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Talking Healthcare at Harvard

By Dr Hsu Li Yang, Editorial Board Member

"... doctors should know their country's healthcare system, and understand why things are done in a particular way – what are the trade-offs in the system in which they work."

An Interview with Professor William Hsiao

Professor William Hsiao has been the K T Li (Li Kwoh-Ting) Professor of Economics at the Harvard School of Public Health since 1992. He has been involved in healthcare economics, as well as policy and social insurance research in both developed and developing countries, and is perhaps best known for leading the Resource-Based Relative Value Study which led to a series of NEJM papers – and far more importantly – a reordering of the US Medicare physician reimbursement payments that was passed by Congress and signed into law in 1989. His current research focuses on developing an analytical model for diagnosing the causes for the successes or failures of national health systems.

He is also a regular advisor to US government agencies, foreign governments and international organisations such as World Bank, IMF, UNICEF and World Health Organisation. Using an analytical framework of national health systems, his team is assisting in the health systems reforms of several countries, including Vietnam, Cambodia, Taiwan, China, Sweden, Poland, Mexico and South Africa.

Prof Hsiao has been interested in the Singapore healthcare system for some time. In 1990, he was part of a team of economists invited to Singapore for a panel discussion with government officials just prior to the launch of the Medishield programme. He has also written several articles contributing to the ongoing debate in the US regarding the adoption of medical savings accounts (that is, Medisave), drawing upon the experience of Singapore in this matter[1,2]. In his hugely popular Health Economics course at the Harvard School of Public Health, the Singapore healthcare system is one of five systems that he discusses at some depth with his students, comparing and contrasting between the different models worldwide.

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Hsu Li Yang: Prof Hsiao, thank you for granting me this interview. Can you tell me a bit about yourself and how you came to be involved in health economics?

William Hsiao: I was born in China, and came to US with my family in 1948 when my father was appointed as an advisor to the Kuomintang UN delegation. We only expected to stay for two years. But my father died unexpectedly, and with the ongoing civil war in China, our family elected not to return. My mother worked as a housekeeper to pay for the family's needs, but developed tuberculosis and was incarcerated in a sanatorium for nine years – they had no effective treatment at that time.

I read Physics at the Ohio Wesleyan University, but thought that I did not have the right talent for that kind of theoretical work. After graduation, I worked as an actuary for an insurance company for a while, before moving on to the Social Security Administration (SSA) because I felt a need to serve the government. As an actuary, you are always trying to predict trends and the future, but I realised that I was more interested in the causes of economic, demographic and social changes and this interest could not be fulfilled at my job at the SSA. So I read Economics at Harvard.

But you are probably more interested in why I became interested in healthcare systems?

HLY: Yes.

WH: Towards the end of the 1980's, I was invited by the Taiwanese government to assist with their healthcare reform. Taiwan had become successful economically, but realised that its social systems such as education and healthcare were not kept abreast of its economic development – common in developing countries.

I had no idea at that time what constituted a national healthcare system – what were the key elements; what were objectively good or bad systems or even how to measure these things. Therefore I asked the Taiwanese if they were willing to commission a study to investigate these. They agreed, and I assembled a team of experts from US and Europe – including people like Uwe Reinhardt, Bob Evans, and Tony Culyer – for this project. And what I found out was that none of the experts had a good answer for these questions: they could describe the healthcare system of their own country, including what went well and what went wrong, but what causes a good or bad outcome, and what should be the basis and fundamentals of a good system? That was not clear to everyone. I felt that this was a gap in our knowledge that I would like to work on, but I was busy with other research projects then, and hence this was put aside for a time.

HLY: What do you think every doctor or healthcare professional should know about healthcare systems and their financing? In Singapore, for instance, we are not taught very much of this in our medical school.

WH: This is one of the biggest gaps in medical education, not only in your country, but worldwide. I believe that doctors should know their country's healthcare system, and understand why things are done in a particular way – what are the trade-offs in the system in which they work. Otherwise many doctors will end up frustrated, or resentful, because they perceive that many things are not optimal, or that they cannot practise the way they feel is best for their patients.

HLY: Yes, we do have a number of frustrated doctors in Singapore.

WH: And this also makes the doctors less useful as a whole when it comes to improving the system. They can only offer clinical input – what is best practice, what has been done elsewhere – but then it is difficult for them to offer a solution that also considers the system within which they operate.

But this is a problem we recognise and are trying to address. Starting next school year, Harvard Medical School will start a compulsory semester-long course on Healthcare Economics and Systems for all medical students.

HLY: You have described in your class how you had been invited to Singapore in 1990. Did our Medishield programme originate from your proposals then?

WH: No, I would not claim any credit for that at all. There were three of us Economists invited by your Ministry to present at a conference in Singapore – Uwe Reinhardt from Princeton, Tom Pyle, who was the CEO of Harvard Pilgrims Health Plan, and myself. We did not know what it was about initially, but the terms were generous, far too generous for what was essentially a one-day affair.

After the conference, however, we met with a select group of Ministry officials. They presented to us the healthcare financing structure of Singapore. The Medisave programme had been in place for a few years by then, but it was obviously inadequate, especially for acute hospitalisation care – it has to

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do with the distribution of risks and the amount that is saved under that programme. They then put to us a detailed proposal for a catastrophic insurance fund – what is now your Medishield. It was clear then that the question of moral hazard was a weighty consideration.

So no, we did not have a direct hand in developing your Medishield programme. I believe we were invited so that we could be sounded out as to whether there were any alternatives, or any loopholes in this proposal.

HLY: What do you think of our '3M' system then? Does it cut down healthcare costs, or at least prevent a steeper increase in costs?

WH: The Singapore healthcare system is quite unique and efficient. It is a comprehensive system designed to meet national goals, and the answer to the question of equity is honest and explicitly clear from the policies – Singapore provides a "floor" of basic healthcare that is accessible to all the people, but advanced and high-tech care is not equitably distributed, nor was it ever intended to be. I believe, from the available evidence, that it has prevented a steeper rise in healthcare costs.

But this attempt to control healthcare costs from the demand side has not been completely successful. In contrast to the US, where the total and government health expenditure as a percentage of GDP is increasing every year, Singapore's total and government health expenditure as a percentage of GDP only creeps up slightly each year. However, it is important to note that Singapore's GDP has been increasing at a much faster rate (5% to 7% per year) than the US. So in actual fact, healthcare costs in Singapore are increasing very fast, at a similar annual rate as the US and at a rate that exceeds most developed countries.

The other peripheral evidence that the demand side strategy has not been successful was your Ministerial Committee's White Paper on Health in 1993[3]. It was not an explicit admission, naturally, but the switch to a supply side control strategy – limiting the intake at the local medical school and the number of foreign medical schools recognised – was suggestive.

Now it is difficult to obtain data on the performance of Singapore's healthcare system. Relatively little is published, and therefore comparisons with other countries' systems are not possible. I would not have an issue with this confidentiality if Singapore did not promote its healthcare system outside its borders. However, because the Singapore Government is actively advocating the '3M' system to other countries (like China) as a means of controlling healthcare costs, I believe that Singapore has a social responsibility to release this data so that others can independently evaluate the advantages and disadvantages of the Singaporean system.

> "... competition does not have to be internal, a Singapore centre can always compete with international centres. For Singapore's size, you will have to pick diseases and conditions for research where your country has a competitive edge."

HLY: Singapore is also trying to capture a larger share of the medical tourism market. Do you have any comments on that?

WH: I think you will have to be aware that healthcare costs will rise in Singapore as a result. There are two main types of medical tourists – they will come either because the costs of treatment are lower than in their home countries, or you have better technology and higher quality of medical treatment. Singapore tries to attract affluent foreign patients with high-technology medicine. That would raise the healthcare cost.

HLY: A bit of both then. We cannot match India or China in terms of prices, but we can certainly offer cheaper procedures and treatment than US or western Europe. And the quality of care in our hospitals is on average higher than in neighbouring countries, for instance.

WH: Yes, but in general there will be problems if you were to offer specialised treatment for foreigners that your people cannot afford, especially in the public hospitals.

HLY: What about starting off this medical tourism drive in our private hospitals first then, before allowing the public sector hospitals to compete?

WH: If your private hospitals are doing procedures and offering treatments that are not available at your public sector hospitals, there is a risk that more of your specialists will leave for the private

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sector. Of course, specialists can also earn much more in the private sector. One of your former Directors of Medical Services highlighted to me that this was a problem. I read in the newspaper that Singapore has this problem now – some of your best specialists are leaving the public hospitals for the private sector.

HLY: You may have heard that Singapore is contemplating the setting up of academic medical centres in Singapore – perhaps two centres – almost akin to the US model, except that there will be a greater degree of governmental and public funding.

WH: Yes, but I wonder how you can have two top academic centres? Your population size would suggest that you could at best support one centre, even with foreign patients. You want to set up two so they will compete internally, but competition does not have to be internal, a Singapore centre can always compete with international centres. For Singapore's size, you will have to pick diseases and conditions for research where your country has a competitive edge. I do not believe you have enough talented researchers or the economies of scale for two centres.

HLY: Thank you very much for the illuminating interview, and for sharing your thoughts and opinions with regards to our system. ■

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3. *Republic of Singapore Ministerial Committee on Health Policies. Affordable healthcare: a white paper. Singapore: Ministry of Health, 1993*

Editorial Note:

Please refer to page 9 for Health Minister Khaw Boon Wan's speech "Let's Face It: We Are Mortals".