(Music)

Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, there seems to be some good news from the census. Did you hear the figures that show a strong uptake in the number of young adults with health insurance?

Margaret Flinter: I did, and that seems like one part of President Obama's health care overhaul that's proven very popular and as the parent of one of those young adults who took that insurance, I can attest to that. Three different surveys, one by CDC, one by Census Bureau, and the other by Gallup found that health insurance grew by about a million young adults as families took advantage of that and you know Mark, for years the understanding was it was all low income families that weren't getting insurance but this proved there are a lot of moderate income families but their kids were graduating from college and had no place to go from an insurance perspective.

Mark Masselli: Well it is a dark cloud out there with lots of economic suffering and fewer young adults finding employment after college graduation. But this is actually the proverbial silver lining in a very dark cloud and it couldn't come at a better time for young adults. But while younger adults are getting coverage, the overall number of uninsured in this country still remains too high.

Margaret Flinter: And that is absolutely right. We will know though earlier rather than later I think if the Affordable Care Act will be able to live up to its full potential to provide insurance to almost every American. Earlier this week, the justice department decided it will ask the Supreme Court to rule on the constitutionality of the individual mandate early next year, and I think the Justice Department has said, it will forego an appeal to the Eleventh Circuit Court of Appeals in Atlanta which could have taken months and delayed the final decision probably until 2013.

Mark Masselli: Well, speaking of the uninsured and underinsured, our guest today is well-known for his work designing and studying health systems around the world that increase access to health care. Dr. William Hsiao is a Professor of Economics at the Harvard School of Public Health. You might also recognize his name these days because he is leading in the design of Vermont Single-Payer System. We are delighted that Dr. Hsiao is with us today.

Margaret Flinter: And no matter what the story, you can always find all of our shows and hear more about us by Googling CHC Radio.

Mark Masselli: As always, if you have feedback, email us at www.chcradio.com, we would love to hear from you. Before we speak with Dr. Hsiao, let's check in with our producer Loren Bonner with Headline News.

(Music)

Loren Bonner: I am Loren Bonner with this week's Headline News. The Obama Administration has asked the Supreme Court to review the legal challenges to last year's Affordable Care Act sooner rather than later. The Justice Department will forego an appeal to the US Eleventh Circuit Court of Appeals in Atlanta. Such an appeal to the court could take months and delay any final decision by the Supreme Court until at least 2013. The relaying is likely to come early next year. A new survey released to this week shows a surge in the cost of employer insurance. The Kaiser Family Foundation and the Health Research and Education Trust found that the average cost of a family plan was 9% this year. The results point to a sharp departure from just one year ago when the same survey found average family premiums up only 3%, on average family plan premiums hit around $15,000. While coverage for single employees grew 8% to roughly $5,500, workers paid an average of $921 toward the premium of single coverage and $4,129 for family plans.

Mark Masselli: Today, Margaret and I are speaking with Dr. William Hsiao, internationally recognized for his work on health systems design. He is the K.T. Li Professor of Economics at Harvard School of Public Health. Welcome Dr. Hsiao. You spent most of your career studying and designing health systems both here and around the world, and you are recognized internationally for your work so from Mexico to China and many countries in between you have been telling people about what the best system might be for them. Tell us here what America might do to improve its health system learning from others something that might improve our quality, increase our safety and control cost.

Dr. William Hsiao: The problem facing United States is not unique that's cost escalation and ensure people ask for quality of care. Other countries are actually walking ahead of United States. We learned throughout the world that you cannot get universal coverage unless you make it compulsory. There are roughly, even if you give subsidy to the poor people, there will be a large number of people who believe they are invulnerable and so they would not buy insurance and when they get sick or they get in an accident, they just become a free rider on the rest of the people, get ____ 5:27 care. So, all the middle income or the advanced countries have put in compulsory national health insurance other than South Africa. So if we want to be in the companionship of South Africa that's our choice. The second part is confirming cost escalation. The world only found one complicated solution; one is you have to change the payment system from fee-for-service payment system that encourages the physicians to do more regardless of medical procedure or test that's necessary or not, then their revenue will go up. The world has learned that you have to shift away from that

kind of incentive system to a case payment system and/or to a global budget system and United States is trying that but it's understandable hospitals and doctors do not like it and that's a political resistance we face. And we see that in other countries too so again it's not unique to United States. However, I think what's unique to United States is we have spent so much money on health care, we are denying ourselves to other public goods like better education or investment research and so forth. In terms of improved quality of care that's a tougher problem. First of all it's hard to define what's quality of care. It's a really nice term but it's ill defined and a great deal of quality of care cannot be measured. So the world, throughout the world, countries are groping with that problem with not really a radial good solution. We only have partial solutions like you pay people bonus if they do more prevention. let's say if doctors can help the patients to keep the blood pressure under control or if diabetic patients have better biomarkers. But that's only disease-specific, other kind of quality is hard to define and measure. But my basic message is United States can really learn a great deal from other countries and we do not have to put ourselves up as guinea pigs.

Margaret Flinter: Well Dr. Hsiao, I think that's a great lead into perhaps asking you about let's just take one country and let's take China though you have been involved as Mark said in so many. So you have this, an economic rapidly growing country that's trying to redesign care, redesign financing, improve outcomes and to do it hopefully without repeating mistakes of the past and other countries and to really forge some new territory. So maybe you could just share with us from your work in China what are some of the innovations in providing access to care and redesigning and refinancing the system there?

Dr. William Hsiao: First, China learned that to give people financial access to health care then you will have to have a universal health insurance. You are correct, China had very poor insurance programs even up to about 6 years ago but since 2003, China made a concerted effort to make social health insurance available to everyone. So by beginning of this year, China has 92% of the people covered under one of the three insurance programs they have and they aim to reach at least 95% if not 97% in another five years. So in a way China is ahead of United States in terms of insurance coverage right now. However, the insurance provider in China is quite shallow. Let's say they still require patients to pay 40% of the outpatient services or 50% of the inpatient services. So what China has to do is to expand its insurance benefit package to not only cover everyone but to give everyone a reasonable benefit package. That would solve the problem of financial access for the Chinese residents. Then China is doing something which is quite different from United States and other countries that is they are shifting their resources to basic prevention.

Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Dr. William Hsiao, K.T. Li Professor of Economics at Harvard School of Public Health. I am going to claim you as a Connecticut resident. Harvard might

claim you as one of the esteemed faculty there but you actually started your career right here in Connecticut as an actuary for the Connecticut General Life Insurance Company in Hartford, predecessor to CIGNA, and that led to your appointment as the Chief Actuary of Social Security Administration in 1917. You played a really important role in influencing legislation to bolster and preserve the social security system and you can't turn on TV and listen to a political debate without the long term financial health of social security Medicare and Medicaid being discussed. What advice do you have for the countries, the steps that it should take to preserve these important institutions with the focus in on those three Social Security, Medicare, and Medicaid?

Dr. William Hsiao: Social Security does not have a severe financial problem even in 30-50 years from now. It will have run into a slight deficit but by raising the retirement age little bit, by adjusting the inflation indexing for the social security benefit and control the disability program more stringently, the social security pension program can be put back into good health, financial health. This is a point that does not get emphasized in the newspapers. They lump social security with Medicare and Medicaid. Medicare and Medicaid is a totally different ball game. Health care cost is usually rising in United States 2% to 4% faster than our growth in "domestic product" or the rate of growth in our income. So it's taking away a larger share of our government's budgets, it's taking away a larger share of our household budget or it's increasing employer's cost for health insurance premium. That has to be controlled and some serious surgery has to be done. In my work, I show my true color with my working from Vermont. I believe single-payer system is a solution that United States should seriously consider although I do not underestimate the political resistance by the insurance industry, by many physicians and by hospitals because physicians and hospitals have a good living right now and just like the Chinese hospitals and physicians also have a good living, they do not want to reform. But the people who have to pay the bills are screaming. And the single-payer would demonstrate for Vermont that it can lower the, just as one shot, it can lower the health care cost by 25%. For United States as a whole that amounts to $600 billion a year and that money can be used somewhere else. That can increase household's income, that could reduce employer's health insurance premium, that could release fiscal pressure on the state and the federal government.

Mark Masselli: But you have laid out the battleground, it seems to be that we are going to take those out of the pockets of providers and out of the coffers of hospitals it sounds like and you have said that's a huge battle. Vermont got through it, you were part of that but do you see any group of hospitals and providers embracing these models.

Dr. William Hsiao: I think it requires a lot of public debate and education. Providers actually will not be hurt that much. The ones who get hurt are actually some super specialties. The physicians' net income, the physicians who are in private practice, the net income between specialties varies three times. For

pediatricians and general internists, their average income today is $180,000 to $190,000 a year net after their expenses. Some of the super specialties are making half a million dollars a year on average. It is the super specialties that will see a loss but not the average physicians, not the ones who have to use the thinking process to make the correct diagnosis on patient's illness at the initial stage. Hospitals can reduce their cost also by they do not have to lose their surplus; what a hospital would do is to reduce the carrying of the administrative clerks they have now to process insurance claims. So who are the ones who are going to be hurt? One is private insurance industry who offers health insurance, another are the administrative people who are handling the insurance claims, checking on patients' eligibility in different insurance plans and so forth. That means we have a responsibility to retrain these people for new jobs. And in Vermont we demonstrate, if the health care single payer is implemented, there will be new jobs created because the health care cost comes down so households have more money in their pockets to go to restaurants or buy clothing or buy cars and that would create additional demand.

Margaret Flinter: Well we are keeping a very close eye on the State of Vermont. We had Governor Peter Shumlin on our show recently talking about the Vermont move to single payer system. And that's been talked about so often in the United States and people say well it's just not possible, people won't go for it but we may have a chance to see this experiment in Vermont and we are going to be looking at it really carefully. And it seems to me that the issue even for the primary care provider is going to be is there a shift to paying just for the services and the procedures we provide or is it for the outcomes that we get. And you of course were a leader in developing something that's really only known to the health care people, the Resource-Based Relative Value Study or the RBRVS system. When you look back on the time in health care policy when you created that and today, how do you think we need to change our financing and payment systems to be much more focused on the outcome of the patient than just the service that we provide? Have you rethought that initial work that you did?

Dr. William Hsiao: Well the initial work I did was fee-for-service payment system. As I argued earlier, United States has to shift away from that payment method. United States has to pay physicians based on per person, per patient or per episode of illness or per case rather than for each item of service or each test you put forth. So I think the RBRVS should be ready to see its last days if United States shifts to a different payment method and that United States should pay physicians some bonus for patients' outcome. Right now, physicians are paid regardless if patients got well or did not get well. In China, there used to be a system that doctor only get paid when the patients get well. Well, if we can establish a system at least that doctors are recognized and compensated more if the patients got well rather than something was done to the patient, then I think the doctors will pay more attention on healing their patients rather than what procedure can I do or what other tests can I do on this patient.

Mark Masselli: Dr. Hsiao, we would like to ask all of our guests this final question. When you look around the country and the world, what do you see in terms of innovation and who should our listeners at Conversations be keeping an eye on?

Dr. William Hsiao: One of the most innovative countries actually in Asia, Thailand adopted a payment method which all the experts consider is the most innovative one, they combine paying per person with case payment and with bonuses. And China has dozens and dozens of experiments going on throughout the country on that. And England is the one which actually emphasized primary care and prevention which United States can learn great deal from. So I would say the emerging economies are experimenting more in their country which United States should pay attention to but for the industrialized countries I would say England is the most interesting one.

Margaret Flinter: Today, we have been speaking with Dr. William Hsiao, the K.T. Li Professor of Economics at the Harvard School of Public Health. Dr. Hsiao, thank you so much for joining us today on Conversations.

Dr. William Hsiao: It's my pleasure, thank you.

Margaret Flinter: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and every day lives. This week's bright idea pays tribute to the 50th anniversary of the anti-segregation Freedom Rides.

They were highlighting to me that other people wanted to ignore. We also want to highlight an issue that could get ignored if it wasn't for people pointing it out.

Margaret Flinter: Food & Freedom Rides organized by a group called Live Real continues this journey for justice but now with food as a focus. In the same way that Riders in 1961 worked to change the most urgent issue of their generation, racial injustice, Live Real seeks to do the same thing about our industrialized food system. 13 young leaders kicked off their road trip in August in Birmingham Alabama then traveled up the Midwestern states before heading off to the California Coast in early September. They traveled through eight states in total spreading awareness about America's broken food system and the impact that that has on health, on our workers and on the environment. The riders were not only teaching communities about federal food policy but they were gathering stories and innovations from communities that can inspire others. Honoring the Freedom Riders while at the same time focusing on this injustice and empowering a new generation of leaders, now that's a bright idea.