

By Dr Toh Han Chong and Dr Jeremy Lim

## Interview with Dr James Mongan



**D**r Mongan is President and Chief Executive Officer of Partners HealthCare, a position he assumed on January 1, 2003. He is also Professor of Health Care Policy and Professor of Social Medicine at Harvard Medical School.

From 1996-2002, Dr Mongan served as President of Massachusetts General Hospital (MGH), the largest and oldest teaching affiliate of Harvard Medical School. MGH is consistently ranked among the top few hospitals in the nation and oversees the largest research programme of any hospital or medical center in the United States.

Before his tenure at MGH, Dr Mongan served 15 years as Executive Director of the Truman Medical Center in Kansas City and as Dean of the University of Missouri-Kansas City School of Medicine. Prior to that, he spent 11 years in Washington, DC. He served as a staff member of the United States Senate Committee on Finance for seven years, working on Medicare and Medicaid legislation, and he served in the Carter Administration as Deputy Assistant Secretary for Health and then at the White House as Associate Director of the Domestic Policy Staff.

Dr Mongan is a member of the Institute of Medicine of the National Academy of Sciences. He chairs the Commonwealth Fund Commission on a High Performance Health System. He has served on the Board of Trustees of the American Hospital Association, the Kaiser Family Foundation and was a member of the Prospective Payment Assessment Commission of the US Congress.

A native of San Francisco, Dr Mongan received his undergraduate education at the University of California, Berkeley and Stanford University, and his medical degree from Stanford University Medical School. He completed his internship at Kaiser Foundation Hospital in San Francisco and served two years in the public health service.

PARTNERS HEALTHCARE is a non-profit integrated academic health care system founded in 1994 by Massachusetts General Hospital and Brigham and Women's Hospital. Partners provides a full range of patient care services and conducts extensive medical research, teaching and community health programs.

Source: <http://www.kff.org/about/mongan.cfm>

Page 3 ►

### CONTENT

10 President's Forum - Origins | 12 Editorial - Nine Lives | 16 Hobbit - Movie Awards 2009 |  
20 Reimbursing for Kidney Transplants - 3 Discomforts | 24 A Chinese New Year Special



### EDITORIAL BOARD

#### Editor

Dr Toh Han Chong

#### Deputy Editor

Dr Tan Yia Swam

#### Members

Prof Chee Yam Cheng

Dr Martin Chio

A/Prof Daniel Fung

Dr Hsu Liyang

Dr Lim Boon Leng

Dr Jeremy Lim

Dr Tan Poh Kiang

Dr Tan Wu Meng

Dr Teo Eng Swee Cuthbert

#### Ex-Officio

Dr Wong Chiang Yin

Dr Abdul Razakjr Omar

#### Editorial Manager

Ms Krysanita Tan

#### Editorial Executive

Ms Gracia Ong

The views and opinions expressed in all the articles are those of the authors. These are not the views of the Editorial Board nor the SMA Council unless specifically stated so in writing. The contents of the Newsletter are not to be printed in whole or in part without prior written approval of the Editor.

Published by the Singapore Medical Association,  
Level 2, Alumni Medical Centre, 2 College Road, Singapore 169850.  
Tel: 6223 1264  
Fax: 6224 7827  
Email: [news@sma.org.sg](mailto:news@sma.org.sg)  
URL: <http://www.sma.org.sg>  
SMA Reg. No.:  
ROS 198/59 TAP

◀ Page 1 – Interview with Dr James Mongan

**Dr Toh Han Chong:** Can you tell us where you grew up and how you decided to enter medical school?

**Dr James Mongan:** I grew up in San Francisco and went to college at Berkeley and was interested in Science and Medicine from an early age. I was also very interested in politics, and my father was partially involved in politics in San Francisco. He advised me to be a doctor and not involve myself in politics. That was not bad advice, in retrospect.

I went to medical school at Stanford, did an internship there at Kaiser in the Bay area because I was interested in seeing how that organisation worked. Then I went into the Public Health service, which is a little bit like military duty. I was also interested in learning about the government health programmes; I was going to return for residency training but at that time I had a lucky break being able to have a job working at the Senate. I thought I would go do it for a year before going back to “real life” but ended up staying with the Senate for eight years, and then the Carter administration for four years. I went away from medicine and into politics!

**THC:** Could you tell us a little about your time in Washington? What were some of the healthcare policy issues that you had to grapple with?

**JM:** My time was always spent working on financing issues. There were two main committees in the Senate, one committee that works on health issues like NIH, CDC and problematic health issues, and the finance committee and jurisdiction over Medicare, Medicaid and the other national health proposals.

I would say the issues during my time always concerned cost and coverage. When I first went there, it was to work on a bill – it was the first bill since Medicare was passed, and you could already see costs going up. We were working on various ways to bring costs under control but at the same time, there was a big push for broader health insurance coverage. Senator Kennedy was for national health insurance and President Nixon had a plan, so there was a big debate about health insurance that ending up collapsing. When Carter got elected, he made



*Dr James Mongan delivering his keynote address on "Building a high performance public hospital – from great ideas to winning results" (on 7 October 2008, at the auditorium of the College of Medicine Building)*

another try and that was what I was working on; designing the Carter administration’s plan for health insurance. That also collapsed, so I saw two train wrecks in my career.

**THC:** The health reform is a difficult issue and with the US presidential elections, both candidates have very different plans for healthcare. One wants to regulate private insurance, individual responsibility and choice, the other perhaps a broader coverage and responsibility at a national level with more safety nets. Can such a reform really be implemented in such a big country with so many different lobby groups in the state?

**JM:** Two years ago I would have been very pessimistic because I have seen not only the two train wrecks I directly participated in, but also there was another train wreck under the Clintons. I have seen this fail three times. The lessons that I extracted from that were the major difficulties of money and where the money is coming from, so it has really been a finance issue and not a health issue. The strongest political force in America is the anti-tax movement. If you can’t raise taxes, then you can’t make employers do things and it’s very hard to go forward.

#### 49<sup>TH</sup> SMA COUNCIL

**Dr Wong Chiang Yin**

President

**Dr Chong Yeh Woei**

1<sup>st</sup> Vice President

**Dr Toh Choon Lai**

2<sup>nd</sup> Vice President

**Dr Abdul Razakjr Omar**

Honorary Secretary

**Dr Wong Tien Hua**

Honorary Assistant Secretary

**Dr Lee Yik Voon**

Honorary Treasurer

**Dr Tammy Chan Teng Mui**

Honorary Assistant Treasurer

Members

**A/Prof Chin Jing Jih**

**Dr Raymond Chua Swee Boon**

**Dr Ho Kai Wei**

**Dr Lee Pheng Soon**

**Dr Tan Sze Wee**

**Dr Tan Yia Swam**

**Dr Toh Han Chong**

**Dr Bertha Woon Yng Yng**

**Dr Yeo Sow Nam Alex**

Page 4 ▶



Group photograph taken after the keynote address. (L - R) Prof Edward Holmes, Executive Deputy Chairman, Biomedical Research Council; Prof Ivy Ng, Deputy CEO, SingHealth; Ms Yong Ying-I, Permanent Secretary, Ministry of Health; Mrs Jeanie Mongan; Dr James Mongan; Mr Bernard Chen, Chairman, SingHealth; Prof Tan Ser Kiat, Group CEO, SingHealth; Mr Noel Hon, Member, SingHealth Board of Directors

So two years ago, I would have told you that in spite of all the rhetoric, I think it would be very difficult to pass and implement something. I must say I was made more optimistic by my work in Massachusetts on the Massachusetts Health Reform Bill which really did show me that if we all worked together on a political coalition we could pass something and implement it.

If you were to ask me two months ago, I would have been a little more optimistic. I think this latest financial meltdown is going to make it almost impossible for either candidate to do much in this area. If anything, it will force them into a much larger governmental role on cost, similar to when Nixon was President. Even though he was a Republican, he started to impose wage and price controls and I can see something like that coming.

**THC:** The Massachusetts Health Reform certainly has increased the coverage for the average citizen who is uninsured; has it impacted health outcomes?

**JM:** It's too early to demonstrate outcomes, I think. We can show clear coverage and we can show that unit costs are somewhat higher than anticipated because of more people enrolling, not because of cost per capita going up. It has clearly showed that you can expand coverage and you can do it without removing cost. However, the aspect on outcomes is too early to tell.

**THC:** Could this be translatable to a place with a lot more uninsured people, like California?

**JM:** Well, I have been pessimistic when there was a lot of demand for people in Massachusetts to talk around the country, and my last presentation slide would always be on the two issues faced by other states which have higher rates of uninsured to start with, so it's twice as high a mountain to climb. Massachusetts had a pre-existent tax pool that the other states do not and I think that would have also made it harder. And that's what we saw in California.

**THC:** If you had to give the best advice possible to somebody who would eventually succeed you in running a powerful health system like Partners, which includes Massachusetts General Hospital, and Brigham and Women's Hospital, what would you say?

**JM:** In our organisation, I think the main piece of advice would be to continue in striving to find the right balance between central direction and institutional autonomy. We are a complicated organisation, perhaps the kind of internal political pivot point whether he or she is going to make it through seven years. I also think, in terms of getting things done, it's important to have a balance point that keeps moving us forward but doesn't shatter the organisation.

**THC:** Are there any concerns, since you benchmark the highest level with Harvard medical school as the flagship University in Boston? Is there any chance that other organisations are going to catch up with the reputation that you guys have in Partners?

**JM:** I think that is a tricky question in some respect, because as we were saying in a previous meeting, it's hard to actually differentiate the quality difference. A lot of it is less quantifiable and a lot of it has to do with reputation and brand development. Over the years, the doctors at Massachusetts General liked to recount the great saves that happened or would not have happened and these are hard to measure. I must say that I sense there will be more pressure on us to demonstrate not only equivalence, but also superiority. Above all, I don't think the reputation that we have is going to dissolve overnight. I don't think some other institution can surge ahead within a decade, given the kind of resources everybody has to deal with.

**THC:** You have been in Singapore for four days; do you have any initial impressions about our healthcare system and the way we run our hospitals?

**JM:** Well, I am always reluctant to opine as an expert when I have such a thin layer of exposure but I must say that I was very surprised and impressed. Even though I know and have seen all these statistics about how the United States isn't

the best, and that other countries have equal or better quality of healthcare, to a certain extent there is still an expectation that maybe things would not be quite up to our level. I must say I was disabused of that notion when I came here – the breadth and depth of services that are provided, the quality and cost indicators are pretty impressive. I would obviously say that there is a difference in our levels of expenditure. Your facilities look a little more like a general hospital in the fifties or sixties in the United States. I don't want to exaggerate to people and say that it is exactly like how it looks like – the facilities here do not exactly look like that, but I wouldn't expect them to due to different levels of investment. But when you go to the key statistics like the quality and the cost measures, I would say the onus is on us to explain our situation rather than explain yours. *(Laughs)*

**THC:** The 3M scheme that was discussed earlier will be hitting pressure points with health inflation. What is your view on co-payment?

**JM:** This is perhaps controversial; I am going to have to think about that on my flight back. I had pretty much locked myself into the position that modest co-payments for patient-initiated services not only makes sense but is defensible. I mean, if someone is going to run to the doctor when they get the sniffles, they have to pay some money. When patients demand an MRI or when their knee hurts, they should pay some money too. But I think that 90% of costly medical services are ordered by physicians and I don't think the burden should be on your patient with cancer who has to decide whether he wants to have a more expensive or less expensive drug because of co-payments. So I am supportive of co-payments done on patient-initiated services and have been intellectually less comfortable with the idea of physician-ordered services. I am trying to learn more about that.

**THC:** Looking into that, for example in the UK, the National Health Service (NHS) has expensive cancer therapies that are not utilised by the patients because the National Institute for Health and Clinical Excellence (NICE) does not allow that due to cost-benefit analysis. The NHS has "nine lives", so it seems, as they haven't collapsed yet. What are your thoughts on the NHS type of healthcare and financing structure?

**JM:** Well, I guess I stopped thinking about the National Health Service years ago. It's just a brick wall in the United States. The NHS has been painted as socialised medicine and the worst thing that could ever happen, and I don't think the Liberals are going to ever win the argument in the United States. So I think most Liberals in the United States have instead, focused on a government financing system looking at Canada and our own Medicare programme and saying that it is what we ought to have. Consequently, various lessons can be drawn from the British system, I don't mean to be dismissive – I admire them terrifically and wish we could do some of what they do – but it is just not very applicable in America.

**THC:** In Hong Kong, enforced savings and Medisave were pushed for in every part of the legislative council. The citizens of Hong Kong are a little like Americans – they don't want the government telling them where to put or how to save their money. So I guess that plan will be easier to implement in the United States?

**JM:** Again, I think I have to learn more about Medisave. I have been quite strongly and reflexively against the McCain health savings approach because to my mind, it moves to break up the whole insurance market from group insurance to individual cover. That leads to higher administrative costs, but more importantly, it squeezes sick people. If you are young and healthy, you are able to get a great policy, save a lot of money and this is another tax break. But if you are poor and sick, you will not be able to get enough money to put into your health savings account – you are going to have to utilise it so you can't really save. Also, the cost of your private cover is going to go way up because all the good risks have left the market, so I think there are many fatal flaws with the Health Savings Accounts proposed in the United States. I have to think through how it relates, I think there are enough differences here with the catastrophic umbrella policy and the low income umbrella policy that everybody has, which would probably buffer those negative effects and give you the positive effects of people feeling that they have a piece of the action.

**THC:** Do you think that it is sufficient to reduce the role of moral hazard in healthcare?



*Massachusetts General Hospital*

**JM:** I personally think moral hazard is overdone because I think mostly it is the doctor who does the ordering and not the patient. In cancer therapy when you are following your patients, you have a schedule to follow – if you want more imaging done or if you think more imaging is needed – generally it is the doctor making that decision and not the patient requesting for it.

**Dr Jeremy Lim:** How do you think the patient's financial status impacts on the doctor's decision making?

**JM:** Clearly in any place, some extremely wealthy and spoilt patients can impact on doctors' decision making; they can push for tests and examinations. I personally think it is not as far reaching a phenomenon in terms of the total amount of healthcare costs that are driven by.

**JL:** On the flipside, how much do you think doctors consider cost issues on an individual patient level? For example, in Singapore, many oncologists would hesitate to recommend the most expensive treatments if they know that

◀ Page 6 – Interview with Dr James Mongan

patients cannot afford to pay for it, and will then be more creative in looking for “middle-of-the-road” options.

**JM:** I guess like everybody, I would like to see an ideal world where the doctor didn't have to worry about the patient because there was equality and justice. But on the other hand, the doctor should be mature and professional about the issue, that whether the patient is rich or poor, the doctor would order the right thing. Obviously that would drive up costs somewhat because we are under-providing things we would like to provide. Alternatively, this could drive costs down in the US because we are overpriced.

**JL:** On the aspect of culture at Partners, what are the things that you are most proud of and what issues are you somewhat concerned about?

**JM:** I think the part that I am most proud of is our role in research, teaching, leadership and building medicine in the United States. There are really only a handful of hospitals which employ these roles in a significant fashion. I guess what I am most concerned about would be trying to maintain that excellence but doing it in a more efficient manner, because I don't think we are going to have that level of resources available going forward, unlike what we had in the past.

**JL:** What is the culture in Massachusetts General Hospital? It is a culture that is driven towards excellence in services, education and research but is there an underbelly that is not so positive?

**JM:** I really don't think there is a negative underbelly. I would say that there is some unseemly competition between the institutions that we still haven't fully dealt with; that is a bit of an unbecoming underbelly. I think there are also a couple of little twists on the culture in the two places.

Both of them value academics, research and leadership roles. In the Massachusetts General culture, they view themselves as – I wouldn't say private practice culture – eminent clinicians working with the patients, in that you will see them in the hall at eleven o'clock at night and they are very hands-on as clinicians. The Brigham side sees themselves more like upstarts

who are catching up on the big kids and making more progress over the past two decades than the other one. So there is a bit of a scrappier culture at the Brigham, and a little more of a reverential clinician-master model on the other side. These are the differences in cultural visions.

**THC:** What is your view on competition and healthcare costs in hospitals?

**JM:** In the past twenty years in the United States, I feel that the issue on competition is a mirage in healthcare. I am frankly cynical about how it all started. The conservatives in the United States did not like what they saw in terms of the Federal and regulations, and the interest groups in particular; the doctors and hospitals saw all these Medicare regulations. I think it was a certain sense of not being able to fight something with nothing, and they could not always be against something. They had to decide what they were for, if not regulation, and I think the easy answer then glibly sold by Porter and Thurman was the idea of competition. If there was competition, then there would not be government regulation or more taxes because a free market would work. So to me it was a very easy thing for provider groups and conservatives to buy in to.

I don't pretend to be an economics major but in my mind there are a few fatal flaws in healthcare. For example, in our country at least, 20% of the people cannot get into the stores so how can a free market work? For the other 80%, I thought the fundamental definition of a market place was an informed buyer dealing with an informed seller. I think it is very hard to get that with a cancer patient; no matter how much time they spend on the internet, it's unreasonable to put them in that position so I guess for those as well as other reasons, I think it's an illusion and it has been a “free path” in government financing. But I don't mean to apply this paradigm to Singapore or other countries around the world.

**THC:** You travel very widely and have been to countries like India and China, what has struck you about these large countries? Much has been said about how they have been growing rapidly, what are your insights?

**JM:** It is easy to think about your own circumstances, and our knowledge in the world is

◀ Page 7 – Interview with Dr James Mongan

thinner than it ought to be. I spent a week in both China and India so I cannot comment too much. I was a little more uncomfortable in India than I was in China because the vast discrepancies in India were in your face; whereas in China I'm sure there are rural areas but there weren't these huge clashes that I saw in India.

**JL:** On the issue of globalisation and a flat world, how should tomorrow's doctors prepare for this increasingly tenable role whether it is in service provision, education or even in leadership?

**JM:** This may sound more dismissive than I intend it to be but I suppose as compared to other industries and sectors, healthcare in a way would be less globalised because its heart is always local. Unlike whole businesses that can move from one continent to another, I think there is always going to be healthcare in every country so to that extent, I would say that there are no unique preparations needed.

Having said that, research advances are an arena that doctors should be conversant in, with regards to what is going on around the world. I guess a lesson that we have learnt in the recent years is the globalisation of infectious diseases; everybody is an airplane ride away from an epidemic that starts halfway around the world. I think globalisation has put more emphasis on infectious disease and treatment, but I would also say research and infectious diseases are the first two things that jump to my mind without ruling out other emphases.

**THC:** Are any of your children doctors?

**JM:** Neither of them has expressed any interest. My son came home from high school once, having taken one of those vocational tests and I had never seen him so depressed. I asked him what was wrong, and he told me that the test results indicated that he should be a hospital administrator. *(Laughs)* He went into Foreign Service; he is as different from what I can be, and my daughter went into education.

**THC:** In Singapore, there is a reputation of managing doctors. In your opinion, is it more difficult to manage doctors than accountants, teachers or the military?

**JM:** I think it is more difficult but I don't think it is all bad news. I treasure some concepts of individual autonomy; I don't want an army of bureaucrats or clerks who are going to be clicking their heels but on the other hand I would like to see a bit of heel clicking from time to time. *(Laughs)*

So I would like a happy medium, but it is quite difficult because doctors tend to be independent thinking professionals.

**JL:** Perhaps there are more doctors who are taking the non-clinical path, like practising for a couple of years and then moving into administration or other fields. Do you have advice for this group, and if they wanted to be the CEO of Partners, what sort of grounding should they strive for?

**JM:** That is a question I get fairly often, because in large institutions there will be always be a medical student or resident who will want to come in every other week. I have always said in those conversations, that it is a difficult career area because it is much less clear. If you want to be a neurosurgeon, you know exactly where to go each year – what programme and in what city. If you want to go into management or policy, the field is less well-defined. There are different pathways, into which you get an MBA, a Masters in Public Health (MPH), a Hospital Administration degree, or if you get a degree at all.

Generally I advise people who are interested; first to focus more on what they mean by management or policy because it can range anywhere from working for a drug company to running a hospital or health department, managing a medical group to being in a pharmacy. So the first part is to focus on the prospective you are interested in, and then I think, make decisions on what further training complements that part, whether to take an MPH, MBA, some other training or just finishing your specialty training and moving into management in a more clinical fashion.

The other threshold or decision you have to make is whether to enter full time into this, or to be somebody who practices part time and works part time as a medical director in institutions. I think those two decisions of full time or part



*The Bulfinch Building, built 1821*

time and deciding where you want to be are the important ones.

**THC:** What do you do to relax?

**JM:** I don't have traditional hobbies. I like to read and travel but specifically, I don't play golf; I guess that is the main American hobby. I don't garden or play cards either.

**THC:** For the readership, many doctors travel widely so if they were to go to Boston, what are the places and restaurants would you recommend?

**JM:** Downtown Boston is a very compact area and the history trail is something well worth doing. Given that many doctors have academic backgrounds, going to Cambridge to see Harvard is something I still enjoy. Walking over there, there are many used-books stores and coffee shops.

So I would say downtown Boston, the history trail and the Cambridge intellectual scene are recommended. For restaurants, I guess the one we go to most often to is called "Upstairs On The Square" at Harvard, it's very good and one that we enjoy. There is one down on Charles Street by

Massachusetts General Hospital called "Toscano's"; it's a very nice Italian restaurant so those are the two starters.

**THC:** Charlestown is fifteen minutes away by shuttle from Massachusetts General Hospital, has that impeded the cross translational discussion? It would make a lot more sense to have Charlestown right next to Massachusetts General.

**JM:** Yes, we built the new research building just over two years ago, and it is near the main gate. Behind Holiday Inn hotel, we built a fourteen storey research building. In the process of building and planning, there were a lot of who-would-be-where discussions and I am afraid I am going to have to tell you that regarding the much discussed synergy between the basic scientists sitting next to the clinicians, to be honest, I don't think it happened that much. Even though both are fifteen minutes away, you can still have departmental conferences. There was a lot of pressure to be in a building closer to campus but half of them didn't subscribe to that, which I would call legitimate concerns, and half would be concerns over convenience.

**THC:** Thank you very much. ■