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Health Journalism 2008 – Day 2
Roundtable Session: Election 2008: Which way health reform?
The Commonwealth Fund and Kaisernetwork.org
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JULE APPLEBY: So when we were planning the conference, I said to Len, I said, hey, let's do a session on health policy, that'll draw a crowd. And he sort of hedged the bets and said, let's throw in lunch, so [laughter] in the rare tradition of Washington, here we are. We've had lunch, and we're going to talk about health policy.

I want to welcome you all here. I'm Julie Appleby, I'm with USA Today, and I cover health policy and health business, and various sundry of other things that have the word health in them. When I first started covering health care a number of years ago, I wrote about a gentleman named Albert Serrano. And Albert had the misfortune of ending up in the hospital with a disease that they thought was going to kill him. And he was uninsured, and he was in a county hospital.

And it was at a time when states and counties were struggling with their healthcare budgets. They were struggling to try to find a way for pay for things. Employers were facing double-digit insurance premiums. The nation had a rising number of uninsured, and people were worried. And Albert actually ended up on a television show. And the first night home from the hospital, he actually survived. Nobody thought this guy was going to survive.

And he ended up home from the hospital on the first night and he saw this television show. And he was actually

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featured in this show. And it was a show about how can we decide what to do with, how can we take our limited resources and spread them around appropriately?

And the message Albert got back from this was, and he cried when he told me this. He said I felt like they had put a price on my life, and had said if I had just died, they could've hired a bunch more nurses. And this was back in 1989.

So fast-forward to now, it's almost twenty years later. We've got states and counties wrestling with how to pay for healthcare. We've got employers facing rising health insurance premiums. We've got a growing number of uninsured. And in the meantime, we have had one attempt by a President to do a major overhaul, and that didn't go very far in Congress, as you know. We've had the rise of HMOs, and we had the backlash to HMOs.

We've expanded SCHIP, and we've added a drug benefit to Medicare, and we still have all these issues. We still have all these challenges. Those challenges, the uninsured, rising costs, along with many Americans who really fear and worry that they're going to lose their health insurance have helped bring about a new debate in Washington about health reform.

And it's not just in Washington. Actually, most of the action, as you probably know, has been in the states. But it's been talked about here again in Washington. And it's certainly an issue on the campaign trail that we're going to hear about and have heard about. And many of you are going to be writing

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about these topics, as you go back and writing and producing shows.

So we've brought together these four panel members today, to talk about health reform efforts and how they could affect your readers. And these four experts have philosophies that pretty much cross the political spectrum, so we're going to try to give you an overview here of what's going on.

These are enormous challenges that defy easy solutions, but since we're limited on time, I have asked each of the panel members to limit their first response to three minutes. And I've asked them in three minutes, if they could describe what they see as the best solution for the challenges facing us right now.

So we're going to start that way with three minutes from each of them. And then I'm going to start us off with a few questions. And this is a pretty opinionated group, so I imagine they may be tossing some questions back and forth to each other as well. So we're going to try to get a little debate going here. And in the last twenty minutes or so, we're going to open it up to questions from you.

And I think there's a couple of mikes somewhere here in the room. There's one back there. We'd like you to use those mikes, because we are recording this session. So you'll be able to ask some questions, and the panel members will be able to respond.

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So let me briefly introduce everybody. David Himmelstein, over here on my left, he is an associate professor of medicine of Harvard Medical School, and he's the founder of Physicians for a National Health Reform, which is an association of physicians that promotes a single payer, Government-run health system.

Karen Davis is President of the Commonwealth Fund, a foundation that supports independent health and social policy research, and it also promotes changes to the healthcare system to improve quality and cover more people.

Julie Barnes is deputy director of the Health Policy Program at the New America Foundation, which is a non-profit group that promotes bi-partisan agreement on health reform efforts. And on the right is Tom Miller, who is a resident fellow at the American Enterprise Institute, which is a conservative think-tank here in Washington that promotes free market reforms as a way of expanding coverage.

So starting with David, each of the panel members are just now going to take three minutes to outline what they see as solutions to these challenges facing our healthcare system. And it's my job to cut you off if you go over the three minutes, which I'll try not to do. So David, if you will.

DAVID HIMMELSTEIN, M.D.: Should we stand, or—

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JULIE APPLEBY: You can just sit there. And we're going to have a little conversation. So if your mike is on, and we'll just have that.

DAVID HIMMELSTEIN, M.D.: Can you hear me okay? Okay. I'm a primary care doctor at the public hospital in Cambridge, and I've spent thirty years taking care of poor people who can't get care in other settings. And started my career, actually, in research with a study looking at patients dumped from private hospital emergency departments, the first study ever published on that, that led to the federal legislation banning patient dumping, and that was really my introduction to the grave problems in our healthcare system.

And more recently, I've come to understand that it's not just the uninsured who have grave problems, but those with coverage. So my colleagues at Harvard Law School and I recently published a paper looking at medical bankruptcy, finding that about half of all bankruptcies in this country are caused at least in part by medical bills or illness. Three quarters of the medically bankrupt had insurance, at least when they first got ill. And that informs my perspective as well as we need a reform that helps the insured as well as the uninsured.

The other major thing that informs my perspective is, we have sufficient resources in the healthcare system at present to take care of every American, to provide superb care

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to everybody in this country for what we're now spending, if we actually spent it wisely. So we spend enormous amounts, \$.31 of every dollar, according to studies my colleagues and I published in New England Journal of Medicine, 31 cents of every dollar being wasted on health administration, versus 17 cents in Canada. And the difference translates to about \$350 billion each year in useless bureaucratic costs.

So what I propose is, what used to be called national health insurance is now referred to as single payer national health insurance, essentially get rid of the insurance companies that provide no added value to our healthcare system, and drain about \$80 billion in unnecessary overhead. We know that overhead in a public system would cost about \$80 billion less for just insurance overhead. And the paperwork they inflict on doctors and hospitals would save us another about \$270 billion.

We could eliminate virtually all hospital billing, virtually all doctor billing complexity, as they've done in Canada. And it's clear this is doable now. We already spend twice what Canada does per capita, and if one is willing to keep spending at that level, one would have a Canada Deluxe System, without the waiting lists and shortages in some forms of technology that Canada has suffered. And you could readily provide care to every American, not only to the uninsured, but to upgrade coverage for everybody in this room.

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Nobody in this room, I suspect, has coverage as good as the average Canadian enjoys, or people in most other nations. So we have something to offer most Americans. We can't offer Jack Rowe, who is the President of Aetna, the \$250,000 a day he made while he was President of that firm. But we could offer job re-training and placement benefits to the million insurance workers who are currently employed doing useless activities.

We have—

JULIE APPLEBY: David, unfortunately, three minutes are up.

DAVID HIMMELSTEIN, M.D.: Okay. [Laughter].

JULIE APPLEBY: And hopefully [laughter], it's a tough crowd [laughter][applause]. But we're going to get a chance to come back and ask some questions. So Karen, if you could please have your three minutes.

KAREN DAVIS, PH.D: We agree on the problem, so I'll try to lay out a somewhat different solution. I think we're on the wrong track. We have growing numbers of uninsured. Certainly we pay more than any other country and get less for it. As Julie mentioned, the Commonwealth Fund is committed to trying to lead America to a high-performance health system. And we have a commission dedicated to doing that. And they've laid out five strategies for an ambitious agenda for our next president to really get at the root of some of these problems.

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The first is simple. It is, cover everyone. So I'll come back to that if I've got minutes left. But that's got to be a part of any health reform. But it's not enough to do coverage alone. So the second, we've got to deal with the cost problem. And we've focused primarily upon reforming the way doctors, hospitals, other healthcare providers are paid.

Third, it doesn't do any good to have an insurance card if you can't get care, if you don't have a regular source of care that's accessible to you. So the commission recommends moving toward a more organized healthcare system, whether that's a patient-centered medical home, or networks of doctors and hospitals that are accountable for your total care, and that are accessible to you 24/7, and help you weave your way through the healthcare system that coordinate care.

The fourth solution is really narrowing the variation in quality and efficiency, and bringing everybody up to the highest level care that is possible to provide. We all know there's wide variation, but we haven't invested in the information technology, the public information, the quality improvement activities, the chronic care disease management activities that it really takes to not only narrow that variation, but to get everybody up to what is the best that's achievable.

And finally, we need national leadership. That's why this election is so important. And we need the public and

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private sectors working together. So rather than abolishing the private insurance industry as David as recommended, we're really looking for a way of getting collaboration between the public and private sector to move to high performance.

Quickly, on coverage, obviously covering everybody is the most important. The commission feels like a mixed public-private insurance system is the probably, the most practical way to go, and would, in fact, achieve many of the goals that it is important to achieve. We believe in shared responsibility, including employers continuing to either provide insurance, or to help finance coverage. And that's an important difference across the presidential candidates. We particularly believe that private insurance, while it should stay in the game, should take everyone, so eliminating some of the practices that lead them to discriminate against the sick.

So it's a historic opportunity with a light at, to see a major issue of this election in the light of people.

JULIE APPLEBY: Thank you. And Julie?

JULIE BARNES: I'm Julie Barnes with the New America Foundation. The health policy program at the New America Foundation, which is a non-partisan--which is a big word in this town, non-partisan--non-profit that is concentrating on national healthcare reform, and making it happen. We have a mission at the Health Policy Program, and our mission is to

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preach hope, and dispel fears about the possibility of national healthcare reform.

It can happen, it will happen, but most importantly, it must happen. So I start by imploring all the journalists in the room to include the solutions in your reporting of the problems. We need to not be negative. We need to be positive about national healthcare reform happening [applause]. Hey, everybody with me? [Laughter] I'll get out the pom-poms later. But that is our mission, and here's what we think.

We think we need to cover all Americans. We think we need to reduce costs, and we think we need to improve quality. These are not new ideas, but here's what's different. We want to do it comprehensively. These are not incremental reforms. Coverage, cost and quality are inextricably linked. I will give you one example, because I only have three minutes.

If you cover everyone, we will have a financial crisis as the system currently is set up. We need to, for instance, change how we pay doctors so that we are not paying them based on the quantity of care; we're paying them based on the quality of care. Can you imagine if we paid doctors based on how much time they spent with the patient, based on coordinating their care across the many specialists they may seek? If we reimburse them to follow up with a phone call to make sure they're getting the treatment they were supposed to get when they left, and they're taking the prescription drug that they

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were prescribed when they left, which we're not, right now, we're told, can you imagine the costs that would be reduced as a result of the second visit not happening, or the in-patient visit not occurring because we were paying based on quality, not quantity. We would even, I would opine, have happy doctors, because they would be getting back to the business of quality of care.

So we cannot cover everyone without reducing those costs. And we can reduce the costs by improving quality. Don't let anybody tell you different. Anybody has any questions, go to our website, the research is there. The second thing I want to say, do I have time, five seconds? [Laughter]. Julie Appleby wants us to solve the healthcare crisis in three minutes. Go. [Applause]. I am from USA Today, so we're brief. [Laughter].

JULIE APPLEBY: Thank you, though. That was very good. One more thought, we'll give you five more seconds [laughter].

JULIE BARNES: Five more seconds. It cannot happen unless it's a bi-partisan approach. When we review proposals, and there's so many of them out there. Whether it's a state reform, a trade association proposal, or a Congressional proposal, the very first thing we do is, we look at whether or not it can garner bi-partisan support, or whether it has bi-partisan support.

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If we do not get sixty votes in the Senate, we can ram something through with one party, and it will not be sustainable. We need to protect whatever reform we have in place from repeal and from attack later on. So we don't want a two-year plan, we want a sustainable plan.

JULIE APPLEBY: We're going to get to that.

JULIE BARNES: And that's my fifteen seconds for thought.

JULIE APPLEBY: Thank you. [Laughter] That was good. That was good. And now Tom, you get the last three-minute session here.

TOM MILLER: Thank you, Julie. And while I'm taking up this [inaudible], I'll remind you to split my remarks [laughter]. Solutions begin with framing the most important problems. We need opportunities; most of all we need to strengthen the incentives and capabilities producing more efficient, higher value of healthcare and better health outcomes.

We need to re-balance our health-investing portfolio. Public policy and private [inaudible] focus less on a standard of quantity in care and coverage, inviting over the political distribution of healthcare dollars. And more on relying incentives, improving accountability, facilitating meaningful competition, and producing more actionable information instead of healthcare choices over more extended time horizons.

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No matter how much we collectively admit to pay for healthcare services to various private and public intermediaries, we would begin to achieve a sustainable value-based healthcare system, until we improve the upstream and downstream factors. We've been hearing no healthcare spending, long-care health outcomes. What's upstream? The population has to become and remain healthier before it reaches the doctor's office or the hospital, in case that's in the interest of health, would not directly increase the health delivery system.

Downstream, healthcare providers would be measured on the efficiency and effectiveness of their performance, and rewarded accordingly. It's the comparative efficiency that is actually delivered by accountable providers and healthcare teams in practicing matters, much more than is theoretically best compared to the effectiveness of any given treatment protocol or reimburse healthcare service or product.

What does this mean in terms of public policy reform? More public and private investments in primary prevention, early education, navigational assistance and decisions for it, less on the illusion of standardized, comprehensive health insurance coverage. It doesn't, at the end of the day, deliver as much value as it pretends to do. Change our policy by, as it relates to regulation and mandates, including more valuable

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information of accountable choices, and level playing field competition.

Second, facilitate and enhance healthcare aggregation information. What we currently have available to use rather than what we imagine. As a public good available for competing intermediaries with [inaudible], consumer preference-weighted measures of comparative provider performance.

Third, reduce our current distortions to the healthcare marketplace, led by public policy, without adding new ones to the list. On the margins, less third-party payment, and workers [inaudible] for control, targeting acceptance for those most in need. We're giving up on the illusion that everyone else will pay for someone's healthcare costs. More equity in planned subsidies for all purchases of healthcare, distinguishing coverage cooling off between simple risk-averaging and risk-reduction. It's the latter, which changes costs for us.

Finally, let's inject some humility and skepticism into our discussion on how much changes in public policy can transform the evolution of our healthcare system. We could do more harm than we've done it before. But doing more good will require the more decentralized, incentive-compatible patient-centered actions of everyone. Focus on producing better health outcomes and lower costs. Thank you.

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JULIE APPLEBY: That was three minutes, thank you [applause]. Very nice. Okay. Let me start out, and this is a question for all of you. And I want to, again, be brief, because this is sort of a theme here today. But briefly, each of you, we'll start with David and then we'll move it around a little bit. What is the single biggest impediment to healthcare reform?

DAVID HIMMELSTEIN, M.D.: Single biggest impediment is the firms that are making hundreds of billions of dollars in revenues out of the current healthcare system. So Jack Roe doesn't want to give up his \$225,000 a day. The drug industry, which makes three times the average profit of a fortune 500, is loathed to give up the billions in excess profits that it makes from our-

JULIE APPLEBY: Okay, so it's corporations.
Corporations are in the way.

DAVID HIMMELSTEIN, M.D.: -so called competitive healthcare system. And you even have Jim Roosevelt, who's likely to decide who's the nominee of the Democrats; he's the chair of the Credentials Committee of the Democratic Party. And his daytime job is the CEO of an HMO.

JULIE APPLEBY: Okay, so that's David's thoughts. Tom, what do you think? What is the single biggest impediment to healthcare reform?

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TOM MILLER: Thinking it is someone else's job to improve the healthcare we receive, rather than our steps to lead us to reform.

JULIE APPLEBY: So we need to have more individual responsibility is what you're saying.

TOM MILLER: Individual responsibility. Healthcare is over-regulated, over-politicized, and over-subsidized. Unlike many other sectors, the reason it hasn't been transformed the way many other industries or our economy have been, is because they always think it's kind of some third party's answer.

JULIE APPLEBY: So it's somebody else, somebody else's problem to solve. Karen, what do you think? What is the single biggest impediment to healthcare?

KAREN DAVIS, PH.D: I'm an economist. I think the biggest impediment is how we're going to pay for it. So what it costs and if it pays, I think there's a fair of understanding. In terms of federal budget costs, it's going to cost about \$100 billion a year. So where do you find that money?

Some work we supported, called Bending the Curve, shows you could get half or a bit more than that, if you're willing to use the power of government to really transform the healthcare system. That means comparative effectiveness with real teams, if something doesn't work, insurance plans won't cover it. And they won't pay more for something that costs more than something that's equally effective.

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JULIE APPLEBY: So it's costs. It's getting a handle on the costs.

KAREN DAVIS, PH.D: So comparative effectiveness, investment in information technology. I agree with Tom on public information and transparency of information. You're still going to have to come up with a third of the dollars. And so that's going to mean getting serious about new revenues. And I don't think the candidates have really focused on this.

JULIE APPLEBY: Okay, so that's the big impediment. What do you think?

JULIE BARNES: I think we can't have a fast enough conversation.

JULIE APPLEBY: What do you mean by that?

JULIE BARNES: I mean, everyone needs to have a conversation, and I mean everyone. The insurers, the employers, the unions, the consumers, the doctors, the hospitals and the policy makers, need to have about a year long conversation so we can get our acts together so we can coordinate and collaborate and have one message to present to the next President of the United States what it is we need to do.

KAREN DAVIS, PH.D: And Julie, let me follow up with this one. Presidents from Truman to Nixon to Clinton all have proposals for universal health coverage. With the exception of Medicare and Medicaid, most major health reform efforts have failed. What makes you think it can happen this time?

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JULIE BARNES: What's different this time? Great question. It is so different this time.

KAREN DAVIS, PH.D: That wasn't a plan. [Laughter].

JULIE BARNES: The difference this time is we're not writing a legislation proposal in a room with a closed door. There are numerous proposals out there, and people are coming together. Strange bedfellows, you notice the unions and the employers are coming together, and things called, like, Better Health Care Tomorrow. There are all sorts of coalitions that are happening out there in the marketplace that represent different stakeholders that I just mentioned, and trying to figure out what they agree on, what the sticking points are and what our coordinated message will be to the public and to the policymakers to make it actually happen this time.

That was not happening in 1993-94. That conversation was not happening. That conversation, that's exactly what the New America Foundation is attempting to do, is be part of that coordination effort, bringing together the research to back up the message for why it's important, and then sell it to the stakeholders, here's what we've got for you, here's what we've got for you, here's what we've got for you. It's a public-private collaboration. But if we don't have that conversation and get our acts together fast, convince the Hill, this is what you need to be saying, and then present the book.

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JULIE APPLEBY: See what happens. Tom, what is different now? Or do you think healthcare reform is going to happen in the next few years?

TOM MILLER: What's different now is that we have two more years to exhaust all of [inaudible] and go through some [inaudible] here in the past before we move on to the solutions.

JULIE APPLEBY: So you don't think it's going to happen for a couple more years.

TOM MILLER: No, I don't. But I think that we're asking better questions, as opposed to questions we asked in the past. We're forgetting about that in the middle of this health policy debate, where we're going back to older solutions, as opposed to moving ahead and planting one on the ground that will work better.

JULIE APPLEBY: Karen, there's been a lot of talk on the campaign trail, and this also comes out of the whole Massachusetts thing. And we've got some differences between the Clinton and the Obama plans on the individual mandate. And that means, do we require everybody to have insurance, if we're going to require insurers to sell it to everybody. Do you think we can reach this goal of universal coverage that you have without requiring individuals to purchase or to have insurance in some fashion?

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KAREN DAVIS, PH.D: Well, I think we'll probably never get to 100-percent coverage, but I think it's important to try for that, and to at least have near universal coverage. And that's first and foremost, putting the dollars on the table that make the premiums affordable. It's secondly having administrative mechanisms that make it very easy to get signed up. My favorite is to do it through the tax system.

So you file in April, in a couple of weeks, and you certify whether you've got insurance or not. And if not, you're going to have to pay a certain percent your income towards that coverage. Be given choices, like in the federal employee's health benefits program.

JULIE APPLEBY: Some people aren't going to like that. They're going to say wow; they're making me buy something I don't want to buy.

KAREN DAVIS, PH.D: Well, I think it's, we're never going to get to a high performance health system until everybody's covered. The single biggest determinate of whether people get care is whether they have insurance. So half of the population doesn't get preventive care, not up to date with preventive care. We've got a half to two thirds of the population that don't have chronic conditions controlled.

And when you look at study after study, why those failures? To achieve the kind of health outcomes that other

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countries achieve. It's because we leave out significant parts of the population.

JULIE APPLEBY: So mandates are one thing. Now Tom, on the Republican side, there's a lot of talk about the tax system and tax credits. But critics of tax credits say they really are only going to help, I don't know, a few six, seven million people of the 47,000,000 who actually go out and purchase coverage. What is the reason the tax credits are sort of the main proposal being offered by the Republicans if it's going to cover so few people?

TOM MILLER: Different vending machine. Republicans like to do it through the tax slot. Democrats would do it and stand aside. At the end of the day, we can re-target that system to pick up what we've kind of been leaving out.

JULIE APPLEBY: What do you mean by that? How do you re-target a tax credit, what do you mean by that?

TOM MILLER: Well first off, I mean there are different versions. Whether we do kind of a flat-type tax credit that means it ends up being in favor to those who are lower income. With the way we're covering taxes.

JULIE APPLEBY: You mean like a refundable one. So even if I don't pay taxes, I would get some kind of a tax credit?

TOM MILLER: Everybody gets a fresh hold of necessary assistance, but people are who not, even more, if they have lower resources. That's the way it works on the tax system.

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But at the end of the day, no matter what we do with tax subsidies, and part of those tax subsidies produced result in higher cost of care, higher cost of insurance and its relative value. So that's great thoughts.

We're chasing after a moving target we can't catch up with. No matter how much we tax ourselves to pay for this care, as long as it continues to grow at a rate faster than the economy, and those revenues we're supporting, you're chasing after it the wrong way.

JULIE APPLEBY: So we'll never cover all the uninsured unless we get a handle on the cost.

TOM MILLER: Well, if you want to get a handle on the cost, you want to get a handle on the value. It's fine to pay more for health care if it's worth it. It's the mismatch between what we spend and what we receive that's the fundamental problem. If people want to spend half their income on really great healthcare, and it's necessary, that's fine. But they need to see it more transparently, and not overspend for it. Because we cannot subsidize everyone to pay for something that's growing faster than the economy's growing, and think we're going to catch up with it.

JULIE APPLEBY: David, you've talked a lot about you don't think mandates or tax credits will work. Why is that?

DAVID HIMMELSTEIN, M.D.: Well, we've actually had the concrete example in Massachusetts, where we have a health

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reform that's very much like what Mrs. Clinton proposed in the optimum circumstances, a low un-insurance rate, a wealthy state with a solid economy when the thing was implemented. And it's already falling apart. In fact, we've covered probably less than half of the uninsured, costs are far higher than were forecast, and there's already talk of repealing the thing, because it's unaffordable.

And basically, you can't afford it because we've left \$6,000,000,000 in administrative costs on the table, that a reasonable reformation, reform of the healthcare system would get. We're still paying \$0.12 of every healthcare dollar to our health insurance companies. We're still paying hospitals and doctors for enormous amounts of bureaucracy, and we have no mechanism for health planning.

So we have a proliferation of technology so that people are getting CT scans who have no need for them, and getting the equivalent of five hundred chest x-rays each time, causing a one in two thousand chance of a fatal cancer. Because that's profitable for the radiologist and for the institutions that are building those.

And we have no mechanisms for confronting those. The things Tom suggests as ways to approach these are, frankly, just meaningless. Half of the country has insufficient population density to have conceivable competition in healthcare. A town's only hospital will not compete with

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itself. The only neurosurgeon in a region will not compete with herself. Karen's group has shown in the existing tax credit program, which we have for displaced workers, 80-percent or more of the total dollars in that tax program, tax credit program, have gone for the overhead of administering that tax program.

So what he's suggesting is actually adding more administrative complexity and cost. We already have the most competitive—

JULIE APPLEBY: So Tom—

DAVID HIMMELSTEIN, M.D.: —healthcare system with the highest out-of-pocket costs in the world.

JULIE APPLEBY: So David's saying—

TOM MILLER: That's not true.

JULIE APPLEBY: —your program's not going to work.

TOM MILLER: Well, let's just get a couple of facts on the table as opposed to allegations and surmises.

Administrative costs. Look at the official data that the CNS reports. 14-percent is the private share administrative costs of record, not your inflated figures. 7-percent [interposing]—

DAVID HIMMELSTEIN, M.D.: Tom, I'm actually quoting 12-percent, but you're ignoring the paperwork they inflict on doctors and hospitals. And the overhead that I'm talking about, it's the targeted tax credit for displaced workers. And in that program, 80-percent or more of federal spending has gone for

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the administration of that program. There's clear documentation on that, Tom.

TOM MILLER: I'm making no case where that the people are in the tax credit program. Now let's talk about another thing you put out. We have the highest health costs in the world? Take a look at OECD data. We are actually below the average of OECD countries, in terms of out-of-pocket costs. Your numbers just are not fair. They're nice theories, just not in reality.

DAVID HIMMELSTEIN, M.D.: As a percent, but not as absolute Tom. And actually—

TOM MILLER: Oh, absolute numbers. Those numbers don't mean anything if you have a larger economy and higher costs. It's the percent of what you spend, not the dollars.

DAVID HIMMELSTEIN, M.D.: Now as a percent of income we have the highest spending.

JULIE APPLEBY: So this is why health reform is so difficult [laughter] and why we're going to have a lot of conversations about this in Washington.

MALE SPEAKER 1: They're talking.

JULIE APPLEBY: I was going to say.

KAREN DAVIS, PH.D.: It's very good. We're talking to each other.

JULIE APPLEBY: It's a conversation. See—

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KAREN DAVIS, PH.D: We're having the conversation that Julie's group wants us to have.

JULIE BARNES: Now I can tell why we're sitting where we're sitting. Is it single payer or nothing? No candidate is proposing a single payer plan.

DAVID HIMMELSTEIN, M.D.: Well the problem is, it's single payer or nothing that worked. So when, in 1988, Mike Dukakis passed a mandated health reform in our state, which was an employer mandate plus an individual mandate on the self-employed. Our group said, nice sentiment, won't work. Two years later, there were more uninsured in the state of Massachusetts than there were when that bill was passed.

In 1993, they did that same thing Oregon. In 1993, they did the same thing in Minnesota. In each case, there have been more uninsured two years after the reform was passed than the day the reform was passed. We've had another attempt in Massachusetts.

JULIE APPLEBY: So basically, you're saying it is single-payer or it's nothing.

DAVID HIMMELSTEIN, M.D.: I would love an alternative to work. It can't work.

JULIE APPLEBY: Karen, do you think there is an alternative to?

KAREN DAVIS, PH.D: I think the lesson to be learned from Massachusetts is that states can't do it alone without

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federal help. I think, in fact, Massachusetts has been a success. In eighteen months, they've enrolled 300,000 uninsured people out of a total of somewhere between 450,000 and 600,000, depending upon which data source you look at. The only reason costs are high is because they've done a fantastic job of enrolling 300,000 people.

In fact, they've held premium increases to about 5-percent a year. I know a lot of states throughout the country would like that. So where you're getting the problem is, when you hit a recession, states are not in a position to take care of the increased numbers of lower income people, and the people who lose their insurance because they lose their jobs. So, I think what we do need is national leadership. We need a federal strategy.

And I think the thing, the connector in Massachusetts has worked very well. The things that are in some of the candidate's plan is to also offer a Medicare-like product. Now that's something a state cannot do. But, rather than something as impractical as saying everybody's got to give up their coverage, we're going to go into a brand new system, if you give people the choice of a good public program like Medicare, that has low administrative costs, 2-percent, not 14-percent, that has lower provider payment rates, you'll find many people will find that premium more affordable.

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Whether it's with a tax credit of \$5,000 per family that Senator McCain has advocated, or a tax credit that protects you from anything over 10-percent of income, as Senator Clinton has recommended.

Give them premium assistance using the tax system, but give them the option of coverage under a public program. Don't require that everybody move into a public program. Just give it as an option.

JULIE APPLEBY: So you're saying it's an option.

DAVID HIMMELSTEIN, M.D.: But it's worth just saying, in Massachusetts, as a primary care doctor on the ground, a lot of those folks who have been supposedly covered have been given cards that are virtually useless. They have co-payments and deductibles so high, the patients can't possibly afford them.

And they've just tripled them in the second year of the program for the near-poor, so that it's now fifteen bucks every time they want to go see a primary care doctor. And I can tell you; we have patients in the hospital, because they can't afford the outpatient care that's supposedly covered under that premium.

I admitted someone a few weeks ago with asthma because they couldn't afford their asthma medication. We have a fake program in place.

JULIE APPLEBY: Julie, you were talking about how we can't do this incrementally. Why not? Why not let states like

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Massachusetts and other states try things and let's see what works? Why can't, why is it not?

JULIE BARNES: Massachusetts is an excellent example of why they have done all the right things, and they still are stopped short of covering all. The main problem in Massachusetts, to be fair, is they miscounted the uninsured, they have fired the contractor now who had miscounted the uninsured. They're going back to Census Bureau statistics, and now they'll be set to provide enough subsidies, which is the cost problem going on in Massachusetts.

And I agree with Karen, it is much more a success story than anything else. They tried to do comprehensive care. They also, unlike every other state in the union, had an uncompensated care pool of money from which to draw. And they had a very low, they have a 5.7 uninsured rate right now. They have an incredibly low uninsured rate.

So they were able to do some of those things. But the reason why you can't do just coverage, is because they're coming up against cost issues. You have to reduce the cost first. And you have to subsidize enough so you don't run into Dr. Himmelstein's problem of having people who can't afford their asthma.

So you have to, and Barack Obama has made this famous, you can't have a mandate unless it's affordable. We're not going to force Americans to buy what they cannot afford, and

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make them go from rent decisions to healthcare decision. No one thinks that's okay. We have to be very, very careful about how we set up our program and our subsidies so they're sliding scales that make sense.

Some states have done this very successfully, although in much smaller slivers than Massachusetts. Look at Indiana. They've got charts and graphs about how they're going to subsidize this person and this person with this income, and this family with this income. And they've thought through that. But they have done it for a very small window of folks, because they cannot cover everybody, because they are a state with very real budgetary crises.

Medicare will drive payment reform. That's the federal government's job. So if we're going to reform payments system and how we pay our doctors, we are going to be looking at Medicare and doing it from the federal level. So there's only so much that we can ask states to do, although they're being incredibly innovative. And I would ask the journalists to go ahead and explore the solutions that are going on in your states.

And if they're not in your state, look at the state next door, because there are some incredible things. I was just at the National Governor's Association yesterday. They're doing some incredible things across the country to try to solve

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this problem. And they're trying to solve the problem because they can't afford not to.

It's causing more problems and more weight on the system and their emergency rooms, and their public healthcare clinics than it is to insure those folks, and to offer the subsidy.

JULIE APPLEBY: So Medicare is going through, we have a war going on, state budgets are tight, and we're headed into an economic downturn. Where's the money for all these subsidies going to come from?

JULIE BARNES: Oh, we've got the money.

JULIE APPLEBY: Where's it going to come from?

JULIE BARNES: [Laughter] We've got the money.

DAVID HIMMELSTEIN, M.D.: Well, that's why the single payer actually makes sense; that there is enough money in the healthcare system. But you've got to take it out of something that's useless at present. And the only way to do that, the only way to do that is to say we're not going to pay for the million people doing useless jobs.

JULIE APPLEBY: [Interposing].

DAVID HIMMELSTEIN, M.D.: And there's a fantasy that we're going to manage care better, and the disease prevention. Actually, studies show that when you prevent obesity and you treat tobacco addiction, you raise healthcare costs, because those people live longer [laughter].

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JULIE BARNES: And if single payer was palatable to the American people, and the insurance industry didn't stop it from happening, we might agree with you.

DAVID HIMMELSTEIN, M.D.: Well, it's palatable—

JULIE BARNES: But it's not. It's not going to happen. Let's be for what's going to happen.

DAVID HIMMELSTEIN, M.D.: I'll quote Julie's paper in this. USA Today poll shows that 62-percent of Americans favor a single payer program like Medicare, paid for out of taxes, covering all Americans, for all necessary medical care. So the barrier is not [applause], if I can ask people. Can I ask? Is there anyone who won't expect an embargo in this room? [Laughter]. Survey coming out next week showing that 62-percent of American doctors favor single payer national health insurance.

More than the proportion who favor lesser reform.

JULIE APPLEBY: Do they favor that if their salaries will be fixed by that government system?

DAVID HIMMELSTEIN, M.D.: Surveys show that doctors are prepared to give up 10-percent of their current incomes in exchange for a marked reduction in their paperwork. So, yes, the answer is, is yes, they would even do that. But not unless we're actually doing something that helps our patients, helps our society, and lets us get back to practicing medicine. And

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stop being business people, and cogs in a giant commercial machine.

JULIE APPLEBY: All of these ideas for saving money are very interesting. When it gets down to it though, don't we also have to start talking about how much we can afford, in terms of new technologies and et cetera. Let's say we've got a new drug that will add four weeks of life, but it costs \$30,000. Let's just assume for a minute that everybody is covered. Do we still need to decide whether or not we use that drug. Tom?

TOM MILLER: Well we only need to decide if we think there that someone else should pay for it, if it didn't cost us anything. And of course there are going to be areas that are going to be infinite. But we're kind of looking in, kind of in this usual pigeon hole, of let's round up the money, and let's kind of tell people what they're going to do.

And if we take enough hostages, we can kind of reorganize the system. Instead, we need to respect the fact that different people are going to have different needs, different preferences, different resources. We can help people are at the bottom of the ladder, to assist them because they can't help themselves.

But we can't subsidize everyone and think we're coming out ahead on volume. Looking at those losses.

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JULIE APPLEBY: And if we go to a tax credit thing, wouldn't that require a lot more people going to the individual market? And what are we going to do to help those people in the individual market actually buy coverage if they have minimum?

TOM MILLER: Well, we could regulate the individual market less rather than more [laughter], because it turns out that everybody functions better in that circumstance than some states have done that before. But in addition, there are other ways to pool individuals in a kind of non-group group market, outside of the employer workplace. But you should get more creative about it if you wanted to do that. If there's demand for it, you've got a different customer base.

Right now, the individual market, it is a residual. But if you can fill in some of the cracks of what it is, then gradually it should be an employer-based market. But let's kind of catch up with a couple other things that have been going on here. We talk about kind of capping people's exposure to out-of-pocket costs or the premium.

The Clinton proposal today. Think about that. 10-percent of your income should go for your premium, right now the standard family policy, and using the *New York Times'* piece as the individual market, which is normally disdained because it costs a lot less for a family policy credit.

We do have an employer-based policy; it's on average about \$12,000, \$13,000. So what's 10-percent of that? Do you

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have \$130,000 to pay 10-percent of your premium? They're just averting wages. So the idea that we're going to have that, we're actually paying much more for our healthcare than 10-percent. Maybe 10-percent out-of-pocket is one in that regard.

Karen talked about kind of how health insurance is such great concern for them. It is. It's the healthcare you receive. It's not the most important determinate of your health, however. If you actually look at education, broader measures of socioeconomic status is a much more powerful determinate of how your health is going to be on a long-range basis. But if you get all those chronic conditions, then all that healthcare you may have been covered for when you were a younger age.

JULIE APPLEBY: I'm going to let Karen respond to that, and then I want you all to think about if you want to ask a question, there's a microphone in the back. And we're going to open up the questions in a few minutes. But if you'd like to respond to the quality thing, and then one final thing, I'd like each of you to also give one idea for these folks on stories that they can go back to their respective outlets and work on, related to this, just one brief idea. But, Karen, I'll let you respond--and, Tom, if you like--and then each of you give me an idea. And then we're going to take questions, so if you all want to line up in the back there.

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KAREN DAVIS, PH.D: Well, I don't think it's feasible unless the financing is shared across federal government, state government, employers and households. So, if employers are making a contribution, and 80-percent of people say they want employers to continue to contribute to health benefits, then setting a maximum, not a minimum, as Tom has implied, of a 10-percent of income ceiling on the most that anyone would have to pay is part of it, as are federal revenues and state revenues.

We can get some savings out of administrative, but we're really only going to get savings if we're willing to make system reforms. I would start with imperative effectiveness. So rather than your example of a drug that gives you four additional weeks of life, let's start with a drug that costs you twice as much and doesn't do any better for anyone. Why should we pay twice as much?

So being willing to use the clout of government to, first of all, determine the cost effectiveness of alternative drugs, devices and procedures. Tie it into benefit design, give it real keys, saying we're not going to pay for things that don't work. We're not going to pay more for things that don't work any more than a current drug that's already on the system, and then instead of waving our arms, really having honest estimates of the difference that would make. So we engaged Luen Group, and on that particular option, they said \$350 billion of savings are possible to the health system over

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ten years, if you're really willing to have comparative effectiveness.

There's some savings from information technology. You don't get them for seven years. So you have to be willing to put upfront money into the system to get where we need to go.

JULIE APPLEBY: To see the results down the line. Great. Well we could talk for a while, but -

DAVID HIMMELSTEIN, M.D.: Julie, just one thing, one thing, which is, this claptrap about infinite demand for health care. I invite any of you who are looking for your next colonoscopy and [laughter] and knocking down my door. To come and say people want the medical care they need, they don't want the medical care they don't need. And when my patients say I want to see T-scan, I say, for what?

Here are the risks. And most of the things we do in medicine have real risks and real costs for patients that are not financial costs. There's not an infinite demand for something that has a one in two thousand chance of killing you the next CT scan.

JULIE APPLEBY: Okay. So, we've got a few people lined up. Real quickly, if anybody has an idea or two for stories to take back, and then I'm going to open it up to questions. So, those story ideas.

JULIE BARNES: Oh no, sure. I didn't know who you were starting with. Write about how we cannot not afford healthcare

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reform. We just published a study yesterday that said the costs, the economic losses due to the uninsured, so the cost to society, due to the uninsured is \$204 billion. So we're going to be talking about the economy, probably for a while. If you want to write a story that talks about the economic recession, you write about healthcare and how we have to reform it if we're going to have any hope of fixing those problems.

JULIE APPLEBY: Tom, any thoughts?

TOM MILLER: I have a simple story idea, which is never written about in health policy circles. Why is it that by somehow shifting costs, we're going to make them go away? Just because someone else is paying, whether it's through the tax system, whether it's through an employer or an individual, that hasn't changed what those costs are. We just rearrange the finance of it. In the same way, why is it that we are willing to pay for individually, it costs too much? Not worth the value?

We somehow think that if it's done collectively, it becomes a better value.

JULIE APPLEBY: David?

DAVID HIMMELSTEIN, M.D.: A couple things. One is that there are 15,000 doctors and physicians for a national health program, and there's at least one in virtually all of your communities who could talk about why it is that doctors are supporting this. A second is related, and that is the costs in

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your communities. Government is currently paying 60-percent of total healthcare costs, if you include things like public school teachers and firemen and policemen as a government cost.

And a story about what it's actually costing in your community, and why it is that transferring to a fully public system is a far lower cost than would otherwise be seen.

JULIE APPLEBY: And Karen?

KAREN DAVIS, PH.D: Follow the money. More stories on the prices that are charged for devices, pharmaceuticals, a whole array of healthcare services, and the different prices that are charged to different kinds of patients. I think we've really got to find out why we are unwilling to use purchasing power of government programs and private insurance to get a better deal for what we're buying.

But I also believe in success stories. So I think looking at better ways of organizing care systems. Things like patient-center medical homes, like organized care systems, like hospitals that are working to reduce avoidable hospitalizations. I think a lot of the answer to the cost problem is keeping people out of hospitals.

So whether it's the asthma, making sure people take their medications, the, what are called, inventory-sensitive hospitalizations, or the things that people go home from the hospital and don't know how to take care of themselves and aren't supported. And wind up back in the hospital again.

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Our studies, our state's score card show the single biggest predictor of variation in Medicare spending is the proportion of Medicare patients that are back in the hospital within thirty days. So find the success stories, point to the examples of excellence, the things that are out there that we can build on of successful ways of achieving better quality at lower cost.

JULIE APPLEBY: Great ideas. All those are great ideas. Okay, let's start in the back with a question.

ANDREW BOLDSET: Was wondering about, we heard several people talk about thinking that any healthcare reform comprehensive. And I'm wondering how comprehensive do you think they can be or should be? Because there are a lot of things where there are a lot of people proposing more comparative effectiveness studies. And yet, in the typical presentations, that's usually comparing one medical intervention to another medical intervention.

The basic premise being that medical intervention of some sort is the best intervention that we should take and the best public policy. When you take a broader look, both within the United States and comparing the U.S. to other countries, there is little correlation, in fact, it seems to be reverse correlation between how much medicine we give and how healthy people are.

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The U.S. continually falls behind other countries that spend a half or less per person, and do much less medical intervention. So should we, in looking at this, take the broader turn? It seems like Tom Miller has been the one most often referring to education, other social policies, that effect health, and perhaps will affect the ultimate demand for medical care.

Should food policy, should farm subsidies, which make junk food cheaper than fresh food, be part of healthcare reforms? How comprehensive does it need to be?

JULIE APPLEBY: Who wants to take that one on?

TOM MILLER: Well, we're building most of our costs into the system well before they arrive in the doctor's office. And it's an all points bulletin. This is community-level, individual levels, families, educational systems, all this stuff matters if what you care about is improved health to the population. But, in fact, our politics doesn't care about that. What we care about is who gets the money, and who's favorite's team gets in doors.

That's what comprehensive reform threatens, to take us down to step to again. Instead of focusing on, are people getting healthier? Are they getting something out of a system that actually works for them? And is there a way to kind of do that so it delivers better value?

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There are other tools beyond insurance, beyond public payments, beyond subsidies. It would be much more effective at carrying that out, but we need to be much more creative about it. Because we keep investing in the same dry holes, and we think we're going to get different results.

JULIE APPLEBY: Anybody else?

DAVID HIMMELSTEIN, M.D.: We've been very clear from the start that reform of the healthcare system needs to be part of a much broader reform in our society. We've said the public health budget needs to be doubled from 3-percent to 6-percent. That's a more important determinant of health than medical care. And not only that, but the standard of living of the poor, particularly, in this society, are a far more important determinant than that. And that's actually one of the major problems we face in this country, is that policies like those that Tom advocates, have re-distributed funds away from those in need and towards the wealthy in the society.

And the reform that he advocates in healthcare would accelerate that by being, in fact, regressively financed, so that a progressively financed healthcare system is very much part of improving the standard of living. And yes, we'd be prepared to divert funds out of medical care into an improved standard of living for the poor and lower-middle class in our society.

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And for raising tax rates back on the upper classes in our society.

JULIE APPLEBY: Karen?

KAREN DAVIS, PH.D: I think the main reason other countries get better results or higher value for what they spend is, they put more money into primary care and less into specialty care. We had the same number of physicians per capita as other countries. A third of our doctors are primary doctors. In other countries, it's at least half.

We've gone for ten years down the road of consumer-directed healthcare, which has really meant high deductibles. Which means we've made it harder for people to afford just to get in to get basic primary care from their physician. We can learn from other countries that make it very easy to get care from a regular doctor who you've been with for a long period of time.

There's no financial barrier to that care, everybody's lined up with a medical home that really takes responsibility for making sure that they are getting all of the basic things taken care of. So those are the big things that differ. I was shocked in New Zealand to learn that they don't even pay for x-rays in the ambulatory sector.

If you're a hospitalized patient, they'll pay for it. But they don't put a lot of money into highly specialized care, or paying a lot for highly specialized care.

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JULIE APPLEBY: You want to tackle that one?

JULIE BARNES: Well, just because one of the reforms that I keep talking about that's going to improve quality, but reduce costs simultaneously, is I don't like the comparative effectiveness. Because I think it stops short of what we actually need. Comparative effectiveness is measuring one treatment versus another treatment, and seeing what is successful across the broad population. And then we decide what the standards are.

Decide what the standards are, but let's concentrate on what the best practices are. So we're learning from sharing the information, what's working for various folks. It might be to have regional differences. But whatever it is, that's a standard that we need to put in place so we can help coordinate care that will help reduce costs. Because the answer might be we don't treat that.

And the answer might be we might treat that cheaper. And I also disagree with spending our money on expanding the public system. I think the private market is coming forward and answering some of these questions about access. The Minute Clinics, attached to Wal-Mart's and CVS's, people are getting their strep throat swabs taken care of at kind of these places.

What we need, though, is to make sure that they're doing it right, that it's staffed properly, that they're attached to a greater healthcare system, that we're sharing

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that information back with a primary care doc. Hello? These are things that strike me as totally obvious, but I'm not running the healthcare system yet [laughter]. So, but we will get there, and we will reduce costs and have more money to play with, and farm subsidies is next.

But I think for now, we've got our work cut out for us.

JULIE APPLEBY: We'll hold farm subsidies for the next luncheon. But next question, please.

IRENE MALOSKY: Irene Malosky [misspelled?], independent journalist. I don't want to talk about healthcare; I want to talk about national politics. And I'd like your opinion just on where this Presidential race is going in terms of any possibility of health reform in the next administration. One of the things that helped to kill the Massachusetts early attempt at reform was, Michael Cox's plan was passed, and ran right into the peak of a severe recession.

And so, there were coalitions created to support reform, trade, under the pressure of that. Anyone who's watched the stock market in the last few months, and looked at the economics [inaudible], I guess there's still some today on the business pages about whether we're yet entered into a recession. But other people have the feeling that we already are in one. It's been said that the next President will inherit a huge number of economic problems.

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And given the history of the progress for the health reform debate in this country, that will eclipse being for reform, if you look at past history. What is your forecast on that issue?

DAVID HIMMELSTEIN, M.D.: I think past history shows us that major social initiatives actually do happen, exactly at a time of major economic crisis. So the new deal is, I guess, the outstanding example of that. And we're facing a period where our country can't afford the healthcare system we have at present. And the pain is broadening far beyond the poor into the middle classes.

And folks in this room are threatened along with people who are uninsured in poor communities around this country. That's the condition for political change. Now, our political leaders in Washington are likely to be the last people to find out about it. And I think the situation in Washington; political leadership has become the ultimate oxymoron.

But the fact is that demand from outside Washington can actually move this country as well. And we had a charismatic President elected in 1960 who did not have very bold, social programs that he proposed. And yet triggered a very broad outpouring of sentiment that succeeded in passing major social initiatives.

JULIE APPLEBY: So David thinks this is going to happen. What do you think?

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KAREN DAVIS, PH.D: I think in a recession, people really get worried about health insurance, so the demand for their political leaders to do something about it grows whenever the economy tanks. The problem with states is, that there ability to meet that demand also tanks, because sales tax revenues go down, unemployment compensation costs go up. And that's why we saw, in Washington, the need for federal fiscal relief to really pump prime.

And I think we, at least, talked about, even though mostly what we did was to get people tax rebates, we at least talked about there are ways of stimulating the economy. And I would say by investing in the healthcare sector. Those are good jobs.

IRENE MALOSKY: But, if I could just make one point. You had said, a couple of times, the states can't go it alone. One of the reasons the states are in trouble is because of federal government, is cutting it's check. And other programs are capping. The financing of these programs the states rely upon to improve coverage. So it doesn't seem to me to be a state-federal.

KAREN DAVIS, PH.D: Right. It's absolutely, you're absolutely right. It was the wrong response to the recession. And there were other ideas on the table, such as increasing the federal match for Medicaid and SCHIP. We ought to have a counter-cyclical matching rate built into those programs. So

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that when the economy tanks, the federal government's picking up more of the costs. And states are getting fiscal relief from it.

JULIE APPLEBY: Anyone else to tackle this? Is this going to happen?

JULIE BARNES: Absolutely.

JULIE APPLEBY: And what are, okay.

JULIE BARNES: Reaching hope. Absolutely.

JULIE APPLEBY: Do we have another question?

JULIE BARNES: The recession is going to effect individuals the most, but employers and businesses are in an excellent position to fix it. They're the ones that we need to look at to determine how to help them. And it fits into healthcare costs, because an employer burden, right now, is offering healthcare benefits. And this is scary, and a little dramatic, but what if we took employers out of the healthcare benefit business? And pooled the individuals instead. And did it that way, because then, we could have the employers back to competing with the international folks.

Ask GM if they think this is a good idea. And then we have more money, because suddenly, we don't have tax credits for employers, right? So the federal government gets back all that money that they're giving to employers right now. And wages can go up, recession? So? You see there's some ways to figure this out. Yeah, sure it can happen.

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TOM MILLER: I'm an optimist. I think it's always dark before it gets really dark, but then it gets lighter [laughter]. You asked about politics. I think in the short-term, I wouldn't expect a lot of independent moving around in a few years, short of that of main blood in Congressional elections, which gives you kind of a 1965 situation. That's not quite there yet.

But it really doesn't matter who's elected President in terms of whether we're going to get this comprehensive great reform. I was on record in 1993, before other people were all saying all the time what's going to be the Clinton in act of reform. It's not going to survive. It's not going to go through. Too complex, too much at the same time.

We can make some progress, but politics is a lagging indicator. It will ratify what people have figured it out. It actually works, then we'll kind of end up kind of a job in thesis. We're not going to have any mandate after two years of trashing around debate in Congress. We're going to get some marginal incentives. We can kind of provide a little additional assistance to some folks to get some more care.

We're going to learn a lot more about what actually works in healthcare, and how do begin to insist on more accountable delivery of care, and people will be able to insist upon that as well. We need to accelerate that process, because that's where the most promise lies. In a time of economic

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stress, there are less dollars to go around rather than more. We're going to re-write a little bit of the tax code in the next two years, and healthcare is going to get less in tax subsidies than it did before. As a result of that, we may rationalize the approach of the facts of financing failed.

JULIE APPLEBY: Okay, we have time maybe for one more question back there.

BRIAN THOMPSON: Brian Thompson, with Kansas Public Radio. Kansas has a plan to reform not its healthcare, but health, wellness and a comprehensive type of reform. They did an actuarial study of five different ways to erase the problem of the uninsured. And all of those ways would raise the cost to the state by around half a billion dollars. Except for one, and that is a single payer plan.

That plan, according to the actuarial study, would cover everyone and cut the costs by about \$800,000,000. And through the way it would be financed, it would put about a billion dollars back in the pockets of the individual citizens. What they pay in taxes, part of this would be less than what they pay now for premiums that they were void. And so, the question for politics, to me, is, why do they say this is not feasible politically? To cover everybody and save the citizens a billion dollars. How is that not good politics?

JULIE APPLEBY: Julie, you want to take this one?

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JULIE BARNES: Well, it's good policy. It's terrible politics, my God. Who are you not ticking off? You're eliminating the insurance industry, the physicians are going to be frightened. You don't frighten physicians, we need them. And consumers. If Kansas can convince the American people, we'll get behind it. But so far, we have seen, over and over again, 1993-94, that was not the government takeover of healthcare, but you couldn't convince the American people of that.

So, it's not going to happen. We need to do what's politically palatable.

JULIE APPLEBY: Karen? Why don't -

KAREN DAVIS, PH.D: I'd just make one plea for reports to really focus on the difference between total national health spending, and federal budget spending. So single payer plans may reduce total national health spending, but they have huge increases in government budget outlays. That's because employers, instead of paying premiums, are now going to be paying payroll taxes. Employers, including the business round table, have concluded they would rather stay in the business of covering the 160 million Americans who get their coverage through employer plans, where they have some control over what's covered.

They can use their creativity to help try to control costs. They can get some credit from their workers as being a

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good employer that recruits and retains good workers, because they have good benefits. There are ways of keeping a mix public-private system with employers still in the business, and achieving total health system savings. In fact, work we support shows you can save 1.5 trillion over ten years if you're willing to do a number of these things. Primary care, patient-centered medical homes, comparative effectiveness, information technology, and cover everybody with a mixed public-private system.

JULIE APPLEBY: That's all. I'm going to let you say something and then I'm going to let David have the last word because of the single payer system. But did you want to respond to the question?

TOM MILLER: Well, we complain a lot about what employers do, what insurers do, and then what doctors do. The only possible party to do a worse job of running our healthcare is the federal government's already demonstrated in performance abilities in many other areas recently.

So you have to think about kind of who ultimately is going to be the decision maker in any system you support? You want to try to do that through the coalition ballot box. You want to be able to do it by committing more of your resources, and determining who your agents are who are answering to you, in terms of accountability for the care you receive. That's

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fundamentally why single payer doesn't fly in the United States.

It's not a bunch of stupid Americans who just won't vote for something that's good for them. It's that they don't prefer that alternative when they have to deal with it close up and actually understand what it means in practice. If you mean dictate prices, and you ensure that you're going to get the same value as before, that's a nice miracle, but it's not going to happen that way.

That's why these cost projections show up that way. Because it's all done in the assumptions, which aren't anchored in reality.

JULIE APPLEBY: David, you get the last word.

DAVID HIMMELSTEIN, M.D.: Well the projections that you cite are very similar to projections by the Congressional Budget Office and General Accountability Office that have found the same thing. Single payer actually saves money, provides upgraded coverage for virtually all Americans. But it's politically difficult, not because the American people don't want it, not because doctors don't want it, doctors want it, but because it antagonizes a few, very wealthy people in this country.

And the question is, can our country do something that two thirds of Americans want, but that takes money out of the pockets of a few wealthy and powerful individuals. And that's

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really the question for our democracy. I'm an optimist; I think we still do live in a democracy. So I think actually it is something that we can achieve.

JULIE APPLEBY: Well I want to thank you all for coming. As you can see, we're going to have a lot to write about in the next few years. So I appreciate you coming [applause], and I think we've got another session on the way there. Very, very good.

[END RECORDING]