William Haseltine Interview with Elizabeth Rosenthal

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Elizabeth Rosenthal (ER): Thank you so much for coming and sharing your experience and your wisdom.

William Haseltine (WH): Thank you for the invitation. It has been a great morning. I have enjoyed all the presentations.

ER: I would like you first to look into a crystal ball. You have been right about a lot of things in your career. Where do you think the healthcare system is going now? Where do you think we will be in five years, ten years?

WH: I am very concerned about the healthcare industry, both here in the United States and in many other countries as well. First, please allow me to give you some of my experience that has influenced my perspectives. My career has been devoted to improving human health, first as a research scientist at Harvard Medical School and the Harvard School of Public Health, later as the founder and CEO of a biopharmaceutical company, Human Genome Sciences, and most recently as president of a foundation I created, ACCESS Health International. As I look forward, I see an increasing resistance to the introduction of new ways to treat and cure disease as a direct consequence of the current and projected cost of healthcare. Our healthcare system is the most costly in the world, accounting up to eighteen percent of GDP. Unless we restrain costs, I believe we will lose our enthusiasm for the basic and applied research needed to find solutions to our most pressing medical problems. We must also seek more cost effective ways to develop and introduce new treatments. National research budgets are already constricting.

We know the healthcare system in the United States is expensive. Most of the speakers today have emphasized the cost of healthcare in the United States as compared to that of many other high income countries, specifically the high cost of pharmaceutical products, medical devices, and the high and often inexplicable cost of medical services. The cost is more than four times that of some of the world's best performing healthcare services and more than twice that of comparable European and East Asian countries.

I believe most of us know that the healthcare system is the most expensive in the world, but many may not know how poorly we compare to our peers. The Institute of Medicine published a report last year: *The US Healthcare System in International Perspective: Shorter Lives, Poorer Health*. The report concluded that compared to the sixteen other high income democracies, "Americans have been dying at younger ages…and the disadvantage has been getting worse for three decades – especially among women." They concluded that, "When compared to peer countries, Americans as a group fare worse in at least nine areas: infant mortality and low birth rate, heart disease, obesity and diabetes, chronic lung disease, adolescent pregnancy and sexually transmitted diseases, injuries and homicides, HIV and AIDS, drug related deaths, chronic lung disease, and disability." Comparative performance in healthcare outcomes was not always poor. The United States ranked among the top nations in the world in health in the 1950s and through most of the 1960s, refuting the notion that it is population heterogeneity, specifically the poor health of minority groups, that accounts for our poor performance today. The report concludes that, "Superior health outcomes in other nations show that Americans also can enjoy better health." In short, we pay more and get less than do other comparable countries.

ER: I share that perspective, and I have seen that in the series. Last night at dinner, I did not ask who are the patients in the articles I wrote on diabetes. The answer: one was a pharmacist, another a health insurance broker, the third a physician, the fourth a dentist. If the system is not working for these people, if they are having trouble affording their insulin and supplies and pumps, it is really not working for anyone.

WH: We have a healthcare system that is currently under stress, both in cost and performance. Yet the stress is about to become even more intense. An age wave is approaching and soon will

be upon us. Unless we are prepared, demographic change will crush our already fragile healthcare system. We know that the ratio of those over sixty five and seventy to those younger is increasing rapidly. We also know that older people require more medical and supportive care. As costly as the healthcare system is now, it will become much more expensive if we do not adapt to a predictable demographic challenge.

My response to the problem is to study which organizations in the United States and abroad have successfully managed healthcare costs and quality. I try to understand which countries are planning most effectively for the future. These are some the of principal goals of ACCESS Health International.

ER: I now want to ask a question that may be surprising. You were really important for a lot of early drug development in the HIV field. I remember when, as a medical resident in the 1980s, the first antiretroviral drugs arrived. They seemed earth changing, and they were. I remember how everyone thought that the ten thousand dollars a year cost was an extraordinary price for medicines, and that no one should pay that much. Now ten thousand dollars a year seems kind of chump change for a new drug. How do you feel about these new drug prices, having been on the other side?

WH: I think that the current prices for many specialty medicines are outrageous. I do not think you can justify these prices by the cost of research and development. I have developed drugs that are on the market and know how much the process does and should cost.

I am working in two areas relevant to cost control of health. One, I mentioned earlier: improving the efficiency of healthcare systems at home and abroad. The second is improving the efficiency of the pharmaceutical industry. Today the pharmaceutical industry is a failing business. Despite

an aggregate investment of more than sixty billion dollars a year in research and development, the industry is failing to renew the current drugs with new products as patents on their existing drugs expire. The industry has a negative return on this massive investment. When a business is failing and profits are falling, several strategies might save it. For monopolies free of price regulation, a reasonable description for the pharmaceutical industry of the United States, you can increase price to increase profits. That is what most companies are doing. Or you can delay the day of reckoning by buying another company that has products with longer lived patent protection. If all else fails you can try another temporary measure: seeking tax advantage by moving assets to another country. I see the outrageous prices charged for new drugs in the United States as a reflection of a failing business model and lack of appropriate price control. Companies should not be able to get away with what I believe are extortionist practices. In many other countries, they do not. Drugs prices in the United States are exorbitant by international standards, as you and other speakers have highlighted in this conference.

The pharmaceutical industry needs to be restructured. I see a future where drug discovery and development will be separated from sales and marketing. The current large pharmaceutical companies will likely become global sales and marketing organizations with relatively low operating margins. These will be distinct from drug discovery research and development organizations that will focus on scientifically and medically based discovery and development programs. Drug development will be focused on the best and most medically effective use of new drugs, not solely on their market potential, as is usually the case today. The cost and time of development by a new generation of companies can be dramatically reduced.

Regarding your question about the drugs to treat HIV infection. HIV treatment is one of the great success stories of modern medical science. I am personally gratified that my early vision of the future of HIV treatment is now a reality. Just after determining the sequence of the HIV genome and upon identifying most of its key components, I suggested that HIV infections could be treated successfully by use of a combination of drugs that inhibit critical steps in virus replication, including the enzyme needed to copy viral information, the enzyme needed to process the viral proteins, and the enzyme needed for the virus to stitch itself into the DNA of the infected cell. I am pleased that multiple versions of such drugs now exist and, when used in combination, successfully treat most HIV infections. The price of the first HIV drugs did seem high, but not by todays standards. The early tragedy was that wealthy countries could afford such drugs, but other countries that bore the brunt of disease could not. As you know, that story has a happy outcome. The price of successful combination therapies in many low income countries is now about eighty dollars per year. I believe the two tier drug pricing model for HIV drugs is a model that should be applied to all essential medicines and devices. That is not to say that pharmaceutical companies should be allowed to charge whatever the market will bear in high income countries. I favor a model now prevalent in Europe that applies cost benefit analysis to drug prices.

I also believe that it is time to thoroughly reevaluate regulations that govern patents of pharmaceuticals. Few will deny that patents are essential to encourage investment in new drugs and devices. However, in my opinion the patent system as practiced in the United States today is abused. One strategy to extend the life of a patented compound is to modify how a drug is delivered. Such patents are generally allowed in the United States but not in many other countries. The case of biopharmaceuticals in the United States is particularly troubling. The

patents on many of these very expensive drugs expired long ago. Erythropoietin is one such drug. Yet, competitors are excluded from the market in the United States by what I believe is a specious claim that they are not equivalent to the original, allowing monopoly pricing to continue for many years. It is past time to change our regulations on bioequivalency for this class of drug.

The way we price drugs and medical services reflects deeply a ingrained political processes system. The biggest purchaser of pharmaceuticals and medical devices in the United States is Medicare and Medicare. Yet our laws forbid Medicare and Medicaid from negotiating drug and devices prices. One explanation is the success of special interests groups. Governance by purchased representation is another. Those with deep pockets can and do influence government policy. And today, who has deeper pockets than the healthcare industry?

ER: And in what other industry would we tolerate that?

WH: Why do we tolerate it? What is the nature of our political system that leads to the healthcare system that we have. The question was asked earlier today, "Wasn't the simplest and most effective way to reform the healthcare system the extension of Medicare and Medicaid to include people without health insurance? We know Medicare and Medicaid work and are popular." The answer seemed to be that our political system would not tolerate it. Shouldn't we then ask the question, what is it about our political system that prevents our government from doing what seems most effective?

What might work given our political realties is a public private partnership for universal healthcare coverage: An extended Medicare-Medicaid program to pay the medical costs for all citizens not protected by current insurance programs or other government programs, such as the

Veterans Administration, coupled to the private sector, organized into larger competing provider services groups, to deliver healthcare services. I believe such an arrangement draws upon our strengths. Given a level playing field and clear enforceable regulations, our businesses can and do compete to deliver high quality, cost effective solutions. Such a system requires transparency of both costs and outcomes to allow payers to select the best providers. Given a competitive delivery system that focuses on cost and quality, we might be able to achieve high quality, affordable healthcare compatible with our particular political-economic philosophy.

ER: Let's now discuss factors in the United States that lead to higher costs and what can be done.

WH: I do not believe we are likely to change the dominant political-economic philosophy of the United States anytime soon. Success depends on creating a healthcare system that operates efficiently within the framework we have. Earlier, we listened to the CEO of Kaiser Permanente Healthcare describe a self insured collective. I would be interested to know how their price and outcomes differ from others serving similar populations. Is it really less expensive and are the outcomes that much better?

ER: Good question. I don't know the answer. Let's now move on discuss what is happening in other parts of the world. The response I tended to get when I started the series in *The New York Times* and mentioned European health systems was, "Oh yes, but that is socialized medicine." Or Canada, "But that is socialized medicine." My response is, and I think yours, too, is: There are a lot of different countries doing a many different things, and some of them are socialized medicine, some of them not. But none of them has the strange hands off approach that we have.

You have looked around the world. In fact, you have written about another healthcare system. Which one?

WH: I looked around the world for the country that has the best health outcomes at the lowest cost. There is no doubt that country is Singapore. I am now thoroughly familiar with the standard response to that statement. Most people dismiss the significance of the Singapore experience by saying that the small size and homogeneity of the population of renders comparisons irrelevant. Others argue that Singapore is is not a true democracy so lessons learned will not apply to the United States. My response is that I have been trained as a scientist to look at a proof of principle. If something works somewhere, let's study it to understand what elements might be useful in our own context.

Some key facts described in my recent book *Affordable Excellence: The Singapore Healthcare Story. How to Build and Maintain Sustainable Healthcare Systems*: Singapore has some of the best health outcomes the world yet spends less on healthcare than any other high income country, just over four percent of the GDP. The government pays slightly more one fourth of the costs and individuals pay the balance from mandatory personal health savings accounts. Most of primary care is private. Most of hospital care is managed by public hospitals organized into five competing corporatized groups. Each group competes for patients based, at least in part, on price and quality. I would like to rebut one specific comment that is often made: The population of Singapore is not homogeneous. The population is diverse, the majority being either of Chinese or Malay descent. There are significant differences in the education and incomes of the population.

In my opinion, studying Singapore is not only interesting for what they have done but also for how they are planning to meet the health needs of the future. Like other high income countries,

Singapore is facing an age wave. The proportion of the population over sixty five and seventy to those who are younger is increasing rapidly. The health needs of the elderly will stress the current health system. Both the government and civil society are now planning for the next thirty to fifty years. The planning process is comprehensive, including coordination of financial, transportation, urban design, housing, health education wellness and fitness training, information technology, and restructuring of how and where treatment is delivered. I am now doing research for a new book, *A City For All Ages,* that will describe how Singapore plans to cope with the demographic shift that all high income countries will soon experience.

ER: If we could talk a little more first about the free market nature of the Singaporean healthcare system. One thing that has always interested me is the essentials like coronary artery bypass surgery will be paid for. But if you want a fancy room in a Singaporean hospital what happens?

WH: You can have a fancy room in a public hospital in Singapore. They exist. There are two ways to pay for expanded hospital amenities: out of pocket or from a premium insurance policy purchased by an individual. Public hospitals offer five categories of inpatient services. The basic service is highly subsidized; the fancier services are not. It is worth mentioning that the medical care is identical for all classes of hospital rooms.

The cost of health insurance is also worth mentioning. On average, a Singaporean pays less than two percent of the average cost of health insurance in the United States. Everyone is required to purchase a basic policy that covers major health emergencies. The annual cost for a young family of four is equivalent to about three hundred and fifty dollars. The average income in Singapore is higher than that of the United States.

ER: And what happens to people with chronic disease in the Singaporean system?

WH: The individual pays for chronic disease treatment from his personal health saving account. Close family members can also pay for care of an elderly relative from their own health savings accounts. There is a growing concern that personal savings accounts will be inadequate to pay for the continued cost of elder care. There are two responses. The government is adding additional money to the savings accounts of older Singaporeans. There is also is a concerted effort to support aging in place, both in the home and in communities, to reduce the cost of long term care. That being said, the anxiety over long term care remains. There is a consistent move by the government to assume more financial responsibility for care of the elderly, shifting the focus from the individual to a more collective sense of shared responsibility.

ER: So the government is responding to the anxiety.

WH: I have recently written an epilogue to *Affordable Excellence* that details the recent government response to the concerns over long term care. The Epilogue covers the period from April 2103 to April2104 and is available on the ACCESS Health website (www.accessh.org).

I do not believe that we in the United States can adopt the Singapore healthcare system in its entirety. But we may adopt some of their best practices. We can learn from the best, both in Singapore and elsewhere. We in the United States differ from Singapore in our fundamental approach to governance. In Singapore, there is a basic trust in government and a distrust of the profit motive and corrupting influence of the private sector, all within the confines of a capitalist society. It seems to me that Americans tend to distrust government and do trust the private sector to look after both their economic and private interests. We place a high value on the rights of the individual and on freedom of expression and tend to minimize our collective responsibility for the poor and disadvantaged. Social harmony is a high value in Singapore. When was the last

time you heard an American politician talk about social solidarity or social harmony? Yet it is the principles of social harmony and collective responsibility, combined in a unique fashion with a sense of individual responsibility, that shapes the Singaporean healthcare system. Healthcare systems reflect social values and political beliefs. Each country will evaluate carefully how to achieve high quality, affordable health computable with its national character. So too must we.

I would like to comment on what some of the earlier speakers have said. One speaker attributed the high cost of our healthcare system to high salaries of our doctors, nurses, technicians, and managers. In my opinion, salaries are not the dominant cause of high healthcare costs in the United States. In Singapore, doctors are the highest paid professionals. Nurses and technicians are well paid. Yet, their overall costs remain low. Many speakers today pointed to the excessive costs of drugs and medical devices and to obscure hospital pricing practices.

The study of healthcare systems in other countries teaches us that increasing the efficiency of medical processes can dramatically reduce costs without diminution of quality. A typical American surgeon may perform two hundred open heart surgeries a year, whereas many Indian surgeons perform two thousand or more a year with equivalent or even better results. Cataract surgeons in some countries typically perform thirty procedures a day, whereas most Americans do only five or six a day at most. Expensive equipment, including MRI and CAT scanners, often stand idle for extended periods in the United States but are used round the clock in other countries. I believe we can achieve similar efficiencies and maintain and improve quality if we reward those systems that deliver the best quality at the lowest cost.

ER: We do trust the private markets more than the government, but my sense is that people are getting frustrated with our faith in private markets. Who would have predicted that we would

enact some of the provisions of the Affordable Care Act? Do you think the United States will ultimately adopt a single payer plan. Do you think that will happen?

WH: If we adopt a single player plan, it will come after a long and painful political debate. I think the system that is most likely to emerge is one in which the government and large health insurance companies (not employers) pay, and large private healthcare systems provide care. Is that socialized medicine? if the government pays and the private sector delivers? Such public private partnerships work well in Japan for example. Japan is a large democratic company with a capitalist economy.

ER: In Japan there is extensive price regulation.

WH: There is. A Japanese official once told me, "Controlling costs is simple. We control price."

ER: I heard many times in the course of writing the series on healthcare costs, "If you want cheaper healthcare you have to pay less."

WH: There is another factor worth mentioning in considering the high cost of healthcare in many advanced economies. Healthcare provides a growing number of jobs in many countries. Even as they struggle to create new jobs in other sectors, healthcare employment is steady and rising. The Deputy Prime Minister and Finance Minister of Italy once said to me, "Sure we can be much more efficient in providing medical services. You show me where I am going to get more jobs and I will help you do that. The only job growth we have is in medical services." That is true for Italy as it is in many other advanced economies, including the United States. A fundamental question we all face is how to become more efficient in healthcare delivery while

providing new jobs to replace those that may be lost. Job creation and job loss are among the most potent political issues in any democracy.

ER: Have you seen interesting ways to repurpose employment in what is now that is now sickness care towards a different kind of elder care or successful aging in Singapore or elsewhere?

WH: You have asked a very important question. The manpower needs of a healthcare system dedicated to disease prevention, wellness, healthy life style, pollution control, and care of the elderly and chronically ill at home and in the community are very different from the needs of our current sickness oriented healthcare system. I do not know of any systematic study of this crucial issue. Job creation is at the heart of any reform process. It is my belief that a new forward looking health system will provide many more new and interesting jobs than does our current system. But the make up of the workforce will be very different. I have seen a new style of primary healthcare develop here in the US. The focus is on wellness. For a single fee, about seventy dollars a month in New York City, members of these plans have unlimited access to a range of health related services in a community setting, including consultations with family medicine physicians, physical therapists, social workers, nutritionists, and social workers. The emphasis is on wellness. New people with new skills are needed as these programs expand.

Caring for the chronically ill is manpower intensive. In my opinion, technology will never replace the need for intensive personal care of those who cannot care for themselves. As the population of the elderly increases, so too will the need for personal care. Today, the industry that provides personal care is badly organized. Many caregivers are poorly trained and poorly paid. Personal service of the elderly is a major opportunity for job creation. Personal care cannot

be outsourced. It must be delivered locally at home and in communities. I also foresee substantial expansion of institutions that train certified caretakers.

Another source of job creation will be in the redesign and restructuring of how we live. I predict that cities will be resigned to create interlocking village sized communities where people know one another and create self supporting sets of activities. The task of designing and implementing health and wellness oriented communities that address the needs of all ages will be a significant source of new job growth. There are enormous business opportunities inherent in the coming social transformation demanded by demographic change: changes in the value of real estate, the construction of new cities and cities and villages within cities, the creation of businesses large and small that serve the needs of the elderly, the creation of local businesses staffed by the younger old that serve both their needs and the needs of the older old. I believe that we can dramatically improve both the efficiency of healthcare services and outcomes while maintain and expanding job opportunities.

ER: Thank you so much for coming here and talking to us.

WH: Thank you. I have enjoyed speaking with you and the opportunity to learn from the excellent panel of experts you have assembled.