Programme OPERA – ENTRETIENS

Entretien – santé n°18

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Interviewer: What did you like in CBO?

Responder: First of all, I got a much better sense of what policy issues are really about than what I developed as an academic. And I also liked doing work at the requirement of a client. At the CBO, the clients are the staff directors of committees in Congress. The sense to do something because the staff needed it in Congress, for me that was important. It was much more meaningful for me that all the freedom I had in academia.

So, you feeled close to the policy makers at the CBO?

Yes, in the sense that some policy makers – not all of them – had a good sense of how research and analysis could be used in the policy process. For those people who did not have this sense, it was part of my job to help them … (alock). Because all the work done at the CBO is done at the request of someone in the Congress. Some staff directors knew how to use research and some did not.

Do you think the role of CBO changed since the 1970s? Because there are more think tanks, research organizations and staffers have a larger choice to get information.

CBO has a very important job of scoring spending and revenues of a policy changes and they only do their job. But what happened is that there have been more people in other think tanks often funded by interests groups to second ghest (?) the CBO. In a sense it surely kept the CBO – the expression is … - knowing that others will be publishing and estimating the same things. The Congress has no choice but they use the CBO estimates. Still they have to, you know it a challenge to maintain their credibility (?). And one thing which happened for the CBO: resources devoted to health care issues have expanded enormously over time. When I started in CBO in the 1970s, I think we were six people on health care for an organization of maybe 225 people. And now there are 40 people on health care. A part of that reflects how health care has become a such large portion of the budget. So CBO has a lot of resources to do its work.

Do you sometimes work with it?

I am actually not a member. CBO, four years ago I think, formed a panel of health advisers and I was a member of this panel.

What's the job?

It's been different depending on who is the director of CBO. Peter Orzag, who is now the director of OMB, when he was the director of CBO, he formed this organization. CBO has for many many years a panel of economic advisers who are generally macro-economists. He thought that it was a good idea to form a panel of health advisers; most of whom are academics but some are more practical. For the first couple of years in that panel, we met twice a year. Thay would raise, challenging things to deal with. More recently, the panel has not been meeting although periodically, emails are sent out asking for responses or conference calls. So it's becomes even more informal.

So it was directly oriented to the reform…

I do not think so. It was depending on the director and his ideas. One of the things that Peter Orzag, he substantially shifted resources through health care. When he began his term, in 2006 or 2007, it was before Hillary Clinton spoke about reform. Reform came out in 2008 for the presidential campaign.

To come back to the CBO, did you meet people there that you still work with?

Well, I think that I knew people in the CBO who are still there but not in health care.

Do you see a reason for that?

It's too small. I could make up a lot of reasons but one reason is that health care is growing field, there are more opportunities in health care that in other areas. It is really too small in number. I could say it is like a family people working on health care.

Would you agree with the idea that there are two generations of health policy analysts, one having working in the 60s for the Medicaid and Medicare; and one corresponding at the end of the eighties, with new ideas, more market oriented.

It is an interesting idea but I do not think that it is true. There were a number of people, my peers, who trained in the late 60s and it was probably the first generation at least of economists in health care. There was no previous generation, except occasion person. I would say that my generation is still at the top of the field. With the Clinton plan and the task force, they just grasped up a lot of people, mostly in the government. I would not characterize that it was a new wave of thinking people. Just the political opportunity rose. We had a president who wanted that. It grasped up the people around.

When you speak about your generation, whom do you think about (which people)?

- **Karen Davis**
- **Jo NewHouse** (Harvard University)
- **Frank Sloan** (Duke University, Professor of Health Policy and Management and of economics since 1993. Director of the Center for Health Policy, Law and Management. PhD de Harvard. Parcours académique + Rand Corp., recently a member of the Physician Payment Review Commission)

When I think to other people who are proeminent, I do not think in terms of wave. I just see them as individual who came into the field at different times. One person who is very preeminent and influential in this administration – even if he is an economist with broader training than health care, anyway – is David Cutler. He is younger but I would say that he is from another wave. He is just an individual who became preeminent. There is another economist, Arlette Fisher at Dartmouth, who is really taking over from Jack Wennberg (en fait John Wennberg) who, back in the 1970s started to study small areas variations in health care.

After the CBO, you came to the Rand Corporation…

Yes, I just became tired of CBO (Six years in CBO). It was a change for me from doing policy analysis to doing policy research.

In what sense?

Policy analysis is: identify issue, understand the issue, draw on research that is available, outline what the policy options are, the pros and cons. Whereas research, I would define it as understand how health care systems work. I would say that it characterize my career of shifting back and forth between research and policy analysis. So I went to Rand Corporation and did research there. I would have staid longer except what to me sounded it was: the idea of job was offered to me for two years. The job was to be executive director of a new Congressional Commission called the Physician Payment Review Commission. The Commission was created by Congress with specific purpose, issue that I should address. It was created to really form proposals for reform of physician payment in the Medicare program.

And the reform passed in…

1989. The Commission began as I mentioned in 1986 and it had some real opposition from some people in Congress because there were some people who thought that the functions of this commission should be done by the executive branch of the government. So there was an uncertainty if the commission would be finally funded. But it got and it did many recommendations. In 1989, the legislation passed and it followed many of the recommendations that the Commission did.

Who were in this Commission?

The Commission had members who were a mixture of people representing stakeholders – or interest groups – and also people appointed for their expertise.

For instance?

There was someone recommended by the American Medical Association, another by the AARP. One of the experts was Uwe Reinhardt, professor at Princeton University and very well known because he an [agency speaker].

Why was it the ideal job?

I guess it was an opportunity to play a very visible role in policy from my stress, as a policy analyst researcher. The chairman of the commission was Philipp Lee, a physician professor at the university of California, San Francisco, very preeminent in health policy field. Another representative of stakeholder was a former president of the Blue Cross Blue Shield Association, to bring the perspective of the insurance sector. We also had a nurse.

Did you have relations with other Commissions on health care, for instance the Pepper Commission?

No. The relations was with a what we called a sister commission which was set up three years earlier and focused on hospitals. Iw was called the Prospective Payment Assessment Commission. Although its job was very different because the hospital payment reform had already been enacted. Their role was really at monitoring and making recommendations on refining the hospital payment system. The two commissions had an identical administrative structure and the two were eventually merged in the late 1990s.

Would you say that you developed more contacts with the Congress than with the executive branch during your career?

Yes, that has very much sense. Because at the CBO, I worked exclusively with the Congress and at the PPRC, we worked mostly with the Congress. Once the legislation was enacted, we worked more with what is called now the CMS for the implementation issues. Even now, when I am in a private think tank, I would say that relationships with Congress are stronger.

Do you think that is was a disadvantage during the Clinton attempt of reform?

Yes, I felt very much on the side-lines. It was clear that neither me personally, nor the commission should be involved in the reform. I actually was invited to the task force for a meeting that I attended and I was asked to be a member of the task force and I said : “no, I can’t do this and still do my job”. My boss, the doctor Lee, who was advising the secretary of HHS at that time, Donna Shalala, was asked by the Congress to leave. It was a frustrating period, there was all this activity and we could not be part of it. [Nobody was …]

You did not want to leave the commission to join the task force?

No. The task force seemed very poorly relevant. Sometimes after the task force was over, the records of the task force became public. I was called by Robert Perott, reporter of the New York Times, whom I had know for a while; he called to tell me what was said about me. I could have been recruited by the administration for a real job but just working in the task force was not very exciting.

Then you founded this organization?

What happened was with the Robert Wood Johnson Foundation. The asked me: “If we gave you founding to do this, what there the vision I had, how would you do it? I was one of 5 or 6 people who were asked that question? The decided to choose me to do it; that is why I left the PPRC.

In 1995?

Right

What was the vision?

What motivated them is when that they saw the direction of the Clinton plan and some of the directions in health care system as far as large organizational changes, crissing importance of competition and markets. They were concerned that the regular government monitoring of health care system would not gonna be [ ] to really understand that development. That was their vision: to have an organization that could really understand and communicate the important change that was happening in the health care system.

What were the major changes according to them?

Probably the profound change was managed care.

What were your propositions to develop this center?

Oh! I do not remember what I said! The process started by having funding for a year to develop concrete [mayons]. That is what we did. They liked the plan and decided to provide funding for a longer project. I would say that the core of what we have done is collecting data with a focus on a sample of representative communities. We collected data by three ways. One is by surveying hassles. Surveying physicians. And what is popular because unique thing, is what we call "…. Community tracking study". We have 12 metropolitan areas and every two or three years, with a team of our staff and some outside people to interview the leaders and different parts of the health care system. We write many reports and articles about those; both the communities and important developments that cross communities in the health care system.

In your opinion, what do these very concrete aspects give to understanding the evolution, for instance managed care?

Concerning managed care for instance, we will be getting the concrete aspects: how the manage in the care, what type of administrative control they are using, how they form their providers at that works, how hospitals and physicians would adapt to this new world of managed care.

Did you help for something in the main reforms in the 1990s and beginning of the years 2000? (BBA in 1997, MMA in 2003?)

I would not say that we had close contact with the policy making it in those legislation.

Why?

I think it is because of the nature of what we do. Teaching the policy community how it works and what the developments are, provide context for policy making. Sometimes we identify problems, sometimes we [ ] - you know, some people think that is the case and we show that it is not the case – and we are not very involved in policy making.

For the last reform?

For the last reform, we were invited for discussions on topic where we are very acknowledgeable about. For example providers payment is something we are very acknowledgeable about and was able to help Congress staff to think reforms of provider payment in regular programs.

Because you know very well the needs of the providers maybe?

We know what is wrong with the current payment system and we know what is feasible for the providers and for the different payment system. We know the fact that some communities are very well prepared for that [the new system] and others are not at all. Just because of the different structure: there are communities where the physicians practice just in small practices and other communities are with very large hospitals and groups. When the reform was enacted, certain communities were already ready for right now and others are very far away.

Do you think that you have a role of intermediary between providers and policymakers? To help them to understand each other?

Yeah, except that is it broader than providers, because we understand the insurances, the employers as well. Intermediary between what is called the financing and delivery system and the policymakers. [I think it is wrong that hopefully people trustee the delivery system] it is called Wall Street comes to Washington. This is an example: equally analysts in Wall Street, their job is to give an opinion of who is gonna win money, who is gonna loose money. I started doing is, when a [ ] comes to Washington, I will ask you questions and, instead it would be audience for investors, it would be an audience of policymakers. As soon you remark what policymakers should learn from, it is going on on the industry that you cover.

Since you were not very involved in the reforms of 1997 and 2003, do you think that your center has been influential in some way since its setting up?

Yeah! The center actually run a war (won award) for being influential! AcademyHealth, which is the professional society for people who do health policy research and health policy analysis created HSR, how research impacted the world. We won the award the first year, about five years ago. Why we won it for, is that we had in porvoteside visits and we became very award of the rubber growth in some communities for the specialties in hospitals. – and the implication it has for the rest of the health care system. So we published a number of studies on it and did conferences on it. Congress became award of the issue and enacted, it created a moratoria on construction of specialties in hospitals. That was we won award for being infuential. Another for which we have been influential is for the physician payment, which for me is a return to my previous root. I started to look at it again when I saw how vigorously physicians practicers were responding to some of the insators in the payment systems: they were really not attending; and so for more and more physicians payment, and in a believe of being influential. Especially in spyering the physicians payment provisions in the reform, they just ask.

I also have a question about your personal views: did you have personal views when you started in the field, or did you get personal views later? And did your personal views evolve over the years?

Well, actually, I keep some of my views for myself because in this organization we made the decision at the very beginning that we would not advocacy policies. It makes a difference from many other think tanks. We thought that it would make more sense for people to pay it to make our research as credible as possible. We should not be involved in making policy recommendations. We give up some things that way. But I think that we have been successful. I don't get invited to testify as much as I think I should. It is because they want witnesses who will strongly advocate their point of view. There are hearings where they just want to learn, and I am invited for this kind of hearings. And there are hearings – which have become typical these days – where they want to present their views. So anyway, concerning mys views about the direction of reform, I just keep my personal views and hopefully they don't come out too strong with the work here.

What are they?

I do not know where it starts! The basic design of the reform, a mixture between the expansion of Medicaid – covering the poor through Medicaid – and then having insurance exchanges and subsidies for people who are not poor enough to get Medicaid but still need help, I think that it is the right model for this country. Actually I had a point of view which evolved over time. I think that the single payer system would be much less successful in the United States than it is in Canada or in France because of our political system.

Why?

Because the ability to limit the resources into the system, that what we would [whod] down. When I was younger I though that it was a very good system. It changed as I got much closer to the policy process. I started recognizing and I was concerned that it would work here.

Could you precise when these views changed?

No. Just when I learned about how the policy process works and the lobbying process, I became less optimistic.

In the eighties?

It is hard to say because it is not because of the events of the period but it's my becoming familiar with how the policy making works. I do have a prospective. I do not think that we will be able to control cost without engaging more the patients and customers in comparing providers on the basis of costs. I do not think that we gonna get it that far in that area. I think that we automatically will have to use a regulatory process to specify the payment system and put limit on what providers could charge. That is a perspective that I definitely had in the 1970s, when managed care was in [fool bloom]; it seems that would not be necessary. But then, when we rejected managed care, it became the only course.

When you describe the right model according to you, it is quite similar to the new reform…

Yes, I was very content of the new reform. The new reform, which copies the Massachusetts reform, gives in our system a view a what was politically feasible. It was really the only viable way of pursuing.

Did you work in bipartisan commissions? Because I know that at the beginning, the Democrats and the administration tried to get a compromise with the Republicans.

You know, the political history of health care reform in our country seems to be an history refuse of compromise. People in the course of this reform have notices that, after Clinton proposal had reached some obstacles, there was a potential to compromise with Republicans that was actually very similar to what was enacted now, it could have been enacted without any antagonism, but the opportunity was not seized. In fact Senator Kennedy whose the activity had been very visible for decades on health care, often told people that his greatest regret in his political life is not to have made a deal with Nixon in 1974 over the Nixon plan for health care reform.

Do you think that Senator Kennedy was very involved in finding a compromise with republican in the last reform or since the Clinton attempt of reform?

In the last reform, he was too sick. In the Clinton reform, I do not know who decided not to compromise with the Senators Dole and Cheffy who are moderate Republicans.

You, at the Congress, do you have relationships especially close to some senators or representatives?

Not over the long time. Because of the turnover. I remember I wrote an article in Health Affairs about the future of employment-based coverage under universal coverage. I found meeting with two senators because one in their staff had read the article and wanted to talk about it. There are some staffs that I know for a very long time, ansd in many cases I know them, because they left Congress and they are back. I would say, since Democrats both in Congress and in the administration have much more people who would like to work for them, when Democrats came back to the Congress in 2007 and to the presidency in 2009, many people who I know for very long time, very senior level, returned. They are not concerned by earning less money because they would be part of the policy process, which is, when Democrats run power, so attractive for them. So people that I knew for a long time ago came into position of power.

The Democratic people are more involved than Republican in health care…

Right. Because when Republicans seem always bring new people in, then they leave to become lobbyists. There is someone I know, ….. [Alice Feller], in the Finance Committee. She has been in the same Senate Committee before and left for a large insurance, Well Point. Then, when the Democrats were back in control, she was offered a job in the staff again, and she decided to do it.

How many people work here?

25.

And when it was created?

I was the first! But I would say that the center grew up fairly quickly to the point of 30 people. Then it went down below 20 and then it grew up again. A lot depends on fundings.

Is it difficult to find funding?

We look for the type of fairly unique type of funding. There are funding for projects and then there are what I call core funding, that support the organization, and support the activities not automatically related to particular projects. We started being fully founded by the RWJF. One of the things they asked beside research is having a very aggressive publication and media agreach, what has been very successful. We can support activities from the foundation. The foundation affairs started on a number of stages they cut back their supports; but then they decided that they want not to continue the core support. We got a lot of project support from other foundations, and some from RWJF. But for what I wanted to do, I needed a core support and I found another core founder. It was a founder called the National Institute For Health Care Reform. The United [Unions] Workers and the free [on the bill] companies jointly decided to created an health policy research think tank. I was approach to lead this think tank and quickly said "I am not interested in leaving where I am but why don't you operate resources for this organization?" and they agreed. So we had a core founding and that why we were growing again.

In the think tank New America, they have a group made up of leaders in the private sector who advocate for a national reform on health care. Is it the same kind of groupe as the National Institute For Health Care Reform?

No. The National Institute For Health Care Reform does not push the perspective of the oil industry. It has the goal of reflecting issues important to very broad things of oil companies, oil workers. In agreeing to support non partisan research and also the no-recommendation because the institute does not make recommendation, other companies in the US do. It is really divorce from their advocacy. It is really for better understanding of health care system. How to run this program this better, or how to reform the physician payment, that is something relevant for them.

My last question is about the evolutions of the research centers in Washington. Do you have an idea to explain why there is an explosion of the number of think tanks or consulting firms on health care issues since the eighties?

Yes. There are two aspects I can think of. The first is that the policy process changes. The policy process is more interested and opened to research. That is an opportunity but I am not why it happened. Maybe it was because research was demanding more. The other thing is that there are more foundations, which want either to push a point of view, or, like the RWJF, to provide better information to policymakers. So some of the explosion of think tanks has been caused by the interest of potential founders who support these activities.

Why do you think there is more money?

Part of it is because health care is a big part of our economy. There are all different shapes of think tanks. For example, there are a lot of interest groups with funding to, and organizations like these, we do not work for them. The ones that have the best reputation would only accept funding from organization that let them doing their research in a very objective, unconstrained manner.

For instance?

The Brookings Institution, the Rand would be example.

Do you think that the political parties are looking for resources in expertise outside the party more than before?

It is a change in policy. There is much more of the requirement of information, research results to do policy now than it used to be before. That is some of the irreversible changes. People are looking for data, good policy. The other change is between the two parties and this is unfortunate. The have become very apolorized. They are very few Republican moderates. They are not welcomed in the party and even the Democrats have become the opposite extreme. That makes more difficult to make policy.

Do you think that the think tanks have a role in this process?

I do no think so. In think as more parties become polarized and political debate becomes more ideological, the think tanks have a smaller role. It is only when you don't have a major ideological component to an issue, that the think tanks can be influential.