



PRESCRIPTIONS FOR HEALTH REFORM:

A PODCAST FROM THE BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION

Transcript of podcast interview with
T.R. Reid, author of *The Healing of America: A Global Quest for Better, Cheaper and Fairer Health Care* 11.06.09

Q. For those who haven't read your book, would you start by telling us a little about why you went on this global quest to look at various health care systems?

A. Yeah. All the other industrialized, free-market democracies, countries like us, all of them provide health care for everybody, of good quality, and they spend half as much as we do. So I went around the world to try to figure out "How do they do that? How can you do it?" And I think I got it. I think in my book I figured out how each of the countries do it. It's not all the same. It's not all socialized medicine. A lot of them cover everybody at reasonable cost with private docs, private hospitals, and private insurance.

And then along the way I realized that just as important a question as how do they do it was why do they do it. Why would a country commit to provide health care to all its citizens? You know and if you think about that one for two or three minutes, you start to wonder why doesn't the world's richest country provide health care for everybody? So those are the three questions that I tried to deal with in the book.

Q. And you had a personal ailment that you were looking to have alleviated as well, yes?

A. That's right. Thirty-some years ago in the U.S. Navy, I bashed my shoulder, and at the moment it hurts when I wake up, it doesn't move all that well, and I figured, hey, since I'm going to doctors and hospitals around the world, I might as well take my shoulder along with me and see if somebody can fix it.

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Q. So why did you choose the countries that you did?

A. I was mainly looking for countries like us, that could be models for the United States, so they had to be big, industrialized, rich democracies. Japan and Britain were really obvious, because our family had lived in both of those countries, I could sort of speak the language in both of those countries, and we'd used the health care system, but in addition to that, I was looking for examples of each of the major models of how to provide health care. As I said, they're not all the same. They're not all socialized medicine, so I tried to find different countries that represented the various established models of health care provision.

Q. One thing I found interesting in your discussion of these models was how you showed that the U.S. has really adopted components of them already.

A. We've got them all. Yeah. I mean, some countries really are socialized medicine, like Britain, Spain, and Italy. The government owns the hospitals, government employs a lot of the doctors, and government pays all of the bills. I think I'd call that socialized medicine, wouldn't you?

Some countries have private docs and private hospitals, but a government payment scheme. Canada invented this idea. What do you all that? Half socialized? Quasi-socialized? And then as I said, a lot of countries — Germany, France, Belgium, Switzerland, Japan, etc.—cover everybody with private docs, private hospitals, and private insurance. It's universal coverage, there's definitely not socialism, and the striking thing is, we've got every model. If you're a Native American or a veteran, well then, you live in Britain for health care purposes. Government owns the VA hospitals, government employs the docs, and you don't get a bill.

If you're over 65, and on Medicare, you go to private doctors and pay for them with a government insurance plan, Medicare. That's the Canadian system. If you're a working person sharing the cost of health insurance with your employer, well then you live in Germany. That's the model that was invented in Germany. And for the 45 million Americans with no coverage, well they live in Angola, or Afghanistan, because in all the poor countries in the world, you can only go to the doctor if you can pay them out of your pocket, and that's true for tens of millions of Americans.

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Q. Now, one hears opinions all across the board in terms of how the U.S. stacks up against other countries. We either stack up really well, and we're providing the best care in the world, or we have issues in terms of costs and extent of coverage, so I'm wondering what your opinion is about how we compare to these other countries.

A. Well, whatever you want to say about American medicine compared to the others is true. For some Americans, we have the best care and the best facilities in the world, with almost no waiting. If you're really rich or you have good insurance, you're going to do great in America. The problem with our system is the tens of millions of people who never get in the door, and no other country has that. All the other rich countries have decided to provide a basic floor of coverage that will cure your disease and keep you alive, whether you're rich or poor, young or old, they don't care. In the United States, we ration health care on the basis of income, and a lot of people just can't afford to go to the doctor.

They're not poor people, by the way. The poor people get Medicaid, or they can line up at the public hospital downtown. The people who die in America, and tens of thousands of them do, because they can't see a doctor, tend to be working people who get sick and lose their job. In America, you can't get insurance if you're sick. They have too much money to qualify for Medicaid or for welfare, but too little money to pay for the doctors and hospitals to keep them alive, and the result is, according to the National Academy of Sciences, 22,000 Americans die every year of treatable diseases because they can't afford a doctor.

Now, what I found in my book is that doesn't happen in any other country. In any other country, whether you're rich or poor, they're going to treat you if you're sick.

Q. Leaving aside the fully socialized model, the Bismarck model, which is used in Germany and a number of other countries, uses a system of private providers and private insurance, but manages to cover everyone. Now, why hasn't the U.S. been able to do something similar?

A. I think the fundamental difference is the way those countries handle the private insurance industry. In all the other countries that rely on private insurance—as I said, there are many—they have really strict regulations on insurers. The insurers have to cover everybody, they have to pay every claim. Usually they have to pay every claim really fast. Get this—in Switzerland, if your health care insurance claim isn't paid within five days, next month's premium is free. That is, the government penalizes the insurer for being late, whereas our insurers sit on the

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money for two or three months because they want to make some interest on the float, and that's allowed in America. All the other countries have very strict limits on the administrative costs the insurers can run up, and that's why American private insurance is the most wasteful, the least efficient payment system in the world. Our insurance companies have administrative costs in the range of 20 percent. In France, private insurance, four percent, Germany, five percent, Japan, about five-and-a-half percent. All the other countries just do a more efficient, effective job than the American health insurance industry of paying people's bills. And that's because the government makes them. They're regulated.

Q. Aside from the broad structure of those systems that you studied, were there any specific features in any of the countries that you particularly liked, that you think could be adopted here?

A. Well, another thing I thought was quite effective was in all those countries, they have fairly strict cost controls, the kind of cost controls that we're probably going to have to have, but as we've seen this summer, are extremely controversial. And guess what? Those cost controls actually drive innovation. The argument is made in America, particularly by the drug companies, well, gee, if you cut our costs, we couldn't do research. It's certainly true that the U.S. has world-class medical research. There's no doubt about that. But guess what? So do other countries that have much lower cost structures. France has really rigid cost controls, and yet anybody listening to this who's walking around on an artificial knee or an artificial hip, that's French technology, artificial joints. The only treatment that seems to work for Alzheimer's is this deep-brain stimulation. That was invented in Canada, a much lower cost structure than we have.

Even the drug companies' greatest achievement, Viagra, that was invented in Britain, so the idea that we have to spend through the nose to get medical innovation is just simply wrong. In my book, I show over and over again, that in these countries with strict cost controls, the controls actually drive innovation.

Q. Let's talk about some of the down sides now. You note that in France they've had to establish pretty strict cost controls. And I know you spoke about how reforms a few years back made their sickness funds, which are their version of insurance companies, operate more like branches of the health ministry, and the general practitioners began acting as gatekeepers to specialists. I think that's a big fear that people have in the U.S. about any government system or government regulation.

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A. Well, almost every health insurance system in America has gatekeepers. Most of them, if you're in what's called a PPO, a preferred provider network, you've got to go to your GP first, you have to sign up with one. That's true for about 70 percent of the Americans who are on private insurance. So we've got that already.

Actually, in France, they've done a terrible job of instituting the gatekeeper system, because the French people won't put up with it. In France the deal is, if you want to go to a specialist, you can go to the specialist, if he checks that you came on recommendation of a GP, then your bill is four Euros cheaper. You save six bucks, and guess what? The specialist always checks the box anyway, so France has tried to do the gatekeeper, but they haven't done it. Germany has a gatekeeper system. Japan doesn't. In Japan, you go to any doctor, any lab, any chiropractor, any hospital, and insurance has to pay the bill within a week or two

Q. [And how is that working out in terms of their being able to control costs within their system?](#)

A. Oh, they're all controlling costs well. Their problem is, particularly in Japan, an interesting problem—you think about America, our problem is we spend too much and still leave tens of millions of people with no coverage. In Japan, they cover everybody, but they don't spend enough. They have hospitals that are in hock to banks, they're borrowing money from banks just to operate day to day because the system isn't paying enough, so Japan's problem is the problem we'd like to have: spending too little on health care to cover everybody. The Japanese—you know, it's an aging society. They're definitely going to have to spend more.

That's also true in Germany and France. In Germany, they have very strict controls on what doctors can earn, and they divide it quarterly, so that if a doctor on March 15 has earned all the money for that quarter that she's allowed to earn, then she doesn't get paid for the next two weeks, even if her patients are sick. Many of these countries have cost controls that I think we would consider to be too strict, but boy, that's a problem America would love to have.

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Q. You write about the Canadian system, and show that while it started as a provincial plan, it was then ramped up to be a national system. Because I'm sitting here in Massachusetts, I have to ask: Massachusetts has enacted some reforms—an individual mandate for insurance coverage and an insurance exchange—that look similar to what's being talked about in Congress now for a national system. I'm wondering if there are any lessons from Canada in terms of taking a state or a provincial system and making it national, that would be useful for us to keep in mind.

A. Yeah. I now think, having looked at our debate this summer, and the kind of, I would say, timid bill that's coming out of Congress, the way we're going to get to universal coverage is state by state. I think states are going to experiment. And you got to give credit to Massachusetts for giving it a try, and I think they're up to 98 percent coverage. That's admirable. That's pretty good. What Massachusetts failed to do, at least so far, is to put controls on costs, so that the system costs too much. But in theory, if you get everybody covered, then you have the political will to impose cost controls.

I think what's going to happen is starting next January, there are going to be bills in 25 state legislatures aimed at getting to universal coverage, and a couple of states will get it right, and then the others will copy it. As you say, that's exactly what happened in Canada. One province, Saskatchewan, decided in 1944 that everybody would pay government insurance and when you went to the hospital, it was free. It worked. And the other provinces saw that and demanded it, and by 1964, it became national. So today, I mean, Canada's not a great system. They really do have long waiting lists. You've read about that in the paper, and it's true, for elective care. But if you're sick in Canada, they treat you, and they treat you free. Nobody goes bankrupt in Canada because of medical bills. About 700,000 Americans do every year. So Canada's a pretty good system, but they keep a lot of people waiting. No doubt about that.

Q. You've talked a lot about the financing here, but one thing you did say the U.S. does well when it comes to care is providing that care. We have good quality doctors and other health care professionals. Now some health care experts have tried to show that because of the way our financial incentives are tied to the provision of care, we can't reform one without modifying the other. I'm wondering what your thoughts are on trying to change the delivery of care in our country—whether that's something we need to do along with looking at the financing.

A. Well, that argument makes logical sense. We have this fee-for-service system. The more stuff the doctor does for you, the more money she makes. In Britain, they're

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on a pay-for-performance scheme, that is, the doctor gets paid for having a patient on her list, and gets paid whether she ever sees the patient or not, so when I lived in Britain, my doc kept saying to me, “Hey, eat better, take care of yourself, don’t do this, don’t do that. I don’t want to see you. He didn’t want me to get sick. He really had an interest in keeping me healthy.

On the other hand, I think maybe this need to revise the billing system in America is overstated, because a lot of countries, Japan, France, Belgium, Germany, have pay-for-performance, and still have very quite effective cost controls and cover everybody, so I don’t think the payment scheme is the problem. The problem in America is we’ve never made the commitment to cover everybody. Our problem is it’s not at the top. At the top, people get fantastic care in America. It’s that we let tens of millions of our neighbors go without care. No other rich country lets that happen.

Q. You mentioned the fact that your doctor in England was very interested in keeping you healthy, and you’ve observed that even in some of the other countries, a lot more is put into public health efforts than in the U.S. I’m wondering if you think that public health efforts need to be written into reforms here, or will they follow reforms once we give everyone a greater stake in keeping everyone healthy?

A. Well, the U.S. has great science of public health. A lot of the major advances in preventive medicine in the last 50 years have been American ideas. My argument in the book is you need an economic incentive. Preventive health definitely keeps people healthy and reduces suffering, but it costs money. You need an economic incentive to spend money now that really won’t save you anything until 40 years later, when the person is older. All the other countries have everybody in the system, cradle to grave, and therefore, they really have an interest in keeping you healthy, as I say in the book.

In America, the average customer of private insurance is with the insurance company about five-and-a-half years, and then you move on to the next job, and the next insurer. That insurer has no interest in worrying about whether you’re going to be healthy in seven years, because you’re somebody else’s problem. If you’re in your 50s, by 65, you’re going to be the government’s problem, you’re going to be on Medicare, and they have to pay a profit to their investors, so they don’t have an economic incentive to keep you healthy, and that’s why I think preventive health works better in the other countries where everybody’s in one system, and the system has an incentive to spend the money they need to keep people healthy.

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Q. I think a lot of people say that it's going to be hard to reform our system, just because there is so much that is entrenched in it. But you've also given the examples of Switzerland and Taiwan, which went from fragmented, expensive systems like we have to ones of universal coverage and greater cost containment. What made them able to change, and do you think it's still possible for the U.S.?

A. Yeah, I really like Taiwan for two reasons. In the first place, they did what I did. When they decided to reform their health care system, they went around the world and looked at all the systems in the world to see which ones worked. That's what I do in my book. In the end, they picked the Canadian model.

The main thing that I saw in the other countries, Taiwan and Switzerland both fixed their systems in 1994, and this is true in all the other countries, too, they first decided on the goal. That's the most important thing. They first made what I would call a moral commitment. They said, doggone it, anybody in our country who needs to see a doctor can have access. This is our commitment. Once you make that commitment, then you can come up with a mechanism to get there. If the insurance companies make a little less money, if the hospital corporations make a little less money, well, that's worth the price because you know what the goal is, is universal coverage at a reasonable cost. In the United States, for whatever reason, we've never made that commitment. We've never decided to be a country where everybody who's sick can see a doctor, and that's why in the richest country in the world, tens of thousands of people die each year of treatable diseases, because they can't see a doctor.

I think the most important thing is first, make the commitment. Keep your eye on the goal, which ought to be coverage for every American. In our debate, we get so hung up on insurance company reimbursement rates and hospital company profits that we keep losing the goal. I think that happened again this summer in America.

Q. You note that in both Switzerland and Taiwan, one of the drivers of their change was that "Liberal political parties stepped up the pressure for change to such a level that the conservative parties were unwilling to resist." Do you think that we're at that point in the U.S., or is that even going to be the driver in the U.S. as it was for the other countries?

A. Yeah, you're exactly right about the political dynamic. In both of those countries it was the lefty kind of democratic labor party that pushed for universal coverage, and in both Taiwan and Switzerland, the Republican, pro-business party saw that this was a popular initiative and grabbed onto it. In both countries it was in the end the Republican party that instituted universal coverage.

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That clearly hasn't happened in our country. Our Republicans have decided to oppose universal coverage, and there is not the wave of feeling in America that we want to have every American covered, and I think that's partly a matter of leadership. If a leader went around and said to the American people, "We want to be a nation where everybody who needs a doctor can have one," I think most Americans would agree with that, but since the argument was pitched in terms of "Hey, if you've got good insurance, don't worry," that made it a selfish issue. That made it about me, rather than about us, and the result is, we've lost sight of the us. We've just lost sight of the goal, which I think ought to be universal coverage at reasonable cost. There are a lot of roots to that goal. That's what my book says. It doesn't have to be government medicine. But you gotta keep your eye on the goal.

Q. I know you talk about it being more of an ethical argument than an economic one.

A. That's the main lesson of my round-the-world tour. In any country, the design of a health care system is obviously a medical issue, it's an economic issue, it's a political issue. But primarily, every country's health care system reflects its moral values. The design of a health care system is a moral question. If you make the moral decision, doggone it, we're a rich country, we're going to give health care to everybody who hurts, well, then you can do it. The United States, the world's richest country, has made a different moral decision. We've decided to leave tens of millions of people uncovered, and it's not an accident. This is the system that we've settled on, and this is the system we're going to end up with at the end of this process in Washington. Americans have decided they don't care.

Q. If you were going to give President Obama and Congress some key points to keep in mind about systems from around the world what would those key points be?

A. The key points would be, in the first place, universal coverage can definitely be achieved in the private sector, because I saw that in many countries. But in order to do it, a) you have to have fairly strict cost controls on the docs and hospitals, and b) you need much, much tougher national regulation of health insurance companies than we've ever had. Now, I think in our current bill, there is more regulation of insurance companies than we've ever seen. They're going to make them cover everybody, and they're finally going to make them stop cutting off people who've been paying their premium, but then get sick. I don't know if you know this, but in America, health insurance companies cut off people, they cancel your policy,

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if you get hit by a truck and you're going to be expensive. They're finally going to make that illegal. No other country would allow that.

And then the other thing that I don't think we're going to do, but all the other countries have done is to have one system for everybody. I mean, some have socialized medicine, some have private medicine, but everybody's in the same system. If you do that, you get huge administrative savings. There's one set of rules, one set of forms, one set of prices, and everybody has the same access to the same care, at the same price. It's just so much simpler and cheaper that it would save us, according to our government, it would save us hundreds of billions of dollars. President Obama has said "No, no, we're not going to make major changes in our system. We're just going to adjust what we've got," and as long as we do that, we're going to keep the administrative crazy quilt, the hugely expensive system we've got, but at least you could make it work if you were willing to put pretty strict regulations on doctors, hospitals, and insurance companies, which so far, we haven't been willing to do.

Q. Well, as a last question, I have to ask: How is your shoulder doing now?

A. I went around the world, and many, many different approaches. Lots of countries offered me a broader choice than my American did for different treatments, all covered by insurance. In Japan, the guy said, why don't you try acupuncture, and the woman twisted her needles in my left thigh to treat my right shoulder. It didn't help a bit, but it didn't hurt. It was kind of interesting. Why not try it? But in the end, mainly because of physical therapy around the world, I came home with more movement and less pain in my shoulder, so that was a win, and I came home convinced that we could cover everybody at reasonable cost. I know we can do it because all the other countries like us already do it. So I came away pretty optimistic on both scores at the end of my book.

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