An Economist’s Perspective on the U.S. Health Care System: An Informal Conversation with Professor William Hsiao

Does Lipitor — $6 per dose in New Zealand — really need to cost $124 in the U.S.? Why are Americans charged up to five times more than patients in other countries for a colonoscopy or hip replacement? Why do just 40 percent of American medical graduates choose to practice primary care when the ratio is 60 percent in Europe? Can ethics balance profit to shape an American health care system that is equitable, affordable, and effective?

These were just some of the provocative questions that Professor William Hsiao invited students, faculty, and staff to explore on November 21, 2013, as part of the Harvard Global Health Institute (HGHI) “Informal Conversations,” a series of roundtable luncheons that invites dialogue on cutting-edge cross-disciplinary issues, exploring new ideas, challenges, and opportunities that impact global health. An internationally renowned expert and consultant on health care system reform, Hsiao is the K.T. Li Professor of Economics in the Departments of Health Policy and Management, and Global Health and Population, at the Harvard School of Public Health (HSPH) and currently Scholar in Residence at HGHI. His presentation at the roundtable conversation session was introduced and moderated by HGHI Faculty Director, Dr. Sue J. Goldie, the Roger Irving Lee Professor of Public Health at HSPH.

Answers to these tough questions are — not surprisingly — complex. National health systems are created by forces shaped not only by politics and the market, but also shaped by cultural values — and how those values are linked to health. While a country’s decision makers ultimately determine the balance of factors that shape a health care system, he noted, “Among all advanced economies, the U.S. relies most on the market.”

Procedure-based medical reimbursements often pressure young medical graduates into difficult career decisions based on income potential. For example, if you want to be a primary care doctor, but you know your income would be less than half that of a radiologist or surgeon, “and you have a debt — which specialty will you choose?” The resulting disproportion of specialists in the U.S. leads, studies suggest, to unnecessary and even contraindicated medical procedures that harm rather than heal. Nor does expense promise quality; the U.S. healthcare system overall generates worse outcomes and more health care
Hsiao’s perspective on the U.S. health care system is rooted in his deep understanding of how things work in other advanced economies. After some years supporting early efforts toward an American universal health insurance program, he said, “I had a rude awakening.” In 1991, asked to consult with top leaders in China on developing a national health policy, he was startled when the meeting began with a question he never encountered in American health care decision making. “Tell us,” the Chinese leaders asked him, “What is the nature of health and health care?” Only an answer to this question, they said, could equip them to decide how to best balance the roles of government and the market in developing a national health policy that would ensure basic care for everyone in society. “This is an ethical question,” he said.

Such egalitarian ethics contrast, he noted, with a libertarian philosophy that prefers individual rights over the idea that “I am my brother’s and sister’s keeper,” that is, the idea that one has a moral responsibility to one’s local and global neighbors. Tension between the egalitarian and libertarian perspectives generates sparks in the current American health care debate, especially as it relates to the role of government.

Since 1991, Hsiao has advised a number of other nations on health system reforms, including Colombia, Malaysia, Poland, South Africa, Sweden, Taiwan, Uganda, and Vietnam. He also continues to consult with government officials in the U.S. In 2011, for example, the state of Vermont commissioned him to design a single-payer insurance model that the state adopted later that year.

Students at the lunch had lots of questions. “You’ve talked about the U.S. and China,” said one undergraduate; “but what does this mean for trends in developing countries?” Indeed, said Hsiao, different issues influence different economies. A country that cares about ethics and is committed to equity may need to depend entirely on government funding for health if its private and NGO sectors lack the means for building basic health care services. But if such governments are ineffective or corrupt, developing the market or NGO sector may be the best route to universal health care. Building health care delivery infrastructure is essential; Insurance is useless, for example, if your village lacks a clinic. The biggest “bang for the buck” will come from making primary care a priority, financing the poor first, and drawing on local community health workers for delivery.

“But what direction can we take to make a difference?” asked another student. Is there really any hope for health care in America? Yes! While Hsiao is disheartened by the history of national health system reform in the U.S., he pointed to several hints toward optimism. “I observe that physicians are changing,” he noted, “And I have not observed a country that — short of revolution — is able to reform its health care system unless physicians agree.” More and more, doctors are choosing salaries over procedure-based profit. The medical profession can be a powerful lobby for change.

System agility offers another hope. Canada, for example, addresses inequities by shaping health budgets according to specific communities’ health status. Similar agility at the organizational level is one of the strengths of the U.S. system — “the strength of competition” said Hsiao. Let us use it to support the cultural, social, and racial pluralism of
America in a way that recognizes the tough ethical questions, and works toward equalizing health for all.

And be creative, he added. Discover high-impact, low-cost scientific interventions, or innovate at the community level, under the radar of health policy, then work up. Hsiao credits the successes of Vermont’s new policy to its effective bottom-up grassroots political structure.

Dr. Sue J. Goldie, HGHI Faculty Director, wrapped up the discussion by encouraging students in the room to take action informed by Hsiao’s wisdom and insight.

"Don’t waste one moment being quiet," she urged. "You can make a difference."

References:
