Transcript of Interview with Ashish Jha

JAMA: Dr. Jha, thanks for talking to me.

AJ: Thank you so much for having me.

JAMA: Your study is a bonanza of data. What would you say are the most important patterns or findings?

AJ: There's been a lot of interest in international comparisons between America and other high income countries. And there's been a lot of vagueness about what exactly explains the fact that our spending is so much higher, and our health outcomes are not necessarily better and often worse. And the study really tries to fill in gaps, I think, across a wide range of issues, from structural capacity, to utilization, to prices, to outcomes. And I think the main sort of big picture findings are that, on a lot of the things that we have assumed explain the differences, such as primary care workforce, we actually look pretty comparable to the rest of Europe or certainly to be compared, or countries that we examined. So -- and the other areas where we -- again -- very similar include utilization for most healthcare services, doctor visits, hospitalizations, even medications. The big differences in spending really seem to be driven by prices and we know that by looking at salary differences of doctors and nurses, much higher administrative costs in the U.S. Those are really -- and much higher pharmaceutical costs. Those are really the big differences that are driving the spending gaps. Utilization, primary care workforce, you know, some of those factors don't really seem to be at play.

JAMA: I thought we already knew that, the U.S. was unique in its administrative and drug costs. I think the papers Reference 13 shows that the increase in the prices in those categories -- or at least in drugs -- was an explanation for the rise in overall healthcare spending. Was there really uncertainty about that if that's the kind of take home message from your paper?

AJ: So -- no, it's a good question. So, drug costs, at the end of the day, only represent, you know, 10 to 15% of healthcare spending, right? So, that alone won't explain the fact that we're twice as expensive as other high income country health systems. So, I think the fact that drug prices are higher here, I think, is not a surprise. I think some of the surprises on pharmaceuticals is that we have actually much higher rate of generic use than most of the comparator countries and that -- at least from the data that we could look at -- there didn't see any much in the difference in the way of utilization of drugs and that it really is being driven by prices of drugs. But that's actually part of a broader story, which is if you look at the 85% of healthcare that's not about pharmaceuticals, again, we're seeing these very large differences in salaries between physicians in the U.S. compared to Europe. We're seeing large differences in salaries for nurses but not seeing big differences in utilizations, as I said, hospitalizations, doctor visits. You know, if you go through the entire kind of literature that's been out there, you could piece much of this story together, but I think what is important here is bringing all of that data into one place and being able to see the full picture of the entire health system.

JAMA: One of the subtleties of the work, as you know, is that different countries measure their indices differently. I know you used OECD data primarily as a data source for these cross country comparisons but I wonder if you could speak to the consistency of the many measures and whether you're really comparing the same things cross country for each of the many rows in your tables.

AJ: That's a great question and actually, that was probably the -- I think -- most important part of this work, is we spent an enormous amount of time going through each metric and making sure that we were comparing apples to apples. Now anytime you do a cross national comparison, there are always going to be subtle differences but what you want to make sure is you're getting the story right. And so, there were multiple instances where we felt that the OECD, despite its best efforts, had not quite created an apples to apples comparison and we went back to original countries. We changed around definitions, all of which we lay out very openly in the paper. But the effort here really was to say, how close can we get to metrics that are really capturing the same thing. So, for instance, primary care is defined completely differently in every one of these countries. And just saying what proportion of the of the physician workforce is primary care wouldn't actually mean anything. And so, we went back to looking at what do physicians actually do, what kind of patients are they taking care of, what kind of services are they providing, and how do we just create a definition of primary care that's really consistent whatever the label the country might put on it?

JAMA: One of the messages of your paper is that despite the costs or the expense of the U.S. healthcare industry, many important public health outcomes are substantially worse in cross-country comparisons, one of those is maternal and neonatal mortality. And in a related way, I was speaking with an obstetrician colleague in a completely different context to express concerns about dinging the U.S. on that measure because she says her community can barely agree on a definition of what constitutes maternal mortality that's attributable to either healthcare or errors and how to measure it. So, what do you make of that, those definitional questions?

AJ: so those are very good questions. You know, and actually, we had a viewpoint earlier in JAMA in the fall where we actually talked specifically about maternal mortality and the difficulties of making these comparisons and asking the question, what's the responsibility of the health system versus kind of society at large. You know, one of the things we try to do in this paper is we kind of -- on maternal mortality -- specifically, for instance, we try to show some data that does two things, one is lays out the fact that maternal and infant mortality is of course higher in the U.S. than in many other high-income countries. But then it digs down into metrics where you think the health system is much more responsible, such as saving babies that are born low birth weight. And the U.S. actually does pretty well in that measure. And so, what you have is societally driven things that your colleague is bringing up that's completely appropriate, where the U.S. is not doing as well as some of these high income countries. But once you then agree on what happens to a baby, for instance, a low birth baby -- low birth weight baby -- in those contexts, the U.S. actually tends to do much better. Similarly, you know, we have -- we may have more cardiovascular disease but once you have a heart attack, outcomes in the U.S. are actually quite good. And so, that, I think is an important distinction.

JAMA: Is there a proper interpretation of that because it's easy to take away from your paper, we're spending much more and our outcomes are worse on some important measures, but we're kind of saying that depending -- they're worse or better, depending on how you split the measure. And I'm just wondering if there's a take home message or whether it's a subtlety that's going to get lost inevitably because it doesn't fit into a soundbite?

AJ: So, it's a great question. I'm -- actually, we've been thinking a bit about this. What I would say is a couple of things. First is on a -- if you're looking at health outcomes of a population, the U.S. is a -- it's a very -- it's a much more diverse country and we have pockets in the U.S. that are comparable to the highest income countries in Europe. And so, we have -- in one of the tables, we show life expectancy, for instance, in Hawaii, Minnesota, and Connecticut. It's as good as any northern European country and of course, you know, some of those countries, like Sweden and Finland are 5, 10 million people, the size of our states. And so, one, I think, really important point that I'm hoping comes out of this is that the comparisons have to take into account that we're a much bigger, much more diverse country, and that average life expectancy, or health outcomes, between us and Finland is probably not the right comparator. Second is there are many social things that that drive health outcomes, where we tend to do worse than -- again -- some of these high income European countries. But when it comes to the actual healthcare delivery system, once you get in, people tend to do very well when they get sick. And so, that's, I think, also an important distinction. And then maybe the last point that I'm hoping people will come out of this is, you know, so much of the debate around healthcare these days is about over utilization and that somehow our health system is uniquely bad at avoiding unnecessary services. I think these data really put that argument to rest. Except for a few pockets, utilization really is not different between us and these high income northern European countries and so maybe we need to spend a little less time focusing on that and a little bit more time focusing on prices of our healthcare system.

JAMA: Is the variation at the state level enough that it's kind of a Federalist argument that really healthcare reform should be happening at the state level and there shouldn't be any national federal healthcare reform imposed on the states?

AJ: Well, whether there shouldn't be any is I think, of course, a high bar. What I would say is that our data and other data suggests that, you know, the issues and challenges in Minnesota are probably pretty different than the issues and challenges in Mississippi. And there isn't one solution that's going to come out of Washington DC that's going to be equally valuable for Minnesota and Mississippi. And so, we certainly need a certain amount of federalism. Whether the federal government has a role to play, I think it probably does and it should be setting some basic standards, some guidelines, some guardrails for what states do. But there's little doubt in my mind that when you look at the variation in outcomes and spending across states, states should have a bigger role in reforming healthcare.

JAMA: And what would you say in response to defenders of the market system for the healthcare industry and maybe the pharmaceutical industry in particular who claim that the pricing structure incentivizes excellence and innovation that the reason the U.S. is a leader, say, in the pharmaceutical industry, in developing new agents is because of the profit motive and that a really expensive drug is always going to be much less costly than an untreated disease?

AJ: I'm not sure that more expensive drugs is going to be less costly than an untreated disease. I actually think that a lot of the very expensive drugs are not -- only not cost saving, they're not even cost effective. That said, there's also like no doubt that America and its prices really is the innovation engine of the world and we show a bit of that in our paper by pointing out that, you know, sort of new chemical entities, new drugs, come out of the U.S. much more than they do out of anywhere else. And so, the question from a policy point of view is, do we want to continue to pay for the innovation that the whole world benefits from? And, you know, Americans benefit from it, sure, but we're paying for the innovation that the whole world benefits from and that -- and that's a challenge and it does suggest that we have to do something to deal with our drug prices. And ideally, it also means getting other high income countries to pay more.

JAMA: You and your colleagues write that the data might foster informed discussion and informed policy decisions. That's really beautifully noncommittal. These trends are in place when the democrats had a go at healthcare reform in 2008 and '09, do you think that we're in a place where we can use these data to have reasonable discussions and make policy decisions and move reform forward in a way that's good for the U.S. healthcare system?

[00:12:55]
>> I do. So, I'm always optimistic that we can make -- we can come up with bipartisan solutions that will move the healthcare delivery system forward. Look, I think if you look at our data, the conclusion out of this, which is -- you know, in some ways, not that different from a -- from the famous paper by Jerry Anderson and Uwe Reinhardt arguing that it was the prices, you know, the paper from 15 years ago, is that really what's driving our extraordinary healthcare spending is the very, very high prices of almost everything. And this is a place where we know that, for instance, having more competition in a marketplace -- more competition among hospitals, among doctors, among generic companies, congenic drug companies, all of that lowers prices. That should be a completely bipartisan agenda because if you

lower prices and if you have more efficient pricing, it's a market-based solution. The Republicans should like it. And it makes healthcare more affordable and therefore, more accessible, which is something everybody should get behind. I think that in the ACA, we missed an opportunity to focus on prices and we really focus on utilization. And I am hoping that these data spur on some amount of action so people can think about, how do we get our price problem under order.

JAMA: So, are you in favor of CMS negotiating prices for drugs directly with industry?

AJ: I think in certain instances, I think that's probably reasonable. Pharma is a -- is a specific issue because, again, CMS is such a dominant purchaser. But if it lowers prices, it will have some impact on innovation. Now the question is, is that tradeoff worth it? How much lower prices? Those are, I think, where that decision ultimately needs to get made. So, I guess I'm being -- sounding noncommittal. I'm not opposed to it, I just think it has to be done carefully because it probably will have some impact on innovation. But I'm very much in favor of other efforts that lower prices across the entire healthcare system, the prices of hospitals, and doctors' services, and MRIs, and CTs. You know, there's no reason that an MRI in, you know, Wichita, Kansas should cost twice as much an MRI -- as an MRI in London. That just like makes no sense. And that's a place where I think we can make some real progress.

JAMA: And give me one or two strategies to do that.

AJ: Well, so what we know is that, again, [inaudible] about the evidence, look, there are two ways that we know how to lower prices, one is the government could just pay less, so Medicare could just make payment cuts to a whole bunch of services where we pay a lot more than other countries. The other part, again, certainly on the private insurance side, is we know that more competition is the only other mechanism we have for lowering prices and we know that in markets, for instance, that have more hospitals, hospital prices are lower. Where there are more doctor groups, doctor prices are lower. So, I think competition and then selective price cuts by Medicare is probably the combination that gets us the [inaudible].

JAMA: Is there anything else you want to say to -- as a quote for a video or audio interview -- get out to listeners?

AJ: No, I guess the big picture point I would say, Mike, is I think this set of data helps us look at our problems I think with a fresh pair of eyes and dispels some of the sort of simple solutions that we've had like, we just need to have more primary care physicians or we have way too much overuse, and pushes us towards I think more evidence policymaking, which has to deal with both administrative complexity and our very high price structure of our healthcare system.

JAMA: Dr. Jha, thanks for talking to me.

AJ: Oh, my pleasure. Thank you.