Programme OPERA – ENTRETIENS

Entretien – santé n°17

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(Sebastien Guigner and Responder speaking French until 35:34)

Responder: --stepped outside of their data, and speculated about reasons where there was a little bit of evidence, but it wasn't well-established.

Interviewer: Right, okay.

And I think what happened was that they started getting involved in policy discussions, and were asked by various public officials to come speak, inform them, et cetera, and very often, when you have an idea about how to make the world better, you get caught up in the enthusiasm of it, and sort of forget that you're wearing a scientist's hat at the same time. I think that's what happened there.

I mean, these are very good people. Elliott (ph) and Jon (ph) are smart, dedicated, really serious scholars, and it's unfortunate that they got caught up in this.

I'll try to meet them, because I would like to ask them how their report entered politics. Maybe you have an idea about that?

There has been a-- this started in 1978 or '79.

'70--

Yes. The first paper on this subject was written by the man who actually led them for many years, named Jack Weinberg, and he pointed out variations. He showed that in very similar communities, the same number of doctors with, just everything the same, the rates at which you did tonsillectomies and hysterectomies and things like that varied by a factor of 80%, 100% or more. He just kept saying, “Why is this,” and it became more and more sophisticated, and they looked at more and more issues, and started saying, “Gee, if we made everybody look like Minnesota, we would save 3 points of GDP.”

So, that's a very long process.

But the important thing is that Jack created this center at Dartmouth to do these studies, and Elliott was one of his star young people who he brought in, Elliott Fisher, and Jon Skinner was an economist he brought in, and they then dramatically increased the sophistication of the work and have gotten a lot of notoriety as a result.

So, Jack has been bringing this to Washington for 20 years.

Okay, that's perfect, for our study is for 30 years. Yes, I asked you questions about your relation with career people here, and what about your relation with the White House? Do you have some relation with it?

A little bit. I work on one part of health reform called the CLASS Act, which will establish a new long-term care insurance policy, that is somewhat similar to the French one, which is a cash benefit, and is sort of a hybrid between the French model and the German model, of course, with an American flavor, which means it's voluntary, as opposed to universal, and because it's a very complicated and very new and, potentially, very large and also risky program, the White House has given it a lot of attention, and since I've been the main sort of economist working on it here, I've had a fair amount of dealings with the White House.

So, for example, during the run-up to the legislation, I worked very closely with the Office of Management and Budget to put together the sort of economic analysis and some ideas about remedies for some of the problems in the bill.

You said it's risky. Why is it?

Well, voluntary programs, voluntary insurance programs with-- aimed at people with disabilities, some of which are hard to measure, like, cognitive-- you know, cognitive impairment, risk what we call adverse selection, and maybe, as a political scientist, you don't know that, but what it is is, the tendency, when you offer an insurance program for people with disabilities, for people with disabilities to enroll in greater numbers than other people, which makes it very costly, and because it gets costly, the healthiest people drop out, and you're left with, essentially, the policy becomes financially unviable.

It's a vicious cycle.

Yeah, it's called a death spiral, and there were a lot of criticisms of this part of health reform in the run-up to the legislation, and so because of that, the White House gave it quite a bit of attention, so I spent a lot of time working with them, particularly in the Office of Management and Budget, but also a little bit the Office of Health Reform.

And--

And here you work alone on this project, or--

No, I have 7 of my staff working on it, there is a department-wide working group that oversees the policy that I chair and things like that.

Do you have relations with think-tanks, or--

With who?

The think-tanks, like the Heritage Foundation, or maybe not this one, but--

Brookings.

Brookings, or the Center for American Progress?

Center for American Progress. The relations are mostly personal, so, you know, I have friends at the American Enterprise Institute, I have friends at Brookings, I have friends at the Center for American Progress, and I even have a friend at the Heritage Foundation, and I talk to them. I have been invited, I gave a talk, I guess it was in March, I gave a talk at Brookings, at a conference that Mark McClellan sponsored.

I am giving a talk next week at the National Health Policy Forum, things like that. So, it's a venue, we talk to these people, because they know things and--

And with the academics, do you still have some relations?

Yeah, I mean, I'm on leave from Harvard, and my intent is to go back, so-- yeah, we had a conference, and one of the things that is in the bill is a provision that talks for changing the way that we pay for end-of-life hospice care, and so we had a conference here to sort of pull together all the best thinking, and probably, you know, half the people at the conference were academics, there were a lot of government people, and then some think-tank people, et cetera.

So, you take (inaudible) where they are, you don't have any special structure?

No. In fact, I think one of the good things about having political appointees that-- they have spent a lot of time outside the fishbowl, right, the (inaudible) fishbowl, so we reach out a lot and talk to people, and we have lots of people coming in-- all the groups that are interested in this come visit, and it's their government, they get to come and tell us what they think, and they do that, and we often learn a lot from them.

And do some states come to see you, too?

Absolutely.

What is their position, usually? Do they want more flexibility?

There's a lot of things. In some cases they want technical assistance, in some cases, they want flexibility, in other cases, we are putting together new programs, they want to let us know what will help them best solve their problems, so, for example, we had a proposal that we're putting together that would bring housing vouchers together with Medicaid together with some specialized mental health and addiction services in order to address chronic homelessness, and so the states have all come in and said, “Well, here's the way our population looks, here's the problem we face. You know, can you address this as you shape this.”

So, we've-- they've talked to-- on that one, we've talked to probably 10 or 12 states about it. You know, they've been in to visit us, we've had conference calls with them, we've talked to their state association. I've been to two of their conferences and spoken at conferences and told them about this and asked for their feedback.

And, on the contrary, to they sometimes inspire you or your policies at all?

Yeah, I mean, certainly, Massachusetts was very influential in shaping the health reform here.

And for your specific issues on your office?

My office? Yeah, some. So, for example, one of the things that we're doing right now is, we're working on supported housing for elders, ways of keeping-- using Medicare and Medicaid to keep older and somewhat impaired elderly people living in their homes, keep them out of institutions, and we've been to visit several state programs, and one of the ones that we've been most impressed by that has shaped our thinking about this is one in New York, and so we went out there, spent a day with the people who run it.

We're going-- I went to one in Massachusetts a week and a half ago, and so I-- I'm going to have to go.

May I just ask you one last question?

Sure.

Just to conclude this, would you say that the government, the central government, the federal government, sorry, has increased its power or its influence in the field of health or healthcare during the last 20 or 30 years, or is it more complicated?

No, it's absolutely-- if you just look at the money, 20 years ago, the government would have been, I don't know, 30% healthcare spending, or, 30 years ago, it would have been 20%, 30% of healthcare spending. Today, it's over 50%. So, right there, the fact is, it's-- because of Medicare, because of Medicaid-- and then, you know, health reform will continue to rely on markets to some extent, but it changes the regulatory environment.

So, you know, I think there's no doubt that-- I think it's sort of a fact.

Yes, it's a fact, but I think it's more complicated, because the big government increases its role, but also the states, private insurance, everybody--

Well, I mean one of the issues is that the health sector has grown so much, but the government's role has grown faster than the roles of the other two, the federal government.

Alright, I really do have to go.

Okay, thank you.