The Affordable Care Act and Innovation

"Why" in Behavioral Economics

The Yelp Effect
New Markets in Home Cooking
Integrative Medicine
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Correction
In the Summer 2013 RBJ Issue’s Emergency Preparedness (pg. 31) article, Peter Davidson was incorrectly referred to as Peter Danielson.
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THE AFFORDABLE CARE ACT:
The Only Certainty is That We Live in Interesting Times

by Mike Murphy

As we welcome in the new year, I am sure we would all agree that for various reasons we are living in interesting times, not the least of which is the Affordable Care Act and health care reform. A day does not go by where we do not hear significant negative and positive headlines about the possible impacts of the act and, in particular, its most significant components: The individual mandate and the insurance exchanges that offer coverage effective Jan. 1, 2014. What will the short- and long-term impacts be? Will more people be covered? Will health care be more affordable, accessible and of higher quality? I do not think anyone really knows at this point; there is so much complexity and uncertainty.

As I have surveyed the environment since the passage of the act in March 2010, I have often borrowed a quote from Donald Rumsfeld when he was being interviewed about the situation in Iraq. I believe his words very accurately describe the current status of the act and health care reform:

“There are known knowns. These are the things we know that we know. There are known unknowns. That is to say, there are things we know that we don’t know. But there are also unknown unknowns. That is to say there are things we don’t know we don’t know.”

These are indeed interesting times as the actual impacts unfold and as the politicians, regulators, providers, patients and citizens all grapple with the impacts of the act and the future corrections and changes that will be required.
I think it is important for us all to reflect on the reasons we have the act, which was passed nearly four years ago. At that time, health care in the United States consumed nearly 18 percent1 of the gross domestic product and was growing. We had nearly 50 million uninsured people with limited to no access to health care, we had health care costs for those who bought insurance raising at more than twice the rate of inflation, we had Medicare and Medi-Cal cost increases that were crippling state and federal budgets, we had baby boomers aging into Medicare at the rate of 10,000 per day for the next 10 years, and we had variable quality outcomes by providers and a system that incented payment for volume rather than quality and improved health2. The system that existed in 2010 was not sustainable without significant change. Whether it was this act, or whether it will be future changes to this act, or a different direction all together, we should all acknowledge that the status quo was not an option.

There is much to like about the act: coverage for adult children on parents’ policies up to age 26, insurance companies’ inability to deny coverage for pre-existing conditions, no annual cap on health benefits, coverage for preventative services, expanded coverage for Medicaid-eligible patients, a new insurance marketplace for individuals, subsidies to purchase coverage for United States citizens earning under 400 percent of the poverty level, defined Essential Health Benefits that are included in all health insurance policies and payment models that reward quality not volume.

There is also much to be concerned about the act. Can government, employers and individuals afford it? Are the cost assumptions accurate? What will be the effect of the individual mandate and employer penalties, and will we see a large shift to part-time versus full-time employment? How will the act impact providers and access to care, insurance premiums and actuarial assumptions if the young and healthy choose not to be in the system? Will providers be able to collect, or patients be able to pay, the high deductible and co-insurance amounts built into products?

Given the size of the health care system in the U.S., the complexities of the many programs and the magnitude of the changes included in the act, I believe the level of uncertainty and noise around the impact is very understandable. Change is never easy; significant change is very hard.

The most significant goal of the act is focused on delivering on what has become widely known as the triple aim: Improving the quality of health care (both individually and to the overall population), improving access to health care, and bending the cost curve. Many of the specifics noted above were aimed at changes to the existing systems and programs to positively impact improved quality, access and cost.

While there have been many changes implemented under the act over the last three-and-a-half years, many of the most significant changes (particularly as it relates to access) are only now being implemented, and even the Obama administration acknowledges the many shortcomings of the recent rollout. In addition, there have been and continue to be continuous congressional and administrative changes to the act that are materially impacting some of the original cost and access assumptions (i.e., one-year delay of employer penalties, optional expansion of Medicaid benefits by state, changes to the individual mandate and catastrophic coverage to name just a few).

Within every aspect of the health care delivery system, these certainly are interesting times. I believe that the next six months (and likely next several years) will bring significant confusion, uncertainty and some chaos as the implementation of the act continues. I also believe the goal of delivering on the triple aim is a good goal and that despite the uncertainty and barriers that have been and will be presented under the current act, that all stakeholders need to remain engaged and work proactively to be part of the solution. As acknowledged above, the status quo was not an option. In all likelihood the act as passed and being implemented is not the final solution. We all have a responsibility and a requirement to continue to work to ensure that the current system, when combined with future changes, will provide us with a better and more sustainable health care system for all.

Mike Murphy is president and chief executive officer of Sharp HealthCare, where he oversees a workforce of more than 16,000 employees, 2,600 affiliated physicians and 2,100 volunteers. Murphy, whose career in health care spans more than 30 years, was appointed to his position in June 1996. A Southern California native, Murphy is a graduate of California State University at Long Beach and is a certified public accountant.

1 http://www.pbs.org/newshour/rundown/2012/10/health-costs-how-the-us-compares-with-other-countries.html

2 http://www.aetna.com/health-reform-connection/aetnas-vision/facts-about-costs.html
When President Obama signed the Patient Protection and Affordable Care Act into law on March 13, 2010, he cemented his legacy as the architect of a new U.S. health care system. The bill ignited political conservatives who claimed it was a step into socialism, and provided fuel to boil any liquid left in the tea party’s pots. When informed of the term “Obamacare” for his revolutionary health care bill used in a derogatory manner by conservatives, President Obama responded with his typical style. At a press conference in Atlanta, President Obama utilized a technique that Bruce Lee would admire: “You want to call it Obamacare — that’s OK, because I do care.”

The bill is the largest piece of legislation that most of us have ever seen; it will have significant impact on every single U.S. citizen by redefining our nation’s health care system. The encompassing changes will occur at the individual as well as organizational, company and industrial levels. There has not been a more influential legislative act since the GI Bill in 1944. Obamacare has already altered the landscape of innovation and technology development in the United States, and will continue to for many years to come.

Unforeseen Downstream Effects of Innovation

The reputation of the United States as a pioneer in innovation is clear; it is a global leader in intellectual property applications and grants. The country’s ability to develop innovative ideas in response to the changing needs of our nation is also impressive. The assembly line was invented to make cars at a low price for the growing number of workers who needed low-skilled jobs after moving from the rural areas into urban centers. This innovation led to previously unimagined inventions such as the stoplight and the crash test dummy. These were capitalistic responses that improved the customer experience while also generating profit, proving the efficiency of the free market model. The development of commercial flight was a result of our nation’s involvement in World War I and produced numerous technologies in communication and air traffic control. Nylon was first invented as a silk substitute while the nation parachuted into Europe during the World War II.

On Tuesday, Nov. 28, 1939, residents of St. Louis woke to a thick black layer of smog covering their city. The day would be remembered as “Black Tuesday” and would be the catalyst for the development of air quality regulation in the United States. The regulation would provide the incentive to reduce air pollution while retaining performance and result in the invention of the first catalytic converter in the 1950s. Since the mid-1970s the device has been installed in every vehicle made in the country and has produced significant benefits for the residents of industrial cities by reducing the harmful gas formed by industrial and consumer combustion.

Perhaps the most convincing evidence of America’s ability to innovate quickly in response to challenges issued is this fact: When Neil Armstrong landed on the moon in 1969 and took “one small step for man, one giant leap for mankind,” sewn into his spacesuit was a piece of silk that he had personally chosen. This giant leap was in response to President Kennedy’s challenge to the American people in 1961 to put a man on the moon by the close of the decade. Armstrong and the silk fabric traveled the same 237,000-mile journey from Earth into history, but unlike Armstrong it was already notorious. Less than 70 years earlier the fabric had been part of the wing of the Wright brother’s plane that launched man’s first flight at Kitty Hawk, N.C.
Why America Needs Health Care Reform

However, the American health care system is not soaring. In fact, it is crashing. Other nations have avoided this quagmire through a mix of socialism, political shenanigans and the adaptation of foreign medicinal innovation—all meaningless buzzwords for patients on the operating room gurney under the knife. According to the official U.S. Social Security website, German Chancellor Otto Von Bismarck is recognized as developing the earliest form of employer-based health care in the late 1800s. Germany continues with a complex system of sickness funds known as “Krankenkassen” that are a form of universal health care and continue today resulting in a national population that is healthier and has greater longevity than the United States population. In fact, according to a New England Journal of Medicine report: “In 2006 the United States was 1st in terms of health care spending per capita but ranked 39th for infant mortality, 43rd for adult female mortality, 42nd for adult male mortality, and 36th for life expectancy.” The cause may be the American pay-for-service model that is an example of asking for one behavior but rewarding an entirely different behavior, as described by the strategist Steven Kerr in his academic essay On the folly of rewarding A while expecting B. Doctors want healthy patients but are financially rewarded for providing treatment, regardless of the patient’s health. America does not have a “health” care system, we have a “disease” care system.

In 2010, the American Association of Medical Colleges reported that there were 709,700 physicians in practice and a shortage of 13,700 relative to demand. By 2015 the shortage is expected to be 62,900 doctors, and by 2025 the projected shortage is well above 140,000, or about 19 percent fewer doctors than needed to provide adequate care of the population. This makes sense as doctors are seeing more patients but pay additional fees for insurance against increasing malpractice lawsuits. Smart people once dreamed of a lucrative medical career, but today are now lured to the low risk and high salaries found in financial or legal careers.

The physician brain-drain is especially disturbing considering the explosion of baby boomers that are about to enter, and over-utilize, our declining health care system. From 1945 to 1965, the rate of childbirth mushroomed, brought on largely by the effects of GI’s returning home from World War II. This generation will soon be the largest segment of health care consumers as 86 percent of a person’s lifetime health care costs occur during the final years of their life, leaving a strained health care system for the rest of us. It is estimated that 60 percent of baby boomers will have at least one chronic condition; over 20 million boomers will be obese and one quarter will have diabetes. According to the Department of Health and Human Services, almost half of the demographic will have arthritis, resulting in eight times more knee replacement surgeries than performed today.

What “Obamacare” Really Means

The bill will have significant effects on every American by requiring every citizen to have health insurance starting Jan. 1, 2014. This is the “individual mandate” that was upheld by a five-to-four Supreme Court decision and is the foundation that Obamacare rests on. Requiring 30 million healthy people to pay for insurance will spread the total cost among more people, thereby lowering the cost for everyone. In 2014, the tax is $95/per person annually, and increases to $695 in 2016 and continues to increase, eventually capping at 2.5 percent of an individual’s income. Like many parts of Obamacare, the issue initially seems simple and independent but is actually connected to other parts of the bill by a gossamer network of influence.

One example of this complexity is the requirement that insurance companies accept all customers regardless of pre-existing conditions. This would be impossible without the individual mandate. Only by requiring all citizens to obtain insurance can insurance companies provide treatment to those most in need. Each piece requires the other.

Understanding these complexities is even more difficult because the bill is still a work in progress, increasing the variability of its effects over time. The various tax scales, timelines and requirements for large companies have not been established yet since their values are dependent on the response of the health care industry over the next several years. Regardless of the bill’s postponed provisions, the Patient Protection and Affordable Care Act is the law of the land and would therefore require a three-fifths supermajority vote in Congress to overturn. Certain conservative lawmakers who are opposed to the bill have decided that rather than shutting down the entire government, a better option is to initiate specific and focused changes directly affecting their constituencies.

Medicare is America’s health care assistance program for citizens over 65, costing $528 billion annually; funding for the program will be significantly cut in order to fund Obamacare. The bill will also be funded by new taxes on large companies and high wage earners. The reduction of Medicare costs has been a goal of the White House since the first Bush administration, but additional questions remain about the ability of insurance companies to function profitably without current levels of revenue from Medicare. Insurance companies are not charities; they are groups of individuals incorporated together that are able to determine the value of risk. The addition of 30 million customers into the health insurance market will cause significant changes directly affecting their constituencies.

| OBAMACARE TAX PENALTIES FOR CITIZENS WITHOUT HEALTH INSURANCE |
|------------------|------|------|--------|
|                  | 2014 | 2015 | 2016 and beyond |
| Flat fee (per adult) | $95  | $325 | $695   |
| or                |       |      |        |
| Percentage of family income | 1%   | 2%   | 2.5%  |
| Family Maximum    | $285 | $975 | $2,085 |
ripples in pricing plans. It is still unknown if private insurance companies will be able to provide services for the people with the greatest need. Obamacare is in part funded by the 0.5 percent income tax to the high wage earners, according to the Congressional Budget Office’s Douglas W. Elmendorf.9

The bill also requires the creation and development of state-run health insurance exchanges to allow individuals and small companies to compare and purchase health insurance plans. States are required to develop these sites themselves or allow the federal government to provide the services. As of December 2013, only 17 states have established their own exchanges, allowing the majority of the nation to utilize the federal website Healthcare.gov that is receiving so much publicity. The negative coverage of the federal government’s health exchange is becoming an unfortunate symbol of many Americans’ opinion of the overall bill, when it is only a much smaller piece of the entire legislation.

The bill hopes to reduce health care costs on the national level by simultaneously promoting preventative medicine while discouraging development of expensive treatments. This new tax on all medical device companies has been established in order to subsidize the additional governmental costs. Most industry professionals and economists agree that this tax will have little effect on already established medical device companies, but may discourage new companies from entering the market since the tax will simply be passed down to the consumer. The bill also extends the patent life of biological treatments from 5 to 12 years, encouraging the development of products that prevent illnesses or diseases through the use of living cells such as blood components, gene therapy, tissue, or vaccines, effectively promoting preventive medicine biologics while discouraging the development of responsive medicine.10

Importance of Timing on Success

The success of any large project is largely dependent on uncontrollable factors that align in order to create a suitable environment where the project can succeed. The ultimate success of Obamacare will be no different. Malcolm Gladwell notes in his book Outliers that Steve Jobs may have been a hard-working genius, but he was a hard-working genius that was given his first job from neighbor Bill Packard, whose eponymous company turned their local Santa Clara Valley into the heart of the personal computing technology revolution, today known as Silicon Valley. Bill Gates also had the unique opportunity as a high school student to obtain extensive experience programming due to the uncommon investments of his school’s technology development program. According to Gladwell, upon graduating high school, Bill Gates had more programing experience than any other single person in the world. Outstanding success is not just a result of intelligence and hard work, but intelligence, hard work and being in the right environment at the right time.

The enormous size of the Patient Protection and Affordable Care Act and the significant changes to the current American health care system create an easy target for the president’s opponents. Only the future will tell if the conditions exist in the current political arena to allow the bill to succeed. The included flexibility of the bill is a
The pressure created by the shrinking number of doctors serving a growing population combined with the numerous changes that Obamacare initiates will create a need for innovative technology

sign that without significant industrial response and adjustment of the bill, it will end up as many already see it: a lame duck president’s attempt to establish his legacy without the consideration of the people he claims to represent. The fate of the bill is largely in the hands of the politicians that support the bill, the politicians that constructively expose the weaknesses, and the health care industry’s response.

In a recent Rady Business Journal article, Professor Chris Parsons discussed the geographic effects that influence growth of industrial cultures and why companies in different industries, but in the same city, share successes and failures. He noted that one possibility is the development of synergistic relationships between employees in different industries. As one company grows, its employees receive financial rewards and then support other local companies. This holistic idea of cities as living organisms is not new, but the social and environmental elements required to develop these beneficial relationships may have been hidden under a spaghetti bowl of high speed Internet wires for the last few decades. This concept can be applied to the interconnectedness of San Diego’s life sciences business community.

Obamacare Effects on San Diego

Fortunately, we are lucky. As residents of San Diego, many of us are aware of the benefits of living in “America’s Finest City.” The temperate climate, proximity to beautiful mountain, desert and beach landscapes and the overall laid back Southern California culture are attractive to recruit the talented professionals to drive our health care ecosystem.

San Diego’s unique combination of communication, software and life science is the distinct advantage that can develop the area into a global leader in the growing mobile health industry. San Diego based Qualcomm is a global leader in innovation in the communication industry.4 According to the San Diego Economic Development Corporation, technology and communication companies that also call San Diego home are a “Who’s Who” of the industry and include Intuit, Leap Wireless, Kyocera, Motorola Mobility, Cricket Communications, Websense and Viasat. San Diego is also home to over 600 life science companies, and the combined pharmaceutical and health care industries employ 42,000 people.5 Obamacare has spurred increased collaboration between the technology and health care sectors.

The intersection of communication technology and health care is known as mobile health, or mHealth, and San Diego is perfectly aligned to become the global leader in this growing industry. Broadly defined as the use of technology by consumers and clinicians for the benefit of health, the industry is dependent on the relationships between several industries, including health care, pharmaceutical, communications and software. mHealth requires technology that improves health along four axes simultaneously: convenience is improved, service is improved, the distance between provider and patient is increased, and costs are reduced.

The pressure created by the shrinking number of doctors serving a growing population, combined with the numerous changes that Obamacare initiates, will create a need for innovative technology. The growing mHealth industry will provide doctors with the technology that provides the ability to improve our population’s health for a lower price.

Residents of America’s Finest City are in a unique environment. If intelligent people work hard to take advantage of the distinctive combination of industries that are already thriving in San Diego, we can create relationships that will result in the technology innovation that the health care market needs. Obamacare will help some and harm others, but regardless of political beliefs it is changing a broken system. The successful firms in this uncharted arena will be those who accurately anticipate and adapt to change in order to position themselves strategically as individual organizations as well as in groups and by industry. There will be significant business opportunities in the U.S., and San Diego specifically.

Matt Archer (Rady MBA, 2014) is the co-founder and Chief Development Officer of the Bionomics Consulting Group and a von Liebig Fellowship award winner. His research has lead to the development of diagnostic tests for HIV and hepatitis and he has worked with numerous San Diego life science companies including Hologic Gen-Probe, the Genomic Institute of the Novartis Foundation, Arena Pharmaceuticals and Vertex Pharmaceuticals.

4 http://ncpedia.org/aviation/wright-brothers
6 http://www.ou.edu/russell/UGcomp/Kerr.pdf
7 http://pediatrics.aappublications.org/content/127/1/119.full.pdf+html?sid=35a54d96-0c5e-4ff2-b24a-39f145439db1
9 http://www.cbo.gov/sites/default/files/cboreports/43471-hr6079.pdf
11 http://www.ucsd.edu/rbj/2013/Winter/urban-vibrancy/
12 http://www.qualcomm.com/media/releases/2012/02/21/qualcomm-named-mit-technology-reviews-2012-cr50-list-worlds-most24
13 http://www.sandiegobusiness.org/industry/lifescience
Today, Gneezy is the Epstein/Atkinson Endowed Chair in Behavioral Economics and Professor of Economics and Strategy at the Rady School of Management. As for behavioral economics, once considered to be a rogue sibling of mainstream economics, it is now a rapidly growing field that is enjoying a meteoric rise in popularity as more and more policymakers and business leaders turn to it for answers to complicated questions. When asked why behavioral economics is becoming so popular these days, Gneezy commiserates that the usual economics courses that everyone is required to take in high school or college are typically dry, boring, and don’t seem all that useful, yet we function in a world governed by economic rules and outcomes. As Gneezy puts it, “We all drive cars but not everyone wants to understand how the engine works.” Enter behavioral economics into this picture. Behavioral economics has the potential to provide answers — analogous to just driving a car — without bogging down the user with too many technical details.

The fall of 2013 has been a busy time for Gneezy, with the October release of his new book, The Why Axis: Hidden Motives and the Undiscovered Economics of Everyday Life, which he co-authored with John List, a longtime friend and collaborator who teaches at the University of Chicago. Asked why he chose to deviate from the usual statistics-laden style of writing academic publications to author The Why Axis with List, Gneezy acknowledges that few economist friends write material that is widely accessible to laypeople in the general public. In the case of The Why Axis, he and List truly wanted to write a book that would speak to the real world. As professors to MBA students and frequent collaborators with businesspeople, Gneezy and List know that the implications of their work must be shared in a way that is not only practical but also deals with the big questions with which society is currently wrestling. However, as data-driven scientists used to letting the numbers and statistics tell the story, the book also served as a challenge to Gneezy and List when translating their work into a format that is simultaneously enjoyable and straightforward to read without undermining their credibility as researchers.

In its final form, The Why Axis features several socially pertinent subjects, including the topics of discrimination (both racial and otherwise), gender and education gaps, charitable fundraising, and business profitability. With catchy titles such as “What Can Craigslist, Mazes, and a Ball and Bucket Teach Us About Why Women Earn Less Than Men?” or “Why Is Today’s Business Manager an Endangered Species?” each chapter of the book tackles a specific question that looms large in our communities today. The underlying commonality that ties together Gneezy and List’s research in all of these major issues is the motivation to capture how incentives work at encouraging certain types of human behavior over others. For example: Are women innately less competitive than men? (According to their research, the answer is no.) Or is it a matter of social conditioning that leads to the pay gap between men and women that we still witness today? (According to their research, the answer is yes.) Previously only a matter of opinion and anecdote, Gneezy and List tackle these questions head-on by investigating the motives underlying why people act the way they do.

Perhaps the true genius behind the experimental approach of Gneezy and List is that they put behaviors that are generally taken for granted to the test. Ever gone to restaurants with friends and had to split the bill? Ever felt miffed when the guy next to you ordered a $50 steak and two martinis while you only ate a $20 pasta, but the bill was divided evenly? In The Why Axis, the authors recount an episode of the sitcom Friends, when the group of friends go out for dinner on the town. The individuals that make good livings — Monica, Ross and Chandler — order full-course meals while the less well-to-do folks — Rachel, Phoebe and Joey, settle for side dishes or soups. When the bill comes at the end of the meal and Ross proposes splitting the check, the table atmosphere
immediately sours. Even though splitting the bill equally amongst all parties sounds simple in theory, the proper etiquette in these scenarios is not as straightforward as it seems. In some cultures, such as in the United States or Israel, dividing the bill equally is often regarded as socially appropriate, whereas spending inordinate amounts of time to figure out who owes what can come across as being tacky. However, in Germany, it is just as acceptable for all parties to figure out the price of their individual bills down to the last cent. Despite social conventions and taboos, how does splitting the bill really affect individuals’ dining behavior?

To answer this question, Gneezy and List conducted a study to see what would happen when different groups of diners – students who didn’t know each other – were presented with various ways of paying the bill. The participants were divided into three groups and each group was told a different method for how the bill would be paid at the end of the meal. In the first group of six diners, the three men and three women were told that they would each pay separately for whatever they ordered. In the second group, the bill was split evenly. Finally, for the last group, the researchers offered to pay for the entire meal. Looking at the results, the method of bill payment indeed affected the amount that each person ordered. Unsurprisingly, people ordered and ate the most food when the authors offered to pay the entire bill. But in the case of the bill-splitting group, the individuals involved actually ordered more expensive items than they did when each person was only responsible for his or her own meal. It wasn’t that the people in the bill-splitting group were “bad” or wanted to take advantage of other people – they were simply responding to the incentives that they faced, where for every extra dollar that they ordered, they would only have to pay one-sixth of the cost. In this simple dining-out situation, the behaviors and outcomes of the participating individuals varied widely depending on the incentives initially presented to them. Throughout *The Why Axis*, the authors again and again highlight the central concept that “incentives shape outcomes,” no matter if it is amongst friends at a restaurant, in a public school with high drop-out rates, or in a multi-million-dollar corporation. By carefully executing experiments in the field, one can gain insight into the incentives governing human behavior and then enact policies for the better.

The attempt to change the status quo or any ingrained mindset is no small feat. In industries where certain standard operating procedures have long been the norm, trying to introduce field experiments can create pushback against such efforts. However, several companies that Gneezy and List have already worked with, such as Disney, Intuit, and Humana, can attest that companies do benefit from experiments where commonly accepted beliefs or practices are actually put to the test. In order to further shake things up from the ground level, Gneezy believes that new business schools, such as the Rady School of Management, have the potential to do things differently from the start. Business schools are in charge of producing future business leaders, and can be at the forefront of leading a revolution towards embracing experimentation in the business setting.

For the authors, *The Why Axis* is a labor of love to translate the in-depth research they have done over the years into a form that the public can understand, enjoy, and apply in their careers and in their everyday lives. To quote Gneezy, it is a “missionary work” – one that will convert people to think on a regular basis in an empirical way. When asked how the public can get involved with running experiments in the field, Gneezy readily replied that everyone can and should do experiments in their day-to-day lives. As a wine connoisseur, Gneezy suggests a quick and easy experiment: next time you go to a restaurant with a friend, order two glasses of wine off the menu – one cheap, and one expensive. Then have your friend try them both and tell you which one is better. Chances are, this could lead to some interesting dinnertime conversation.

Julia Lee (Rady MBA, 2015) has an industry background in HIV and Hepatitis C drug discovery research. Her interests include cognitive science, social psychology, and behavioral economics.
In a society highly dependent upon the Internet for gathering information, online consumer reviews have become the new word of mouth. Ratings on Amazon, TripAdvisor, Angie’s List, Rotten Tomatoes, and Yelp have helped consumers narrow down a barrage of choices.

For local San Diego businesses, learning how to manage these online review sites has become as important as managing the business itself. A Harvard Business School study, conducted by Assistant Professor Michael Luca, found that for every star change in rating on Yelp, revenues of independent businesses are affected by 5 to 9 percent. Chef Peter Briones of La Miche Kabobgee in Kearny Mesa recognizes Yelp’s influence.

“You can tell the trend in the business” Briones said. “When business is being picked up – like last night, we have a couple of good ones [reviews] sitting up on top – people just driving by clicked on [Yelp] looking for a restaurant and it came up. And then what they do, they read the first three, four comments: good reviews. Now, if it was a bad review, then they wouldn’t have come here.”

La Miche Kabobgee opened ten months ago and serves French-Mediterranean cuisine. A majority of their customers work from 9 a.m. to 5 p.m. and come during their lunch break, so the chef has to maintain a balance between delivering fresh, made-to-order food and rapid service. Briones realizes that he may have to deal with unfavorable reviews when several large groups come in at once due to the time it would take to get the orders ready, but he also understands that he cannot compromise the quality of the food, as it is currently their competitive advantage.

The Yelp Business Model

Fifteen years ago, consumers needed to pay for AAA or Zagat membership to receive printed guides with restaurant reviews. Yelp disrupted that model with its free online service. Currently, it is the dominant review platform for restaurants. As of the end of 2012, there were approximately 47 million local businesses nationwide listed on Yelp, but only about 994,000 of these local business locations have claimed their Yelp pages. Businesses can claim and register their accounts at no cost and Yelp verifies the registration through an automated telephone verification process. By claiming the page, businesses can communicate additional helpful information to customers and can address negative reviews.

Yelp generates revenue through the sale of advertising. In 2012, a lion’s share of its revenue stream came from local advertising, which
consists of services such as sponsored search, discounted deals, gift certificates or enhanced listing. However, it is from this same revenue source that Yelp continuously receives allegations of extortion. Several class action lawsuits have been filed by small business owners accusing Yelp of demanding $300 or more a month to hide negative reviews and highlight positive ones. These complaints have been dismissed due to lack of evidence.

The algorithm Yelp uses to sort and display reviews is proprietary. An automated software program screens more than 39 million reviews and only displays the most reliable. About 20 percent are separated in the “Filtered Review” page and these filtered reviews are not factored into a business’s overall star rating. Yelp admits that there are instances when completely legitimate reviews are unavoidably caught in the filter due to sheer volume.

**Astroturfing and False Endorsements**

As more and more customers rely on the reviews of others to make a purchase decision, there has been a proliferation of fraudulent reviews on these online review sites in an effort to exploit the system. This is known as “astroturfing,” or the practice of writing false reviews. New York Attorney General Eric T. Schneiderman announced that a year-long undercover investigation into astroturfing and false endorsements in various online review forums has recently been completed. He found that some businesses paid freelance writers to write positive reviews of their companies to the Philippines, Bangladesh and Eastern Europe for $1 to $10 per review, or solicited to hire reviewers on sites such as Craigslist.com, Freelancer.com and oDesk.com. One company required freelancers to have an established Yelp account that is more than three months old, with more than 15 reviews and at least 10 Yelp friends to get around Yelp’s filtering algorithm. The New York Attorney General’s Office reached agreements with 19 companies to cease writing fake reviews and pay a total of $350,000 in penalties.

According to Mike Teays, Chief Information Security Officer of a large government agency, it can be difficult to find where the reviews originate, even the ones that are being sent internationally. “There are ways that they can spoof,” said Teays. “For example, they can set something up so that the review could flow through a network so it comes out of a local server that’s connected to the Internet.” Gartner.com said that by 2014, 10 to 15 percent of social media reviews will be fraudulent and paid for by companies.

Luca’s Harvard study presents four main findings about fraudulent reviews. First, around 16 percent of reviews on Yelp are false and are consequently filtered. These reviews tend to be either extremely favorable or extremely unfavorable. Second, phony reviews are more likely to be committed by restaurants with fewer reviews or by those that have recently received bad ratings. Third, chain restaurants are less likely to commit review fraud because consumer reviews are less influential to their already established reputations. Lastly, restaurants are more likely to commit review fraud by leaving a negative review for a competitor when there is increased competition with nearby restaurants serving similar types of food.

**Managing Online Consumer Reviews**

Last year, Craft and Commerce in downtown San Diego’s Little Italy chose to be creative in handling their undesirable Yelp reviews — they played a recording of the complaints over the loudspeakers in the restaurant’s restroom. This play on humor and mockery invited quite a bit of media attention to the restaurant. Though, after a few days of receiving publicity, some people started writing bogus one-star reviews just so it could be played in the restroom. The restaurant still continues the practice to this day and has maintained a four-star rating despite attracting false reviews.

The growth of smartphone usage with its location-based service apps makes it easier for consumers to make purchase decisions. Often times, the decision is made passively by browsing through the list, considering businesses with four- and five-star ratings, and disregarding the rest. As a result, online consumer reviews can make or break a business, so it is important to monitor them regularly, manage them effectively and maintain a four-star or above rating. For local mom and pop shops, this is more significant because one negative review may potentially cost them a considerable number of customers, or worse, even their very businesses.

To stay on top, companies such as Brim Agency in San Diego or Reputation.com offer online reputation management services. They provide tools to monitor, improve, defend and repair online reputations. They assist in resolving negative customer experiences and build positive reviews. But even these services fall into a gray area. In 2009, the Federal Trade Commission (FTC) determined that the reviewer must disclose if they have been paid or compensated for writing positive reviews, otherwise, they are committing deceptive advertising and will be prosecuted. The FTC recommends visiting OnGuardOnline.gov/shopping to compare products and check guidelines on online reviews and recommendation.
Furthermore, online reputation management services may not be an option for local small businesses such as La Miche Kabobgee. “We talked to two of them,” said Briones. “I couldn’t figure out how they would charge us. It’s not a flat rate. One was a percentage on the business they bring in. Another one was pretty much set up for just monthly payments. You don’t know if you’re going to get paid or not [whether business will be good or bad].”

With a limited budget, independent businesses can still manage their own online consumer review sites without hiring online reputation management services. They can accomplish this by first claiming their pages on the review sites. This will enable them to enter all the accurate business details on the page and update the information as changes take place. This will also allow them to monitor reviews, actively manage them and limit the damage done to their reputation when negative reviews appear.

In addition, independent businesses can build their reputation by creating a following through social media sites such as Facebook, Twitter and Instagram. Building a loyal customer base presents the opportunity to provide special services for the customers such as sending an invitation for a complimentary visit or offering discounts. Owners must realize and accept that negative feedback is a natural part of doing business and understand that each instance requires a different response. They must be open to receive undesirable reviews and embrace them as a way to help detect the weaknesses in the business. In responding to comments, it is important to stay professional. If an incident is damaging, businesses may consider using the media to clarify the situation and apologize publicly to customers if necessary.

“Pay attention to what is being said about you,” said Teays. It’s a source of what the public is seeing.”

Vanessa Cabiling (Rady MBA, 2014) is a budget analyst for a large government agency. She focuses on strategy, data analysis and market research. Her interests include consumer behavior, predictive analytics, ideation and IT innovation.

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I recently burned roasted yams. Luckily it was Thanksgiving, so nobody really cared because we needed to have yams. Plus they were still rather tasty. But it bothered me, and I tried to think of why. Perhaps because I added maple glaze and didn’t reduce the cooking time. Perhaps my oven is different than the oven used to develop the recipe. It is not uncommon for ovens to deviate by 50 degrees around their setting. Oven temperatures can also drift over time, slipping out of calibration. Accomplished chefs know this, but to the average home cook it is not second nature.

For home cooks, ovens and other traditional temperature-controlled methods of cooking meat—such as using thermometers and temperature sensors—have long been affordable. But products to use those methods may soon be joined on the consumer market by new products that allow home cooks to prepare meat using a unique slow-cooking French method that until recently has been prohibitively expensive for home cooks.

Sous Vide Cooking Method

Sous vide (pronounced: “sue veeed”) is a cooking technique developed in the 1970s that has come to prominence in the U.S. in the last 10 years via influential chefs such as Thomas Keller. Nathan Myhrvold, author of the modern cooking bible Modernist Cuisine, declares that, “Sous vide is an amazing cooking technique; it lets you have total control over how done something is, and you get perfect results every time.” The equipment consists of a water bath, a vacuum sealer, and a tool for finishing the dish. Water is good for two reasons. First, it has a high thermal mass, which means it can hold a specific temperature well because it takes a great amount of energy to change its temperature. Second, because thermal conductivity is high the water imparts heat into the foodstuff quickly. Compare this to your standard oven, which uses air as the heat transfer mechanism. Air transfers heat more slowly, and every time the oven is opened the heat drops which makes it far from precise.

Water does have one drawback: If you put food into sub-boiling water it’s called poaching, and that cooking method yields a specific flavor. In sous vide cooking, the foodstuff is placed into a plastic bag to prevent the water from leeching out flavor. And to make sure air doesn’t slow the heat transfer, the bag is vacuum-sealed. Hence the name sous vide, which in French means “under vacuum.”

Then finally, the method calls for the foodstuff to be finished or seared with high-heat. This can be done in a cast iron pan or, more extravagantly, sous vide enthusiasts prefer a blowtorch. In high heat cooking, like an outdoor grill, you throw the food on and the outside nicely browns while the inside slowly comes up to temperature. Here that process is separated into two steps. First the low temperature for the inside doneness, and another for the outside crust or sear.

New Affordable Sous Vide Products

The consumer space for sous vide is rather interesting. The first products were repurposed laboratory equipment. Water baths used to hold chemicals or biological samples at extremely precise
“A year ago, when the Polyscience was selling for $800, a husband and wife team launched Nomiku on Kickstarter and received 2,000 orders at $330 each.”

PolyScience may be regarded as the leading company with a history of chemistry lab equipment. They worked closely with top chefs like Grant Achatz of Alinea to create a line of food equipment for restaurants. According to Forbes magazine, in 2007 five percent of the company’s $20 million in sales were from cooking gadgets. The original products were much more precise than required, and had box-shaped and inert steel design features. Such features were needed for the equipment’s original function of mixing chemicals together, and no one cared what they looked like. However, high-end kitchen equipment for the home tends to be stainless steel or sleek black glass, and must be easy to use. Hobbyists began playing around with the technology and creating products of their own, creating competition which helped drive down the price. Over the last few years, Polyscience has introduced new models, dropping the price from $1,100 to $300. The retail presence remains slim, with only high end kitchen specialty retailers carrying these products. Williams Sonoma carries Polyscience and Sur La Table carries the Sous Vide Supreme, but in both cases the products tend to be on the bottom shelf or in some back corner. New competitors are going straight to cooking enthusiasts with consumer oriented products.

These new players have been successful marketing their products to the masses via crowdfunding. Crowdfunding is a disruptive business innovation which reverses the traditional startup cycle. Traditionally, an entrepreneur raises money, develops the product, produces a first run—all costing great amounts of money—then launches to the public and attempts to negotiate retail shelf space while hoping that sales realities match projections. Today, through crowdfunding, investors receive pre-orders and working capital if the public buys into their vision. A year ago, when the Polyscience was selling for $800, a husband and wife team launched Nomiku on Kickstarter and received 2,000 orders at $330 each. In the past few months, the blogger Seattle Food Geek had larger success, selling 4,000 units at $200 apiece. The price is now in a reasonable territory for cooking appliances. These were both very successful campaigns, but of course to achieve multi-million annual sales means consistently selling thousands of units a month. Because the technique remains new and complex, it remains to be seen whether it achieves mass adoption.

Steam Ovens for Higher Volume

For cooking higher volumes of food, there are ovens called combi-ovens and CVap, which are essentially precise steam ovens that are often programmable. Starting at $3,000 for small sizes, they tend to require a dedicated water source and an industrial 240-volt outlet, which regulates to the commercial realm. The CVap oven was originally invented to keep KFC chicken crispy while holding for order (think advanced orange glow lamp or bain marie). Quick-service restaurants, the fastest growing segment of the restaurant industry, are helping to grow demand for this kind of product. Chains like Umami Burger use a more defined process to deliver quality hamburgers consistently. A cooking time and temperature is set in advance, followed by a quick sear when it is time to plate the meal. This keeps the quality more consistent than having multiple line chefs cook the entire dish from start to finish. For the traditional diner grilling a traditional hamburger, this was fine, but the new restaurants are pushing the limits of quality to feed the growing foodie population.

With the help of a new wave of cooking entrepreneurs, and financing methods such as crowdfunding, consumers are being presented with new ways to prepare a gourmet meal at home. The increasingly popular foodie movement presents a unique customer niche. New home appliances are driving out the need for extensive trial-and-error cooking in your own kitchen, and at increasingly lower price points. Thanksgiving enthusiasts of evenly cooked, juicy turkey, and perfectly roasted yams may soon have a consistent result each year.

Eric Norman (Rady MBA, 2012) is making it easier to create restaurant quality food at home. At Rady, he was elected by his peers as head of the student body. He lives in San Francisco.

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The U.S. medical system, although referred to as “health care” is largely one of disease care, a status quo that threatens our country’s economic and societal well-being. An inside-out transformation of this system, that teaches and encourages prevention and wellness, not just disease management, is desperately needed. According to the latest World Health Organization data, the United States ranks 46 out of 48 countries in terms of “health care efficiency” – a calculation derived from life expectancy and health care cost per capita. We spend 18 percent of GDP per capita on health care - the highest percentage of any nation. In fact, 20 percent of all U.S. government spending goes to health care – more than double the total amount of any other country. Despite this enormous cost, our health outcomes are among the poorest. In 2013, the National Institutes of Health (NIH) ranked the U.S. as having the lowest life expectancy of the 17 highest-income countries. We are the most obese nation of any Organization for Economic Co-operation and Development (OECD) country, and tied with France as the most depressed population in the world. We seem to be sick on so many levels—mind, body and spirit—and this sickness takes a devastating toll on our health, our society, and our economy. The issues are complex and systemic. Yet, an emerging field called integrative medicine is offering hopeful, multifaceted solutions to the health care crisis and it just may actually work to save our system in time. More than 60 of our top-ranked Academic Health Centers (AHCs) and health systems in North America, including UC San Diego, have opened doors and minds to this new paradigm, with promising results.
Integrative medicine is a growing trend that has the potential to become the new gold standard that will define the “medicine” of the future. There are approximately 60 AHCs across the country that have created a Center for Integrative Medicine within their institutions and have become members of an organization called the Consortium of Academic Health Centers for Integrative Medicine. Members include many of the nation’s oldest and most prestigious universities, the Ivy Leagues, and all the University of California AHCs. These AHCs are harnessing the tenets of integrative medicine throughout clinical care, education, research and in the community, as a way to enact system-wide change at their institutions.

Integrative medicine is about integrating the best of ancient wisdom and modern science to create a system that supports the health, well-being and resilience of the whole person – mind, body and spirit. The term “integrative medicine” evolved from prior terminology such as holistic health, or Complementary and Alternative Medicine (CAM). Studies show that nearly 40 percent of American adults use some form of CAM. In addition, it was estimated the U.S. public spends 36 to 47 billion dollars annually on CAM therapies, with approximately 12 to 20 billion dollars of that total spent out-of-pocket for professional CAM services. This is more than the out-of-pocket expenses for all hospitalizations in a year, and about half that incurred for all out-of-pocket physician services. The difference between CAM and integrative medicine is that CAM exists in theory outside of allopathic medicine, as a complement, or an alternative. Integrative medicine incorporates evidence-based modalities, such as acupuncture or nutritional healing, into allopathic settings so that patients can have the best of all worlds at the same time. Yet integrative medicine is not just about adding new modalities, or having a bigger and better medical toolkit. Integrative medicine is a new philosophy of care that empowers the whole person to actively participate in their own care, by adopting natural, healthy practices that cater to each individual lifestyle. It’s about supporting the body’s innate wisdom to heal. Eating right, exercising, getting sleep and reducing stress are low-cost interventions, but they are unfortunately not well-supported in our fast-paced American society or health care system. Considering all the influencers, it becomes obvious that health care transformation must occur at five different levels: clinical care, education, research, business and community.

Clinical Care Transformation

The technological advances made in medicine over the past century are astounding. Emergency care, high tech surgeries and revolutionary drugs have helped our society solve some of the most devastating and life-threatening conditions. And yet, our high-tech health care system seems to have lost some of the more human elements that are so fundamental to good care, especially when it comes to prevention, lifestyle empowerment and natural approaches. Drugs and surgery are the revered focus of our clinical interventions. In the U.S., we spend the most of any nation per capita on pharmaceuticals. Perhaps low-cost, high-impact natural approaches, such as acupuncture, massage/manual therapies, nutrition, physical activity, self-care, stress-reduction and sleep, should be the first-line prescriptions for preventing and fighting disease. A 2012 survey reports that integrative medicine centers have been highly successful in treating some of our most common chronic ailments: allergies, chronic pain, cancer, depression/anxiety, diabetes, fibromyalgia, gastrointestinal disorders, heart disease, headache, immune disorders, obesity, stress and sleep disorders. Unfortunately, not all health care professionals are adequately trained for this task. Individuals and families need to be empowered with new ways to achieve their health goals and incorporate balance into their busy lifestyles. Therefore, all of the AHC Centers for Integrative Medicine in North America devote a portion of their time and resources to education—for existing health care professionals, future health care professionals and the community.

Education Transformation

Integrative medicine requires that health professionals do their part to act as role models of the healthy behaviors that they want to see in their patients. The existing health care system – and many employee environments – can be very stressful, and take their toll on the health of their employees. Unhealthy employees are detrimental to any workplace, and especially so in health care settings, where the negative effects can mean life or death. In fact, experts estimate between 210,000 and 440,000 patients die each year due to preventable medical errors. Good old-fashioned common sense tells us that it is virtually impossible to give your best in whatever you are doing if you are not feeling well, physically, mentally or emotionally.

Meditation is an ancient practice that modern science is now showing has numerous health benefits: reduced stress, anxiety, pain, and increased focus, mental health, and self-awareness. According to a 2007 National Health Interview Survey, at least 20 million U.S. adults use meditation for health purposes. At UC San Diego, medical students now learn mindfulness-based stress reduction training as part of their practice-of-medicine courses in their first and second years of medical school. UC San Diego employees, students and the community can also learn these skills through the Center for Integrative Medicine/Center for Mindfulness.

Research Transformation

In order for ancient healing modalities, like acupuncture or meditation, to be incorporated into our health care system, the evidence base must be established. Diet and lifestyle medicine is another area integrative medicine researchers are eager to study. However, researchers consider randomized case-controlled trials (RCTs) to be the “gold standard” for research, and RCTs are not the best way to study whole systems. The reductionist philosophy seeks to isolate a single variable from its context in order to study it. However, life behaves differently when isolated out of context because life works in systems. Behavior patterns, eating patterns, sleeping patterns and all lifestyle patterns are important in integrative medicine. Even the placebo effect has a misunderstood, important role in medicine, showing how our psychology and the influence of caregivers (health care professionals, family members and friends) can be catalysts in healing.

The solution: Research that uses whole systems approaches: the whole person (body, mind, and spirit), the whole dietary pattern

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(not just one food or nutrient) and whole systems (environments that surround and influence individuals). To this end, many Centers for Integrative Medicine are turning their time and resources to large-scale, cost-saving, systems-based approaches that analyze patient data, or practice-based research, to evaluate the effectiveness and safety of different treatments and lifestyle behaviors. One such example is BraveNet and the PRIMIER data repository project, which focuses on uniformly collecting patient outcomes and health data across Academic Health Centers. That large dataset can then be used for quality improvement, evidence-based research and determination of “best practices” to help improve the health and well-being of patients. UC San Diego has just applied to participate in this large-scale practice-based research project.

Community

Last but not least, community involvement is key to health care transformation. People spend most of their time outside of the health care system, within the community—as highly social creatures, we tend to be influenced by those around us. Studies suggest that people are more likely to stick to healthy behaviors if they develop those good habits with friends. Therefore, true health care must take plan on the community level and encourage group-based participation with family and friends—wherever people spend their time such as faith-based organizations, workplaces, community centers.

At UC San Diego, the Center for Integrative Medicine acts as a sort of navigator for people to find services like integrative physician consults, manual therapies, acupuncture and other evidence-based modalities at various clinical sites. It also helps clients to participate in group classes that engage the whole family like mindfulness-based stress reduction, self-compassion, mindful eating, tai chi, qi gong or natural healing and cooking. At the same time, all integrative activities are recorded and communicated across disciplines through our electronic health record, Epic. Specialized questionnaires, flowsheets, care teams and a referral system help with tracking and metrics. Education occurs through group classes for the community, continuing education events and courses for existing health professionals and major curriculum changes this past year within the medical school. One major curriculum change is a requirement for nutrition and mindfulness in the practice of medicine for all first- and second-year medical students. UC San Diego Center for Integrative Medicine also collaborates with the University of Arizona to offer an integrative residency program, in which the majority of our residents are currently enrolled. Slowly but surely, a cultural shift is occurring. Viewing our health care system from a much wider, more empowering, holistic perspective has inspired changes already that give us hope—better patient outcomes and higher satisfaction at a lower cost.

Lauray MacElhern (Rady MBA, 2016) is the Managing Director of the UC San Diego (UCSD) Center for Integrative Medicine. She is also co-founder and elected co-chair of the Business of Integrative Medicine sub-committee of the Consortium of Academic Health Centers for Integrative Medicine. Lauray earned her Bachelor’s degree majoring in communication and commerce through coursework in the Wharton School and Annenberg School of Communication at the University of Pennsylvania.

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One night in 1996 I witnessed the late Leslie Nielsen bring the house down at the Oxford Union with this quote, "There is no crime problem. There is a victim problem. If we could lock up all the victims, the crime problem would be solved."

Challenging his role as Sergeant Frank Drebin in The Naked Gun movie franchise, his quip possessed a flawless, if somewhat impractical, logic.

Health care and the costs of health care have dominated politics in the U.S. over the last five years. The more I read and hear, the more the logic of Frank Drebin seems to be the perfect solution. Perhaps to solve the health care problem, we simply need to have fewer sick people?

In the meantime, newspaper headlines have been dominated by simplistic attacks on “Big Pharma.” The costs of drugs, the profiteering. The real story is, as always, more complex and more interesting. Prescription drug spending accounts for less than one-tenth of the U.S. health care bill ($277.1 billion out of $2,809 billion in 2012), growing at only 2.9 percent compared to the annual growth rate of 4.2 percent of health care spending as a whole. In comparison, hospital costs make up almost one-third of the total bill (almost $900 billion). Even more surprising is the assorted costs associated with private health insurers (e.g. advertising, sales commissions, and other administrative costs) which soaks up almost 6.5 percent of the entire national health care expenditure.1

The pharmaceutical and biotechnology industries have struggled over the last 15 years to industrialize the drug discovery and development process. From a purely financial perspective the results have been poor. "Eroom’s Law"2 has taken hold, with dollars being spent for an ever decreasing return–we glance over enviously as our tech colleagues are reveling in the benefits of Moore’s Law.

In addition, the pharmaceutical industry is feeling the full weight of two powerful market forces: generic competition and the increasing power of the prescription benefit manager. Without government intervention, such as capped drug prices or misguided drug importation from Canada schemes, the market ruthlessly operates to reduce the costs of drugs. The recent announcement by Express Scripts, the prescription manager for almost half of Americans, to curtail reimbursement to a host of “me-too” diabetes drugs, powerfully illustrates their growing power and influence.3
As a result, the pharmaceutical industry has dramatically reduced its sales forces and has outsourced much of its research and development to small startup companies. The bottom line is that political and governmental targeting of drug companies will have a minimal effect on health care costs. These costs are relatively small and not increasing rapidly. In addition, market forces are doing an impeccable job of reducing drug costs. It is time to focus on the real issues.

The U.S. health care system is unique. It has evolved in a way that makes it difficult to import foreign solutions. A theoretical U.K. National Health Service implemented in the U.S. could potentially half health care costs, but any politician voting for it would pay a heavy price. The real issue, as Drebin might point out, is that there are just too many sick people in America.

There do appear to be several modest proposals that could have a major impact without causing too much political discomfort. These proposals focus on prevention of illness, and on better treatment of those who are already ill.

Seventy percent of newly graduated American doctors specialize, or choose to focus on one specific element of medicine. This is unique in the Organization for Economic Cooperation and Development nations, where the mean level of specialization is around 30 percent. Almost by definition you need to be sick to see a specialist. Perhaps a ‘slow-fix’ would be to redress this balance, boosting the levels of General Practitioners (GP) and training them to focus on disease prevention? To encourage an uptick in GPs, why not provide them government subsidized medical insurance, waive medical school debt and even allow early entry into medical school? Consider this “community policing” stubbing out illness at the source.

In the meantime, while we wait for an increase in GPs, let’s help the sickest patients. In a classic report in the New Yorker, we follow Dr. Bremmer in his efforts to target the top 36 patients in Camden, N.J. In Camden, 1 percent of patients account for one third of the city’s medical costs (nationally, 5 percent of the U.S. population is responsible for 49 percent of overall health care cost). These 36 “super-utilizers” cost $1.2 million per month in hospital bills before intensive intervention, and just over half a million dollars after intensive intervention by primary care professionals, a 56 percent reduction. By focusing resources on the repeat offenders, costs can be rapidly reduced.

When terminally ill cancer patients are offered palliative care, in addition to aggressive oncology therapy, they live longer than patients given access only to aggressive oncology therapy—up to three months longer. If achieved during a drug trial, this result would lead to near immediate drug approval and a premium price on the pharmaceutical market. The patients receiving palliative care were happier, had fewer side effects, and the overall costs to the health care system were lower. Yet palliative care is almost never offered nor reimbursed. Why not cover palliative care, and give a patient nearing the end a true choice?

The U.S. health care cost problem is not really a health care cost problem—it is a patient health problem. By having more frequent and productive access to GPs, allowing terminal patients to choose the type of end-of-life care they want, and bringing all the resources of the health care system to bear on the “super-utilizers,” we could realize enormous financial and health benefits. And we could stop citizens from becoming Drebin’s “victims” of the U.S. health care system.

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