



PRESCRIPTIONS FOR HEALTH REFORM:

A PODCAST FROM THE BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION

Transcript of podcast interview with
Dr. C. Rocky White, editor of the late Dr. Robert
LeBow's, *Health Care Meltdown: Confronting
the Myths and Fixing Our Failing System* 9.4.09

Q. You are not the original author of the book, so I was wondering if you could tell us a little about how you came to be involved with it.

A. Bob LeBow was one of the founders of an organization called Physicians for a National Health Program. Bob started writing this book at the end of the 1990s and unfortunately, a few years ago, he was involved in a bicycle accident and ended up getting a fractured neck, and then over a couple of months, subsequently died from his injuries. What was really sad about the whole thing was that actually the day that the book came out was the day that he had his accident.

So, the book did fairly well after it came out, but the publisher wanted to do a revised edition prior to the election year process, coming up to the 2008 election. In that meantime, I had also been a very active member of the Physicians for a National Health Program organization, and I go around to several places around the country speaking on the issue of healthcare reform. I was up speaking to the Idaho organization, on going around to different places around the state of Idaho, and that's actually where Bob was from. He was there in Boise, and I got an opportunity to meet his widow when I was up there.

When the publisher was talking to Bob's wife, and said, "You know, we'd really like to put out a revised edition," she said, "I know somebody whose practice patterns were very similar to Bob and his passion for healthcare, and he might be a very good person to take this project on." The publisher, Alan Hood, got a hold of me and said, "Would you be willing to take this project on?" and I said "Sure." That's what happened.

1

Q. When you wrote the book, you described yourself as a conservative Republican, and yet you supported the idea of a single-payer, universal healthcare system, which is not a common combination. What led you to your belief in such a system?

A. It's kind of a fascinating story, I guess, for me, from a lot of perspectives, because it was through this whole process of healthcare reform and me getting involved in it that I began to have a lot of personal anxiety about my association with the Republican Party and seeing what it has done and where it is going. In fact, I'm not even a Republican anymore.

Basically, what happened: I came from a very conservative background, and came from a farming and ranching background, and growing up in Nebraska, which is a very conservative place. I started practicing down in Alamosa, Colorado, back in the mid 1990s. It's a very poor and rural area, very poverty-stricken area.

The group that I belonged to was really struggling. We had a hard time trying to make ends meet. We were seeing a lot of patients that could not afford their healthcare, they were uninsured, or a lot of them were on the Medicaid system, which is not one of the best systems in the country, here in the state of Colorado, unfortunately. Medicaid's like that in a lot of places.

What ended up happening was our group began having more and more financial difficulties, trying to stay ahead of the game. I began to ask myself, "I know how to run a practice, I'm a good physician, I understand the business of medicine from this aspect, but the healthcare system as a whole seems to be really screwed up. I really didn't understand it at that time, so I just started doing a lot of research and trying to educate myself on how we got into this mess from a public policy standpoint, and looking at it from both state and federal policy standpoints.

As I began to do that, I began to recognize the same patterns that a lot of individuals who are involved in this healthcare reform process see. I began to recognize where the policy decisions were made, where things got messed up, why they were inadequate, and then I began to ask myself, "OK, now that we've recognized where these problems are, what can we do to fix it?" As I started to look at this from a global perspective, I began to recognize that if we're really going to fix the healthcare system, we're going to have to make some very, very strong but fundamental changes, not only in the way that we deliver care, but also in the way that we finance it.

I began to realize that there's this total disconnect between the delivery of care and the financing of care. It's totally uncoupled. As a result, there is a lot of perversion in the incentives on both the financing and the delivery side. What happens is that patients get caught in the middle. The only way that I saw that this was going to be fixed is to look to something like a Kaiser model, where actually the financing of healthcare and the delivery of healthcare are fundamentally coupled, and everyone, both on the financing and on the delivery side, are moving in the same direction. Obviously, you can't take Kaiser and make the whole world that, or I guess the whole country anyway, but if we're going to do that, how could we go about doing that?

I started looking at other countries like Canada, and France, and the U.K., and Japan, and all of these other places that are able to do it to a fairly successful degree. I finally began to realize that the only way we're fundamentally going to fix the whole thing is we're going to have to move to some sort of a single-payer system. Until we're willing to move that direction, we're not going to fix a lot of the fundamental problems that we have. The sticks and the carrots are just in the wrong place.

I would love to be able to figure out a way to make the markets work in this system, because I'm a capitalist. I believe in free markets, up to a certain degree, but there are some places where the market just does not work well. Healthcare is one of those places where a free market and allowing a capitalistic ideal to push the whole thing through, it just doesn't work well. Now there are some things about markets that can work in small places in healthcare, to provide incentives, but unless those incentives are lined up properly, they become perverted and they become disincentives.

As a result of moving through this whole process and getting involved in healthcare, I began to realize that for me personally, the conservative Republican ideals, number one, go against that type of grain. They're not aligned towards looking at healthcare from a global perspective. Then there were a lot of other things in terms of education and other things. Finally, it got to the point where I just felt for myself personally, I couldn't stay in the Republican party any longer. It was actually going down this road to healthcare that started that whole process.



Q. That's an interesting personal journey. Now some people will hear you talk about single-payer healthcare and think "socialized medicine." Could you talk about what your vision is of single-payer healthcare and what the role of the private sector would be within that system?

A. If you were going to create a perfect world, maybe that would be the best place to start, is to start at the end and work your way back. First off, we have to make a distinction between single-payer and socialized medicine, because single-payer can be a lot of things. For example, our Medicare system is a single-payer system. Our Medicaid system is a single-payer system, although some comes from the Federal and some from the state governments, but fundamentally, it's a single-payer system. However, when you look at our military healthcare, that's actually socialized medicine. So we already have components of both socialized healthcare and single-payer healthcare right here in the good old U. S. of A., and people really don't realize that.

So the distinction between single payer is that you have one entity that is responsible for the financing of healthcare. That could be a public entity like Medicare, or it could be a private entity like a Kaiser type of model. On the other hand, when you look at socialized medicine, socialized medicine means that the government controls everything. The government owns the financing of healthcare, the doctors work for the government, the hospitals are owned by the government, and so under those circumstances, that would be very similar to what the U.K. does. Or, in our situation here, the military.

One of the things that I try to talk about as I go around speaking across the country is the fact that this is America, we have to come up with something that's uniquely American, and we don't have to have a totally socialized system like the U.K. We could look at a single-payer system like they do in Canada, where each province within the country of Canada collects their money—they get a certain amount of money from their equivalent of the federal government—but each province is responsible for the financing of healthcare, and then the physicians contract with the provinces in the private sector. So the physicians are private doctors, and they just contract with the province. In that way, you have public financing but private delivery system.

Q. How then can we avoid some of the problems one hears about with the Canadian system, like long waits for care?

A. It's interesting when you talk about that because there are so many myths and so many misperceptions about the Canadian system when it comes to the waits [for] care. If you go into an emergency room, and you're having a heart attack, and you need to go emergently into the heart catheterization suite and have angioplasty, their timing is exactly like ours. They don't treat emergency patients any differently. The same can be— if you've got a serious cancer that needs to be addressed, their waiting times are just like ours. There's no difference at all.

One of the problems that has occurred in some of the provinces has a lot to do with the infrastructure. Back in the 1990s when a more conservative government was in control in Canada, there was an attempt to try and back down on a lot of the funding that occurred up there, and as a result, the Canadians got behind in some of their infrastructure. And so things such as MRI's and CT scans, depending on what province you were in, they weren't able to keep up, because the funding was cut back. And so, as a result, if you have a need and you've injured your knee, and you need to have an MRI of that, you may have to wait a week or two or sometimes three in order to get that done. But you know a lot of those things happen right here in the United States, too. People have a tendency to ignore that.

For example, there was an article in the Boston newspaper, in your newspaper back there in Massachusetts, talking about the wait times for screening colonoscopies. Doing a colonoscopy to screen for colon cancer, we now recognize by the literature is the most efficient and cost-effective way of doing that and we can save the most lives. Well, lots of people wanted to get their screening colonoscopies, and you only have so many surgeons and gastroenterologists there in the city of Boston or in the state of Massachusetts, and now all of a sudden, people who were needing a screening colonoscopy were having to wait four and five months. But you see those sorts of things people don't pay attention to. So it's all a matter of relativity.

The other thing, too, is that sometimes waiting periods can be used as a way to triage care and sometimes to even ration care. There's only so many resources in healthcare, and what I find is very interesting, is that every country decides how they're going to divvy up those resources. In Canada, they've made a point that especially on the primary care front, everyone will have access to at least primary care as quickly as possible, and specialty care from there. Here in the United

States, we sort of ration care in a different way. That rationing of care is, if you've got the money, you can get health care. If you don't have the money, you don't get your health care, or you get very poor healthcare. So you can look at it from that standpoint, too. How are we going to ration out our resources? Here in the United States, just by default, we've decided to do that by whether or not you can afford to pay for it.

Q. Now reform always seems to come down to the money. Could you talk a little bit about how you envision finding the money to pay for a reformed system?

A. You know, there's a lot of ways to do this, and quite frankly, as I look around the world, there are a couple of ways that I think are very efficient. I personally like the Canadian system, where I see Canada collecting taxes and some of that tax money then of course goes to the federal government and then comes back to the provinces through that direction, but the bulk of it actually comes from the different provinces, and so each province has a tax system, where it's kind of a combination of income tax and sales tax that is collected and then that money is what is used to fund the system. People of course then will say, "Well the Canadians' taxes are way higher than we are in the United States," and of course, that's true.

But when you look at it from the flip side, when you look at a large company, such as, let's just take IBM, that provides healthcare for their employees, they're spending \$11 to \$12,000 a year per employee and their family, that's going in to private insurance for their insurance coverage, or, if you happen to be self-employed, you'll actually pay more, so if you were a self-employed carpenter, you may be paying, I think we're closer to \$13, maybe \$14,000 a year, that's going towards private insurance. If that money were being taken out in the form of taxes, it ends up being six of one and half a dozen of the other and in fact, what really ends up happening in the long run is that your taxes will actually end up being cheaper than you paying for individual health insurance, because under a single-payer system, you can remove a lot of the fat and the waste and the profit-taking and the bureaucracy that's involved in having this splintered system that we have. We can probably save somewhere around even as high as 30 percent of the healthcare dollars we're spending right now, just in bureaucracy and profit-taking. [It] could be used to be rolled over into actually providing care, which would make it cheaper for everyone in the long run.

5

Q. Can you talk now about the incentives under a single-payer system? You spoke about how the wrong incentives are driving our current system. How would these changes address that?

A. Gosh, you know, you had mentioned that we only wanted to spend about 20 minutes doing that. I could spend about three or four hours talking about it. Let's try and hit the high points.

Probably the biggest one would be on the financing of healthcare to start with. When you have a for-profit health insurance company that is publicly traded, that company has a fiduciary responsibility, not only to run their business successfully, but also turn a profit. What you end up [with] in that industry is looking at a perversion of the monies that people are paying in to an insurance company to cover hopefully the problems that they're not going to have, but ultimately, they're going to tap into the health system eventually, and that insurance is there to help protect them.

The problem is, is that when you have a for-profit insurance company, they're going to sit in an adversarial role between you as a patient and your physician, because the physician is looking at the patient saying, "Okay, here are the problems that we have, and this is what we need to do to treat that." The patient is saying, "I have these problems and I want to get better, and you have the insurance company who's saying, "You know, we've got this pile of money over here, and we need to do everything we can to protect it." So trying to block access to healthcare is what insurance companies are all about. I mean, obviously, when you talk to health insurance executives, they're not going to say that. They're going to say "We're here to provide the best healthcare that we can for our patients." But the fact of the matter is, if there's not certain blocks within the system, an insurance company is not going to turn the profits that they need to stay viable on Wall Street. So they're incentivized to protect as much money as they can from being spent on healthcare.

On the other side of the equation, you have many physicians who operate in a fee-for-service setting, and for a lot of physicians, they're incentivized to try and do more things, and to do more procedures, and to see patients more often, because when they do that, they can make more money in the process. So again, because the physicians have been uncoupled from the financing, you have insurance companies and physicians setting in an adversarial role.

On the other side of the fence, you have patients who say, "I've made my contributions to my health insurance premiums this year, and I've been paying

on these premiums for the last 10 years, and I've got this little ding on my knee, and even though my doctor says I don't need an MRI, by God, I want my MRI because I paid for it." So right now, the system that we have, when it uncouples all of these incentives, everybody's going in different directions. When you look at a system where you're building cars or you're manufacturing widgets, sometimes this tension and these adversarial type of positions are good, because it helps keep a market system viable. But when you place that under a situation like healthcare, what ends up happening is that people get hurt. It's ultimately the patients who will end up getting caught in the wedge between insurance companies and the patients.

One example, one really good way to look at this is to actually look at our current police protection system. You know, when I go around and speak, one of the things that I'll do is I'll ask for a show of hands and I'll ask people who are out in the audience, "How many of you believe in police protection that is based on socialism?" And of course, here in this country, that word "socialism" just rings bells and nobody will raise their hands. But the fact of the matter is that our police protection is socialized. And there's a reason for it. That's because we don't want these perverse incentives going on in the enforcement of our laws and in the protection of our Constitution and protection of our citizens. We have a police department that is paid for by the government and its goal is to protect lives and to enforce the law. If we go back to the days where you hire private police departments, what ends up happening is that only the wealthy get good police protection, and the poor get none. Unfortunately, that's the situation that we have in healthcare right now.

Q. That's an interesting analogy. I have to ask what you think of the Massachusetts mandate that everyone be covered by health insurance. Is that a step in the right direction?

A. You know, to mandate health insurance, and not to fix the fundamental flaws of this system is folly. Unfortunately, I think what happened in Massachusetts is that you had a lot of very good people, very bright people, a lot of people who really care, who really want to help, and we still are locked in in this country, locked in to this idea that it will require the market to fix the system. Unfortunately, what happened in Massachusetts is that you have a mandate and you don't really have a large enough tax base to try and fill in the holes and at the same time you're funneling so much money into a private system, where you have for-profit hospitals and for-profit insurance companies who still have their incentives,

7



which are many times disaligned from the delivery system. What's happened in Massachusetts is you've just taken a system that's really bad, and you've just moved the pieces around on the board, and you really haven't accomplished anything in the process.

Q. Last question, then: What are the two or three key points that you hope the Obama administration will keep in mind as it looks to implement reform?

A. I think that the first thing that the Obama administration has to do is that they have to say, as a guiding principle, "Universal coverage is a must. Everyone in this country must have some type of coverage." Secondly, there has to be a public option. This cry that having the government create a separate, public option will create an unfair advantage to the private insurance companies and the fact of the matter is that it's too bad, it's got to happen. Ultimately, I would like to see the Obama administration move to a single-payer healthcare system, but we know that that's probably not going to happen.

The third thing is that the Obama administration has got to do is they have got to be able to control costs and contain costs, because no matter what kind of a system they create, they have got to contain cost. They have to look at costs from every angle.

Right now, under Medicare, because that's kind of the model that they're looking at, Medicare has the ability to push only in two places to contain costs: to cut reimbursement to hospitals, and to cut reimbursement to physicians. The current system has no other way of pushing costs down. They're not pushing down costs in the pharmaceutical industry, because under the Medicare D program under the Bush administration, they took out the government's ability to use their strength to negotiate with insurance companies. So they've given the insurance industry free rein to charge whatever they want. They're going to have to look at that.

They're going to also have to in some way regulate the insurance companies so that access can be provided across the board equally, and we also have to look at different ways of looking at how we spend our healthcare dollars, especially in end-of-life issues, which is a big Medicare problem.

So number one, it's got to be universal care, number two, we've got to regulate things tighter, and number three, we've got to contain costs. Quite honestly, the only way to do that is to move to single payer. As long as we keep this system that we have in place, we're not going to be successful at it.

