times now, and that's one of the really good programs that we have in place. It'd be nice to see them expand that even further.

And Congress does not allow Medicare to make decisions based on comparative effectiveness, to be able to base those decisions on what kind of coverage, based on comparative effectiveness. So to really accomplish this, from the Medicare perspective, something has to be done to have Medicare become insulated from political pressure. In other words, Congress has to get out of the business, and Medicare needs to be a quasi-governmental activity or some other organization has to replace that as we move forward.

It's a great program for covering seniors; it's just spending money it shouldn't be spending. And they need to change the whole value equation, and it will change the way the whole country practices medicine. And to do that, they have to stop price controls. They basically have price controls. There's no negotiations, and they pay whatever they're going to pay. In exchange for that, though, there should be pricing transparency so everybody can see the specifics.

And I'll finish with this idea of insurance for all. The position that we have is that the individual should own -- all of you -- should really own your own insurance. We think it should be an expectation of being a citizen. I understand not everybody is going to purchase insurance, whether we mandate it or not.

This mandate issue, in my viewpoint, is a complete smokescreen. It's a political smokescreen. All of us are already buying health care for other people. I don't remember being given a choice. It was mandated. It was taken out of our paycheck, and we're putting money in to cover Medicare. We're buying insurance for other people. That's a mandate, as far as I look at it. But nobody's ever said we should all have our own insurance. There ought to be an expectation of being a citizen that we're all participating.

Now, the only question comes is how does is how does an individual pay for it? And that's a big role for government, to help be able to pay and provide that. Employers can help purchase the insurance. It's up to them -- why wouldn't they? -- and be engaged in purchasing that insurance.

The kind of model that people could have, like all of you, if you're like other patients we run into, you would like to have some choices. And a model is available in the federal government level that we could think about, and that's the Federal Employees Health Care model, which would have multiple choices, certain products, and you can buy up if you would like to have more services.

They need to be affordable. The way to get all of this affordable is to focus on value and drive out waste and get the prices down. That's the way to do this. And then the other quid pro quo is that the insurance companies

that would be involved in this would all have to take all comers. They'd all have to be involved.

So to examine some of these ideas, we pulled together a Mayo Health Policy Center effort that started about two years ago. We started with a symposium and we finished with a symposium last week. And we've had a series of smaller forums. All together, we've involved about 800 thought leaders in the country. We've involved over 1,400 patients -- surveys of 1,000 patients and, on a nine-city tour that we sponsored, we got input from 400 patients that went on the record with video or writing their concepts.

And our goal, really, is to influence -- to pull stakeholders together so that we can influence the decisionmakers about the big picture for health care in the next year or so. Because we think 2011 is when we really have to start moving down this track because of the Medicare wave that's coming at us.

Well, of all the things I just described to you, through our process, through the Health Policy Center -- and I'm here now wearing the Health Policy Center hat, speaking for many -- I see many people in this room who've attended one or more of our symposiums or forums -- that they came up with four top priorities. I actually described seven to you, but there's four top that they felt really should be focused on early.

One, insurance for everybody. And there was a favor towards the federal health model. Not the only opinion, but there was a bit of a favor in that direction. Two, coordinated care. We should emphasizing that. Three, that the delivery system should generate value. And four, payment reform needs to occur to pay for value.

Those were the four major items that surfaced, and they're pretty solid among this group. We got a pretty good hearing about that just last week, and it came up those were all reinforced. So those fit into that bigger picture that I was just describing. They fit in perfectly as the four major thrusts that we're looking towards.

So our next steps now, through our Health Policy Forum, is we went through a ranking exercise of some details now underneath what I just described. And we will be taking steps now at the public and at the private arenas, trying to broker discussions about -- more about insurance for all, more about payment reform and paying for value. We'll be doing more about universal clinical information systems, and interoperable electronic medical records and personal health records.

We'll be looking at high-cost programs. How can we develop high- cost programs focused on chronic -- patients that need chronic care and end-of-life care? Those are huge opportunities for this country, huge potential savings. And benefit packages to improve health and then, finally, an idea of a federal board that might be able -- federal health board that might be able to moderate some of this as a quasi-governmental agency, a little bit like the Federal Reserve or the SEC. Some model like that to be able to move some of these decisions out of Congress, to eliminate this political pressure that they're under all the time.

So our next steps is to get some cross-functional groups together to talk about these things. We'll have a medical education conference and a symposium about a year from now dealing with what medical education needs to do. We're going to sponsor a panel there.

We will be pulling together an IT summit, information technology summit, to have folks sort of get together. Because we have -- Mayo Clinic has information from a number of key IT providers in the country. They have told us, get together and tell us what you want, and we'll build it. Now, we're going to test the water and see if they'll actually do that. We want to convene groups of ITs and information technology companies and providers to try to make that happen.

So my final comment, after going through all of this -- I just wanted to paint a picture. This is a complex area, but there's really great potential. This country can do it. It is now time for leadership. It is time that the presidential candidates step forward, and the good news is, they have. Every one of them have taken a position that health reform is among their top priority list. Certainly it's in their top five.

That is really good news, because it gives a chance that maybe whoever gets into office, he or she will really step forward and start saying we need to picture and design something for the future, and set the executive stage. And when I use the word "executive," I mean no details.

The country has to look at the leader as setting the vision and promoting the idea such that the president would wake up every morning -- and they only have five or 10 major things to focus on -- one of them is health care. And every morning they should ask for a five- or 10-minute report on these following questions:

One, do we have a learning system of health care in the United States, and get a report on moving along. Two, is health care value in this country improving? What are the outcomes? Who were killed last night in the United States? Who died because of errors? If he can't get that report -- he or she can't get that report, there's a problem. We have to create something so somebody knows what's going on throughout the country. Are our costs becoming affordable? That's that value equation. Three, are we paying for value? And fourth, does everybody have access?

If the answer is no to any of those questions, then the president should hold some people accountable. For instance, if the IT companies aren't connecting and plugging and playing, the president says, okay, get them all in here next week. Let's sit down and we need to talk about it. We're not talking about legislation here. We're talking about leadership. Totally different issue here.

If the answer ever turns yes to those questions, which I hope it will, then we will have finally created a health care system that works for all Americans. And I thank you for listening. I'd be glad to take questions.

(Applause.)

(Exchange off mike.)

MS. SMITH: (Chuckles.) Which of the presidential candidates has the health care plan that best matches your positions and priorities or approaches the questions the way you think they ought to be approached?

DR. CORTESE: None of them. (Laughter.) What I described as a vision, it is not a plan. I've described -- this is very serious to us at Mayo Clinic.

We're talking about thinking of a future state for this country, and we're talking about describing what we can accomplish as a country. We have to do this because our citizens deserve it. We have to stay competitive. It's our workforce of the future. We're doing this for our grandchildren. It's a vision.

The candidates, yes, they talk about insurance for all. They all have a common -- they disagree whether there's a mandate or not, public-private. Each of them have a vision. The Republican candidate talks a bit about the value, trying to focus on value. But those are the easy things to fix. Getting people insured is the easiest one of all the things I've listed, and you see how hard that is.

The country needs to get on with it and get it behind us and let us start taking care of people like we ought to be able to take care of them. And if we pay for value, that alone will drive the system a long way to get value. If you pay for what you want, you might actually get it. So I'd like to see a little more of that when they discuss it.

MS. SMITH: In the meantime, is there a role that individual patients ought to be playing that's more aggressive, more active? What do I do when I go to my doctor's office? Or what should I be doing?

DR. CORTESE: At the present time, the best you can do at the present time is to get more and more personal information about your condition, and to have in your mind what you expect as a set of outcomes. And they're going to be quite different from person to person, as we know -- all of those things.

If we can get to a learning organization, you will have access to much more information. You'll know more about your physician and what they actually know and what they don't know. You will, I think, expect them -- you ought to expect them to be able to try to conduct an orchestra to get opinions or advice for you.

If you go, let's say, with a sore leg or your hip hurts or something and you go into an orthopedic surgeon, they may evaluate you and say, well, there's nothing here for surgery. There's nothing I can really do. But that wasn't really your question. Your question is what the heck's wrong with me? How do you actually conduct that?

And that's what I mean by the vision. We ought to be looking at the future state. Right now we're all at a bit of a disadvantage because we don't have the complete information. But what you can all do as citizens is to begin to demand better coordinated care, better access to information, and participate more in your own health care.

MS. SMITH: Some of the access to information and the outcomes that you relate to value doesn't seem to me to be the sort of thing often that your profession readily wants to give up. What kind of education needs to happen within the medical field to get that idea to become part of the culture? DR. CORTESE: That's a really good question. And nurses do it pretty well. And when we look at the components of the service lines that we talked about -- prediction, prevention, wellness, chronic care -- when we look at those aspects that all of us would like to have, I would also submit that physicians may not be the right group that should provide that information to you.

Physicians really are much more precise with regard to diagnosis and treatment, but when it comes to advising people, trying to keep them healthy, that's not exactly what they were selected to do, trained to do, and they may not have an interest in doing that. Therefore, that team approach is crucial.

So getting involved with organizations that actually provide the education or information to you is the best option you have now. If we can create a learning organization or system concept that I've been talking about, then the information is available to everybody -- patients and physicians.

Now, notice I've never said that that information is available to insurance companies or the government or anybody else. It's the patients and the providers we should be focusing on so they all have access to the right, accurate, timely information. We have to build that.

There are organizations in this country that are already doing it. And when we look at those organizations and we look at how care is delivered, we find those organizations actually out-performing European systems. We find them out-performing other systems in this country. They actually do a very good job.

MS. SMITH: You mentioned using genetics to improve health care. What about the concern of patients about being denied insurance coverage or facing higher rates if they do have genetic testing and it shows that they have some condition or a precursor for a condition?

DR. CORTESE: Right. That would -- if that happened, it would bring this whole thing to a halt, the new science and the new potential for us in the future. The idea that we're talking about here is that that information would be as private as other information. That's one of the barriers that we have to overcome. Patients can release it if they want to, but it should be their information.

Just like Mayo Clinic, we feel that patients' information are private. We don't release it, we don't tell people, release who was there, who are being seen by Mayo Clinic. We don't release their own individual, private information. That should be kept private. So the issue of having it be available to third parties is something that we do need to control and regulate.

However, if we get to a point where all insurance companies -- whoever is left standing -- are all involved in your health care from start to finish, and they can't deny you coverage for any particular reason, we may have to adjust how much their -- how much money they have, depending on the risk factors of a patient. But they all have to provide that coverage, and that concern goes away, too, because they wouldn't be able to deny coverage.

So these are tactical things that have to be done accomplish what I'm saying.

MS. SMITH: How can the needs of a patient come first if many medical decisions are actually made by health insurance providers?

DR. CORTESE: They shouldn't be.

MS. SMITH: Well, they are.

DR. CORTESE: That's right. (Laughs.) And my answer is it shouldn't be. (Laughter.) And that's exactly right. It should be --

The magic occurs in the room or on the telephone or on the Internet between the physician, nurse, other provider, and the patient. That's where all the interaction takes place. That's where decisions should be made. And as I mentioned before, the decisions should be based on scientific information -- at least the option should be.

But I can give you -- I practiced a pretty long time and took care of a number of patients with lung cancer, for instance. This is very common. Two farmers, Midwest, both the same lung cancer. Both had the same kind of farms. You sit down; you talk about the scientific next steps.

One patient says, Doc, I want everything you can do for me. Please do what you need to do. And the other one says, Doc, thank you very much, but I'd prefer that you just keep me comfortable.

I want to pass on everything I have to my children. Okay, now I practice the art of medicine.

Science helps you make the decision. Once the decision is made with the patient, you now do what you need to do, and you're a physician in either case. And there shouldn't be anybody else overseeing that and telling us what we ought to be doing.

MS. SMITH: Do people forget how to become good consumers when they take off their clothes and put on those nasty paper gowns? (Laughter.)

DR. CORTESE: Yeah. That's the worst time to have to do that. And actually we don't use paper gowns, but they're still pretty bad. They're pretty bad.

Yeah, that's the wrong time. As I was describing before, when a patient is enduring or suffering -- and I would submit even if you're feeling good when you go into the office, you're enduring and you're suffering for a while. (Scattered laughter.) Once you are in that position, the way to get out of that position is to begin to have more control of your own health care.

And I know how hard that is, but with the system we should be working towards, people need to be more engaged so they're thinking of the value; they are choosing their that they value, they trust; they're choosing the nurses or they're working with a nurse coordinator.

My daughter lives in the Twin Cities, she has a fantastic health plan, really good health plan, great service. When she signed up for it, she signed up for the building, picks the building, gets assigned a nurse practitioner who she has really related with -- and a nurse practitioner is always available, knew about her. And when my daughter had a problem -- when she was running and she had some problems, she needed some advice, she calls me. I said, why don't you call your nurse practitioner -- call the nurse practitioner. The nurse practitioner said come in today, and we'll have somebody see you. She got there around 4 o'clock, and she was seen by the specialist right off the bat. That was the conducting -- that was the conductor of her orchestra, was that nurse practitioner. So that's value to be able to do that. And I think you do that upfront; you don't wait until you're sick. You've got to get engaged earlier.

MS. SMITH: We've got some questions of -- a sort of general areas. What are your concerns about the growing mistrust of childhood vaccines and the

increasing number of children whose parents don't get the shots for their kids? Has the Mayo Clinic done anything to get the law changed in Minnesota, where there's a rather broad exemption to the law that requires vaccines for school-age children?

DR. CORTESE: The answer is no, we have not taken any active position on that, and that usually would not be something the Mayo Clinic would do.

Given what -- even having me here talking to you all today is quite a break from our tradition. It's been a painful break, but this is -- (scattered laughter) -- this -- because we shouldn't have had to have to do this. We should be -- I should be still taking care of patients, not sitting around talking politics. But we have a situation here where education and more knowledge and bringing people along is really the key, I think, to make this work.

There are some legitimate concerns that people have about vaccines, and this is where science and research could help quell that, getting more information and moving it forward. And that's a role for the Mayo Clinic, is to try to further clarify the appropriateness or the value of a given technique, or technology, in the care of patients.

And who knows what the truth is? We should be looking at this pretty hard. So we have not taken an active position to create any laws.

MS. SMITH: When you say who knows what the truth is, are you suggesting that the evidence is still out as to whether vaccines cause autism?

DR. CORTESE: Oh. I -- that -- you're asking me an area that's beyond my expertise. But I have no reason to think that there is any substantial evidence that proves any linkage with vaccines to autism at this particular point.

And -- the other thing I would have to say -- it's very hard to prove a negative. It's very, very hard to prove a negative. That's why every time you pin a physician down -- can you say for sure it doesn't, and -- no, you can't. I mean, it's very hard to prove a negative. There isn't any real linkage that proves that they exist.

MS. SMITH: Okay. Does popular television advertising really influence what doctors prescribe? DR. CORTESE: Let me answer that two ways. I do believe -- this isn't my personal opinion, I have some colleagues here who are in the pharmaceutical industry here -- but I do believe that the marketing to physicians, which is done not on T.V., does have an influence on physicians. The patterns of analysis seems to indicate there is an influence on physician prescribing behavior.

The marketing on T.V., I think, for medications is done for a different reason. It's to get to patients. Now, to the extent that patients walk into your office with the -- a printout of the latest device and say, how come I'm not taking this medication, it puts the doctor on the defensive position right off the bat. And perhaps there's indirect influence that way.

But the T.V. marketing, I don't think directly affects the doctors.

MS. SMITH: Would you -- if you could -- if you were king of the world, would you ban that kind of advertising from television?

DR. CORTESE: Yeah, I would. (Scattered laughter.) Just don't know I'd be successful, but I would -- (laughter).

MS. SMITH: (Laughs.) I gave you the king of the world status. You could do it.

One of the things you didn't mention as part of the whole system that we have now is malpractice suits. What's your take on limiting the amount of money a person can collect in a malpractice case?

DR. CORTESE: This one -- I will answer this as a totally personal answer; I can't say speak to anyone because we actually have not dealt heavily with malpractice or tort reform in our discussions.

We do believe that there should be -- my personal feeling is that there should be a way that mediation takes place. I still think people should be held accountable -- I am not opposed to malpractice activities at all -- and I think there should be mediation.

The issue of capping it, I have no position on that. I don't have any -- I don't have a concern about that. It's a big issue, I understand, in different states. But that reflects the public, the public trust in medicine and the way the public responds to some of the mistakes and things that we do. And I think physicians and providers need to gain that trust back so that kind of an issue diminishes. So I don't have a position on it. I'd much rather see mediation, however, as we move forward.

MS. SMITH: How does Mayo plan, or does -- how does Mayo plan to keep fighting the DM&E Railroad Project if purchased by the Canadian Pacific Railroad goes through?

DR. CORTESE: That's a great question. (Chuckles.) The -- I'll make two or three comments. First, we never were opposed to the train. And, unfortunately, the previous leadership of the DM&E turned it into a position like that. What we were trying to do -- this train line actually exists and it runs right through the northern part of our campus. And the idea that these trains would be coming through roughly every seven minutes or 15 minutes, and they're mile-long trains and they're going through at 40 (miles per hour) or 50 miles an hour -- I don't know what it is -- going through -- it cuts the town right in half, so it interferes with the ambulance services that we have and it goes right through about 200 yards away from our large MRI facility, which is quite sensitive to movement.

And if we had a leak in town, our -- one of our biggest hospitals is about -- it's about 300 yards away. Our huge facility, where we take care of people in an extended care-type environment, is right across the street from the track, and St. Mary's Hospital, our largest, is about a half-mile away, we would have to evacuate those folks. We can't evacuate them anywhere because we are an evacuation site -- we're a nuclear evacuation site where people come to us.

So the reason we got engaged is for our patients. What are we going to do? And we asked the company, "What are you going to do to mitigate the impact of the train line." We did not get a satisfactory answer at any time. That train line has now been sold; it's owned by Canadian Pacific. The reason it got stopped is because they had a very poor business plan, and they couldn't justify

the huge loan from the federal government for which they can never pay back. That got killed. That was actually a no-brainer, it should've been killed.

However, Canadian Pacific has the train line. We are talking with them because we're asking, "What is this train line going to do help mitigate the potential impact to patients that come to Mayo Clinic?" Mayo Clinic is the largest employer in Minnesota, other than the state government. So this is a big issue for the state and for us, and we're not opposed to the train line. We just have to figure out a way to mitigate it. Go under, go over, do something, but we have to have some mitigation.

MS. SMITH: We're almost out of time. But before asking the last question, I'd like to tell you all about a couple of speeches we have coming up.

On March 31st, which is the beginning of our 100th Anniversary Birthday Week, we will have Don Ritchie, who is the associate historian of the U.S. Senate. He'll about Scoops, Packs and Clubs: A Centennial Survey of the National Press Club and the Washington Press Corps. On April 16th, we have the president and CEO of the National Council of La Raza, Janet Murguia. And on April 24th, we have Charles Overby, the chairman, CEO and president of the Freedom Forum.

Second, I'd like to present our guest with our centennial gift, which is our brand new mug -- (laughter) -- featuring Eric Sevareid on the -- there will be a series of journalism stamps issued, and he's on them. So if you would take that.

DR. CORTESE: Thank you very much. I've come to Washington, and I've been mugged. (Laughter.)

MS. SMITH: You've been mugged.

And now for the last question. Why are the issue of People Magazine in medical waiting rooms always six months old? (Laughter.)

DR. CORTESE: (Laughs.) Did somebody really write that? I've been set up. This is -- this is -- well, first of all, are they really -- I didn't know they were that recent. (Laughter.) We tend to keep ours a good 20 (years), 30 years old, as old as we can. So thank you very much.

MS. SMITH: (Laughs.) Thank you very much. (Applause.)

I'd like to thank you for coming today. And I'd also like to thank National Press Club staff members Melinda Cooke, Pat Nelson, Jo Ann Booz and Howard Rothman for organizing today's lunch. Also, thanks to the Press Club Library for its research.

The video archive of today's lunch is provided by the National Press Club Broadcast Operations Center, and members -- Press Club members can access free transcripts of our luncheons at our website, www.press.org. Nonmembers may purchase transcripts, audios and videotapes by calling 1-888-343-1940.

Thank you very much for coming. (Strikes gavel.) We're adjourned.

END.