Programme OPERA – ENTRETIENS

Entretien – santé n°35

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Interviewer: At first, could you go back to your studies and the beginning of your career?

Responder: I began my studies in a college in Massachussetts and I started to be very interested in low-income Americans. Then I worked two years for Massachussetts Public Health service and in the service for care of drugs and addictions. Then I did a Master at UCLA in health policy management and I worked at Harvard Medical school. I was very interested in how government can affect public health. In 1976, I went to HHS, initially as an analyst to the head of what is now the CMS. I received a grant to study how government works in the sector of health. Then I became senior analyst for the head of the HHS, doing briefing for the Secretary of the HHS and for the Deputy Assistant Secretary Planning and Evaluation/Health[1]. There I learned how to write recommendations to policymakers. Then when Karen Davis went to John Hopkins and joined her to do my doctor studies and I worked a lot with her, writing books and articles. During my doctoral studies, I also worked part time for the representative Waxman, who was chair of the subcommittee for Health and Environment for the Committee on Energy and Commerce. I continued to work for him until 1991, when I was asked by the Kaiser Family Foundation to lead the Commission on Uninsured and Medicaid beneficiaries. In 1993, I became a senior President of the Foundation. So my policy experience is both in the legislative side and the executive side at the federal level, and much earlier at the state level. I am very a public policy person engaged in trying to affect the communication of new ideas, in a non academic manner.

When you did your master in health management at UCLA, was it a new field?

No I don't think so. But is was more traditionally to run health care institutions like hospitals than to do research. What really changed is the ability to use computer to do large simulations, anticipate the distributional effect of a policy, use large survey and data.
And also, when I was in college, Medicare and Medicaid had existed for only 5 years.

[1] Karen Davis.

Do you remember who you read at this time?

Milton Roemer who was one of my professor at UCLA; I also read extensively reports by Paul Ellwood on health management organizations. Ginsburg and Evis Donbedrum. The very classics!

What did you learn from your experience in the administration?

To lay out recommendations for decision-makers. How to use research in order to make recommendation as clear as possible for the decision. It's important to show all the arguments of the interest groups and to inform the decision maker about them.

Do you remember the general atmosphere in HCFA when you worked there?

There were two concerns: cost containment and improving coverage. And actually they still remain today! They have never been solved!

Were there tensions inside the department?

There have always been tensions on priorities: should we do cost containment first and then improving coverage, or improving coverage first and then containing cost, or doing both together… Finally they chose to do cost containment first and the legislation didn't pass the Congress.

Who made this choice?

It's always the tension between budget people and the department of Health and social security. So economics advisers in particular were for cost containment first. And economists in general. Except Karen Davis who was in favor of coverage first and cost containment second, but she is an unusual economist *(with a very kind smile)*.

Do you remember how the report by Alan Enthoven, the "Consumer Choice Health Plan", was received by people from the department?
It was much later during Clinton era.

I wanted to mean the first time, when he wrote a report for Califano…

I don't remember.

Do you remember if this kind of ideas of consumer-oriented care or consumer choice were supported by some people in the administration at the end of the seventies?

No. You know in my work I focused on Medicaid and especially expanding coverage for children. As you know HCFA was for Medicaid and Medicare programs.

What were the main issues on Medicaid at this time?

How we could engage states that were reluctant to implement Medicaid program. And also what we could do for children and pregnant women.

Did you manage to achieve something?

We worked on a major legislation that would have expand insurance for children and pregnant women but it was never enacted. Abortion was again a big issue and interest groups opposed strongly the bill. Abortion has a big impact on health policy in the US…

You said that in the administration, you learned how to write recommendations for policymakers. Could you describe a little bit more?

You really have to be very clear and concise, explaining very clearly the pros and the cons of the proposition. You have to show how the policy would change the current situtation and whom it would affect. A policymaker needs to be informed in advance on the opposition and the arguments against a proposition. He doesn't want to be surprised by argument of the opposition he didn't expect. Often advocacy people don't lay out all the implications of the idea they are proposing. A policy maker doesn't like that. He expects from his policy advisers to be deeply informed. So you have to be very honest on the arguments against it; and also very concise. Never selling something without explaining all the implications. Advocates usually don't warn policy-makers. In serving a politician, you can sell something and tell why it would be better but also what are the oppositions and what are the alternatives.

Was it very different to work on the Hill or in the administration?

There were much more meetings in the administration because of the gap between policy people and operating people running the administration. In the Hill, there were less people to take into account, although we also had the administration to take into account. And there were also meetings with the opposition, but it was more bipartisan than today and I don't know how it is today.

In the administration, did you feel different culture between older public civil servants and new one?
There is always this tension between bureaucracy and new political appointee. The challenge is to identify key positions in the bureaucracy to work with these people, educate them. It's really the challenge for transition times, identifying the natural leader in the bureaucracy.

Usually the Department didn't not deal with the question of costs…

Actually the biggest change for the department at this time was an organizational change. Before, Medicare was part of social security services and Medicaid part of welfare services. It was decided to join them in a same service and it was a very significant culture reajustment. There were people with a "social security" culture, culture of social insurance, and people with culture of welfare… That was a big cultural shift.

When you were hired by the Kaiser Family Foundation, what was your mission?

I was hired after having worked with a grant from the Kaiser Commission on Medicaid and the Uninsured. I worked to build an analytic staff about poor and Medicaid beneficiaries at the national and state level. The question was how to improve health care for low-income people.

What was your position during the Clinton debate?

Here we don't make recommendation or push policy. We try to refill the informational gap in providing perspectives on how a policy proposal will change situation for people. We work more on the effects on people than on providers or industry because they are able to do their own case. So we hope that the advocates and policymakers will use our data, information and analysis. We analyze for instance 3 different proposals and assess their different effects on people. But we never set a proposal.
We put all these information on our website. We also are often asked to testified as a think tank providing information. But of course, because our focus in on poor and Medicaid and not on the market side of politics… We try to be as neutral and objective as we can but our focus makes us a less conservative think tank than AEI.

For which reform do you think you have been most influential?

Much of our work has been useful I think on piece of legislation concerning Medicaid and uninsured. For instance the Medicare part D drug benefit. It helps to inform, to understand. What is very important for us: we do the numbers but we also do the human faces, the people behind the numbers.

Do you have a Congressional liaison person?

No. We have a communication person who send the report to media and policy makers but it's not like lobbying.
Sometimes policy makers call us want they want comments on policy changes; or the administration when it want to summarize an issue. We don't always have a conclusion.

Who are your main contacts on the Hill or in the administration?

Our former colleagues and staff people. Many are on the staff of committees. And we try also to reach a broader audience through media and our web site.

How have your views on heath care policy evolved since the beginning of your career?

I think I was more liberal. I am still liberal but I have become more realistic. I really was for a universal comprehensive system similar to the European systems. I was idealistic! And when I started to work I really thought that a broad reform like that would occur in the next 4 or 5 years!
At the same time I also saw improvement in Medicaid especially. There is much more coverage for children today than when I started to work.
With a new law, there is improvement but there is still a long way before covering everybody. At least we could be able not to have 15 millions of uninsured and premature death because the way the system is organized.
But we are in such a political gridlock. It's hard to know how to implement the law with such a resistance in Congress. The second problem is the lack of understanding of the law by the public. Even the uninsured don't know that they will get coverage with the law! There is a big misunderstanding. The problem is not the lack of information but too much contradictory information. More information is not always better when it's inaccurate.

What is you general assessment of the ACA?

I think it goes in the right direction. But it's overly complex. It's hard to refill the gap in our system rather than change the whole system.

What did you think about the public option?

It was a good addition. It would have given some point of comparison and competition with the private sector.

What do you think about the strategy of the ACA to reduce cost?

They tried to put in place incentives to increase quality and reduce cost but there is no tough mechanism to reduce cost. It reflects the incredible difficulty in our country for doing anything that really decrease spending. We know that one of the strategies that works is to regulate prices more aggressively but there is no political will. So we really don't know in our country how to reduce costs. Managed care was tried but now people have more choice and most choose other plans. The consumer groups resist this kind of plan and they don't understand that it is in their interest. The nature of our fee-for-service system is very costly. There is some attempts in the new legislation with this Innovation organization, some potential saving. In prescription drug for instance, in which physicians and hospital practice better medicine. To create more incentive for more efficiency.

Who do you work with most?

The Urban Institute, Judy Feder, Sara Rosenbaum in GWU, Robert Blendon, Dr Frank at Harvard.

What reviews do you read most?

Health Affairs as a magazine. ()

What did you do during the Clinton reform?

I was drafting the proposal. I was in the White House, in the task force. I worked with a consultant contract with the First Lady. My work was mostly to lay out pros and cons of the different options and then to draft.
I think there were more cost containment measures in the Clinton proposal than in the Obama one. But there are a lot of concepts that were in the Clinton proposal and that are in the Obama one. ACA really tries the existing system. The Clinton reform could have been smoother if Congress had been involved earlier. In the last reform, it's the contrary, the whote House should have been more involved.

Do you work with media?

Yes, we answer their questions. And we also try to keep a team of reporters involved in health care issues. They were very involved last year but then the media attention got down.

In conclusion, how would you describe the influence of experts in health policy?

I think they have a lot and heavily influence on how to implement policy, question of risk adjustments and so on. A lot of ideas come from experts. Then they have to be sold to policymakers. Then there are different experts for different policymakers. Pitt Stark listens quite heavily to experts on Medicare issues for instance. And Republicans will listen to other experts. So I think they have influence but on different policymakers.

What's the difference for an expert between being outside or inside the government?

Outside you have more freedom. You can change your mind if you find better ideas, you have a broader scope of flexibility. Inside you are locked in that position and you are more submitted to the hierarchy. If you are at the university, you don't mind if the president of the university don't agree with your stand.
When I was at John Hopkins, I could do recommendation and now I have to be very careful.

Do you regret that?

Sometimes it would be nice. It's pleasant to say everyone what they have to do! But I also think that individuals don't have the power of organization and sometimes you are more credible, your date are more credible, because you represent a large organization and not only yourself.

In terms of influence, what's the difference between being inside and outside?

It's really true for the more scientific experts. On drugs, vaccine, outside expert have really a greater role.