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Dr. Robert J. Rubin is currently Clinical Professor of Medicine in the Division of Nephrology and Hypertension at the Georgetown University School of Medicine and an independent healthcare consultant. Prior to becoming an independent consultant, Dr. Rubin was president of The Lewin Group, an international health care consultancy, for 17 years. During that time, Dr. Rubin served as Medical Director for a pharmaceutical benefit management company (1992-1996) and Chair of the Board of a biotech start-up.

From 1981-1984, Dr. Rubin was the Assistant Secretary for Planning and Evaluation at the US Department of Health and Human Services (HHS) under President Reagan. In that capacity he was the chair of the task forces charged with the design, passage and implementation of Medicare's Prospective Payment System as well as the primary policy advisor to the HHS secretary.

As a healthcare consultant, Dr. Rubin worked extensively with pharmaceutical, medical device and biotech companies to develop strategic and marketing plans for new devices and drugs. He also worked with many of the leading academic health centers in the US to help them develop strategic plans especially in the area of biomedical research. In addition, he has and continues to advise several government agencies on health care policy.

Dr. Rubin graduated from Williams College and received his M.D. from Cornell University Medical College. He served as an Epidemic Intelligence Service officer at the Centers for Disease Control from 1972-1974.

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"Our Patients seem to Appreciate our Inefficiency"

Steigende Kosten für Gesundheitssysteme führen nicht nur in Europa zu recht heftig geführten Diskussionen über die Effizienz der Krankenversicherungssysteme. In den USA hat Präsident George W. Bush tiefgreifende Reformen angekündigt. Anders als der gescheiterte "Health Security Plan" seines Vorgängers Bill Clinton baut Bush auf Eigenverantwortung und individuelle finanzielle Anreize abseits von staatlichem Einfluss. Für den früheren Regierungsberater Robert J. Rubin, Professor an der Georgetown University, ist die wichtigste Frage allerdings nicht die, welches System überlegen ist, sondern wie man innerhalb eines Systems den größtmöglichen Nutzen für die Patienten erzielen kann.

Das Gespräch führte Michael Huprich.

conturen: First of all, could you outline the main principles and the philosophy of the American health care system?

Americas health care system as a "non-system"

Rubin: I appreciate the opportunity to share my views regarding health, health care and health care delivery, however, I want your readers to clearly understand that the views I will express here are my own and not those of the Bush Administration or any political party in the US. My views are shaped by my position as a physician and professor of medicine as well as my experience as an assistant secretary in the US Department of Health and Human Services (HHS) from 1981-1984 (the first administration of Ronald Reagan).

The American health care system is frequently referred to as a "non-system" because of its pluralistic nature. I believe that to understand the organization of the system one has to disaggregate the delivery of care from the financing of that care. In the US, ideally every individual should have a primary care physician and have access to the appropriate specialists when necessary. This care is generally financed by one's employer or the government via "Medicare" and "Medicaid" if you are either elderly (over 65 years old), disabled, poor or in a "protected category" such as pregnant women and children. It is obvious that this ideal is not fully realized as we have issues of over and under utilization of resources in our country as well as many people who fall through the "cracks" on the financing side.

Medicare, Medicaid

The fundamental philosophy of the American health care system is that patients can seek out doctors to treat them without the interference of third parties. Increasingly however, payors are interposing themselves between the patient and the physician to influ-

ence the delivery of care. The American people are wrestling with how to resolve this problem.

People dont want accountants and bureaucrats between themselves and their physicians

Americans and, I believe, most people want health care decisions to be between themselves and their physicians. They do not want accountants and bureaucrats making health care decisions for them. Both candidates in our recent presidential election endorsed that view. There is a wide spread view that while physicians may act in the best interests of their patients, payors may be motivated by other considerations in making their decisions. This is a difficult issue and we are struggling with it because sometimes payors may, on the basis of science, improve the overall quality of care by issuing guidelines and „grading" physicians on how they perform relative to those guidelines.

On the other hand, payors can put barriers in front of patients and physicians that result in a decrease in the quality of care while lowering the cost of that care. For example in my specialty of nephrology, there are several studies that show that early referral to a nephrologist for a person with chronic kidney disease results in decreased morbidity. By making it hard for a primary care physician to refer patients to a specialist, the payor may save money, at least in the short run, but not be acting in the best interest of those patients.

conturen: What are the main advantages of the American system compared to other countries?

Broad access to technological innovations

Rubin: In the US there is generally broad access to modern technological innovations in care and in pharmaceuticals. Having said that, I should hasten to add that our system is far from perfect. There are disparities in health care utilization that are geographic, ethnic, racial and socio-economic. America is the world leader in research both clinical and in the basic sciences a fact implicitly, if not explicitly acknowledged by Europe's leading pharmaceutical companies opening major research centers in the US.

US health expenses: higher than in other OECD countries

conturen: According to OECD statistics the US health care system is one of the most expensive in the world. U.S. health spending accounted for 15.3 percent of U.S. gross domestic product in 2003, which is significantly higher than in other OECD countries. However, about 40 million Americans have no health insurance at all. In a study, published in „Health Affairs", a research group around Gerard F. Anderson from John-Hopkins-University came to the conclusion that the American system is highly inefficient. Are those critics right?

40 million Americans without health insurance

Rubin: In the May/June 2004 issue of "Health Affairs" Gerry and his colleagues had two articles. In one he looked at quality indicators in England, Australia, Canada, New Zealand and the US. Among the 21 indicators, the US was lowest in kidney transplant survival and the rate of hepatitis B and first in breast cancer survival, measles immunization, lowest smoking rate (tied with Canada) and cervical cancer screening. The second article asked the question "Why is US spending so high and can we afford it". It is

Different indicators

a balanced look at the US and other OECD countries and interested readers should look at it.

Is the US system "highly inefficient"? I don't know. In contrast to Gerry Anderson, I'm a physician and not an economist, however, if Gerry (who was on my staff when I was an assistant secretary at the US Department of Health and Human Services) concludes our system is economically inefficient he is probably right but compared to what?

Austrian indicators

Austria, for example has 20% more physicians, 14% more nurses and 114% more hospital beds on a per capita basis than the US according to OECD data. Furthermore, relative to GDP, Austrian health care spending rose at roughly the same rate as US spending.

"Quality adjusted year of life": QALY

Economists like to look at the cost effectiveness of spending. In health care they can put a monetary value on what it costs to get an additional "quality adjusted year of life" or QALY. Prof. Anderson and his colleagues write that in the UK there appears to be a ceiling of £30,000 per QALY while in the US that figure is higher. In economic terms that means we are inefficient. It also means we provide care to patients that might not be provided elsewhere on the grounds of cost efficiency. In more understandable terms that means a patient in the US may get a PET scan to determine if a lung nodule is malignant or an MRI to see if a painful joint has a torn muscle to explain the pain. So we may well be inefficient but our patients seem to appreciate our inefficiency.

In economic terms US is inefficient

Inefficient administration

An area where the US in clearly inefficient is in the area of administration. Of course, any pluralistic system will be inefficient relative to a single payer system like the UK or Canada or a system where the purchasers join forces to negotiate prices with providers like some EU countries. Nevertheless, we need to strive to improve in this area and relieve the burden on physicians and other providers of care. President Bush has taken some steps to help with his initiative on electronic medical/health records. He has also been outspoken on another area of inefficiency that is largely absent from the EU and that is malpractice costs both for litigation and insurance not to mention the unnecessary tests physicians order in an attempt to insulate themselves from law suits.

conturen: In 1993 President Clinton tried to initiate a Health Security Plan aiming at a universal coverage for all US-citizens. According to this plan, a basic health insurance without regard to income should be guaranteed. Europeans, especially Austrians and Germans, take such a system for granted and most people could hardly understand why the Clinton initiative failed despite great public support in the beginning. What were the main arguments against the Health Security Plan?

Europeans, Germans and Austrians

Rubin: There were many arguments against the Clinton Plan from the substantive to the political but mainly the plan failed because the American people did not support it. The plan was too complicated to be easily understood and many Americans believed that the government would be too involved in the delivery of our health care.

conturen: In his recent election campaign president Bush also has announced reforms of the health insurance system. What are the outlines and the main goals of his proposals?

Health Savings Accounts

Rubin: President Bush had several proposals that would make it easier to obtain health insurance including tax credits to purchase health insurance. In addition he supported expanding a concept called Health Savings Accounts. These accounts would be owned by individuals and be funded by either the individual or their employer. They would be coupled with high deductible insurance policies. The concept is that if individuals were responsible for the first dollars of coverage they would be wiser shoppers for health care than if insurance paid for the first dollars of coverage and health care was perceived as free. The individuals get to keep whatever they don't spend in their accounts so there is a financial incentive not to consume health care. On the other hand, if they have significant expenses they are covered entirely after they exceed the deductible. This is part of the President's plan to empower individuals to have a more active role in their economic lives. The President also proposed to expand coverage for children beyond the poor to the near poor in partnership with our states.

A more active role for individuals

Bismarck

conturen: The German and Austrian public health insurances have their origins in a law passed by the German chancellor Bismarck in the second half of the 19th century. In this system health insurance is mandatory and financed by employers and employees. The money goes to compulsory public health insurance funds, which pay for the medical treatment of patients. Does such a system meet the demands of modern health care?

Rubin: I am not an expert in either the German nor Austrian systems but I do know that at least in Germany they have frequently revised how and how much they will pay for pharmaceuticals, so it is not clear to me that the systems are meeting the needs of their citizens within their budgetary limits.

The question of aging populations

In addition I do know that the Germans recently adopted a hospital payment system similar to the one I was involved in passing here in the United States 22 years ago – a prospective diagnosis related group or DRG system. Again I want to stress that the system needs to be evaluated both in terms of the delivery of care as well as how it is financed. My understanding is that given the economies of both Austria and Germany, the ability of the current system to finance the care that is needed for their aging populations is of national concern.

"two-class-system"?

conturen: A standard argument in the European discussion against a US-like insurance system is that it creates a "two class system": Rich people can afford high-level medical treatment whereas the poor have to content themselves with minimal medical care. Is this a valid argument in your opinion?

UK-system

Rubin: "Two class system" is too simplistic and inflammatory an argument to be the basis of an informative discussion. The National Health Service in the UK provides adequate care, yet there are a number of private hospitals and private insurance programs to

help those that can afford it "jump the queue" to get care. There are also practitioners who see private patients. Australia has a similar system. All countries need to ensure that all people receive life saving care if appropriate - care that is more than minimal. The well to do in any society have the opportunity to spend their own money to seek care above and beyond (or more promptly) than what is provided to most people.

systems advantages

conturen: What are, in your opinion, the main advantages of a system based on individual provision compared to mandatory and government controlled health insurance like in many European countries?

Rubin: Either way of financing care is valid. The issues are what kind of care and how much care is provided through the financing mechanism.

conturen: Health care, regardless of the system, suffers from ever increasing costs. What are the main cost drivers and what can we do to reduce costs?

Rubin: The main cost drivers are clearly improving technology that allows us to do much more than we did even a decade ago. This coupled with people's demand for better health drive costs up. Two examples illustrate my point. First, joint replacement surgery has allowed people who were in pain and frequently immobile to be relieved of that pain and to walk again, yet it is expensive. Second, implantable defibrillators prevent the premature death of people with life threatening arrhythmias. It too is very expensive, yet our Medicare program just expended its coverage for the device.

Examples surgery and defibrillators

conturen: Is the limitation of prescription expenses by public law like in Germany a passable way to reduce costs or will such a measure have negative impact on medical research and development?

Rubin: I'm not familiar with the specifics of the German law but in there is no question that pharmaceutical companies need to do research if they are to continue to bring new life saving or life enhancing therapies to the people. They can only fund that research from their revenues. At the present time there is little question that the American people through higher drug prices are subsidizing the rest of the world. Our leaders have called upon the leaders of the rest of the developed world to pay their fair share. It is not only the price per pill that is causing expenditures to increase.

Costs of research

For example in the US if everyone for whom a statin is indicated to lower their cholesterol to prevent heart attacks took it, our drug bill could have a double digit increase according to an editorial in the New England Journal of Medicine last year.

conturen: Does a future society have to accept cut backs in the quality of medical treatment?

Rubin: No, we can and should demand the highest quality of care from our medical providers.

No reduction of quality

conturen: Many European countries are discussing health care reforms. Increasing costs seem to make decisive changes necessary. What principles must a reform follow in your opinion, to assure sufficient medical care for the next decades? Most of the reform discussions are only about the question of costs. Is this the right approach or don't we rather need a change in thinking?

We need to stress preventive care

Rubin: We need to get back to basics. We need to stress preventive care and devise incentives for both patients (consumers) and providers to prevent illness as much as possible. In the US there are strong anti-smoking provisions in most of our states as an example. Medicare, our program for the elderly and disabled is covering more preventive health services. We are also experimenting with new ways to treat chronic disease such as diabetes and congestive heart failure that not only are less expensive but also provide better care to patients.

Different traditions, beliefs and financial capacity

We must insist that providers practice evidenced based medicine; doing the things that work based on science. Finally, society must agree what we won't do, not because it is expensive but because it is not worth doing. After we do these things we need to see what it will cost and then decide how to pay for it. I believe that each society may reach different conclusions based on their traditions, beliefs and financial capacity.

If we set high goals we achieve small successes

In a more ideal world we need to replicate the global effort we undertook to eradicate smallpox and extend to other infectious diseases and beyond to other common diseases. I know that to many this is an audacious goal but perhaps if we set high goals we can achieve small successes.