Programme OPERA – ENTRETIENS

Entretien – santé n°42

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Interview with two actors (Responder 1 & Responder 2)
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Interviewer: Maybe a few words about our research. As I told you, it involves three universities in France, Paris, Rennes – this is my University — and the University of Montpellier, and two universities in the U.S., American University and Denver University.

Responder 1: Denver.

Interviewer: And we study healthcare reforms in the U.S. and in the EU to compare this, but we are not so much interested in the details of the reforms, but more on the actors. We try to understand who plays, where do the ideas come from, what are the powerful factors and less powerful ones in terms of individuals, but also institutions. So, we wanted to meet you to know what is the role of the HHS and, in particular, your service, and the reforms in the U.S. concerning healthcare.

So, with that--

Responder 1: So, are you political scientists, or--

Interviewer: Yes.

Responder 1: That's my training. I have a Doctorate in Political Science from Columbia University.

Interviewer: Yes. Okay. I will now ask a question, because my first question was, what was your first, initial training.

Responder 1: Well, I actually started in-- I have a Master's in Public Health degree, so with-- I don't know if you have a separate public health training program--

Interviewer: Yes, we do.

Responder 1: Yes, for non-physicians. I'm not a physician, and then from there, Columbia had a program where you can do both political science and public health together, so I worked-- but I also work with a lot of economists as well, so that was my training.

Responder 2: And I have a Master's in Public Administration.

Interviewer: Okay, from what university or--

Responder 2: Cornell.

Interviewer: Okay, Cornell University.

Responder 2: Yes.

Interviewer: Okay, I ask this question because we try to identify networks and the process of facilitation actions. We find often it comes from in the university.

So, could you tell me how you arrived here, what was your career, in a way? I know it's a huge question.

Responder 2: Well, I came into the government in what's basically a management intern program, sort of a junior manager kind of thing, through the-- into the National Institute of Health's-- I'm sure you've heard of NIH, and basically I've been in Health and Human Services, which is the bigger agency, for 45 years.

Interviewer: A long time.

Responder 2: And a variety of jobs during that period, but almost the entire period in really one version of planning and evaluation or another, and sometimes it was planning and evaluation within a small program, and sometimes it was at a sub-agency, and now at sort of a full-agency kind of a role.

Interviewer: So you change a lot.

Responder 2: Yes.

Responder 1: Basically, for-- how many years have you been at HRSA?

Responder 2: Within HRSA-- it was established 27 years ago, and I have been here the whole time, within the Health Resources and Services Administration.

Interviewer: Okay, so you are in the (inaudible) of the institution.

Responder 1: I think you should try to maybe understand the nature of what this part of the HHS is. It has various names, but it is basically resources and services, as opposed to the financing piece, and not the biomedical piece, and not the drug piece, so this agency is-- has all these grant programs which basically give money to the states and to local communities to establish clinics, fund health professions, training, and then all sorts of special problems that arise, like when HIV/AIDS came, they needed to set up clinics, a plan. This agency got that.

Organ transplantation is a sort of separate thing, but they didn't know where to put it, so they put in our agency. We used to-- building hospitals and, a long time ago, sort of in this agency. So, there has always been a function of sort of helping states and local communities have the sort of capacity to deliver the care, and that's separate from the agencies that finance services, do biomedical research, do drug regulation, there is a separate mental health, substance abuse agency.

Then, the Centers for Disease Control does epidemiology, sort of, you know, health investigation kinds of things.

Responder 2: And most of the financing comes out through what's called the Centers for Medicare and Medicaid Services. Those are the two big financing pools that spend money on it, Medicare on the-- mainly on the aged, and Medicaid on low-income people. We work with them, but they are a separate agency.

Interviewer: So, you are an agency-- does that mean that you are independent from the government? The federal government?

Responder 2: No, no, we're part of Health and Human Services.

Responder 1: No, we're part of it. We're like a department in--

Interviewer: Okay, a sub-part.

Responder 2: A sub-part of Health and Human Services. It's like us and NIH and Medicare, Medicaid, and a few others, FDA, Food and Drug.

Responder 1: And we all report to the Secretary of HHS.

Responder 2: Secretary Sebelius, you've heard of.

Interviewer: So, could you tell me what--

Responder 1: So, after I did all that education, I came to Washington, and I have been sort of back and forth between the government and something called the National Academy of Sciences has something called the Institute of Medicine that does Congressional-- Congress decides if there needs to be a study on something or other, so they have, like, expert committees, and I used to staff those committees.

So, I was on-- did a number of studies there, and then have gone back and forth between the government and that sort of not-quite government, kind of quasi-government. So, my role has always been like having one foot in the research policy community and one foot in the government, and try to translate research back and forth between the government and between, you know, between policymakers and between people who do mostly health services research.

Interviewer: And in the HHS, to get your position, had you been contacted by someone, or did you apply to a (inaudible), opportunity, or what--

Responder 1: I mostly got it through networking, in other words, when I was at the university, we did some projects with the-- our former boss, and so he said "Why don't you come to Washington and work," and so then I applied. You still have to go through sort of the competitive application process, but a lot of people get their jobs because they have networked and somebody wants their skills.

Interviewer: And your boss was-- who was your boss?

Responder 2: A fellow named Ron Carlson (ph).

Responder 1: See, Lyman has the job that our former boss had, and so when we retired, Lyman became the boss, and I work for Lyman.

Interviewer: Okay. So, I have a question, and it's still about history, but why did you choose to invest in the field of-- why did you do health, in fact? Is it a personal choice, is it by chance, or a personal interest?

Responder 2: I think it's a personal choice. When you look at all the different functions that the government carries out, I mean, the health field is probably one of the most interesting. I mean, there's a lot of things going on, there is activity at the federal level, there is activity at the state level, activity at the community level, the non-profits, the hospitals.

So, I mean, once you get into the field of health, there's 100 different things that you can do, and so I think that-- I always thought Health and Human Services would be a good place to work.

Interviewer: I see. So, you have a good life? You are doing-- have the job you wanted?

Responder 2: Actually, when I was in 9th grade, a teacher said, "What would you like to do," and I said, "I'd like to work for the federal government," and she said, "What? In the ninth grade?" But, yeah, I've always thought-- I mean, the leverage you have from here is very big, very strong.

Interviewer: Is it why you wanted to work for the federal government?

Responder 2: I think that's part of it, yeah. I mean, you can-- I mean, within HRSA, we have a budget of $7 billion, and so that's, like, 5 billion euros, and that's a fair amount of money. If you can influence it and put it here and there and everywhere, you can get a lot of leverage with that kind of money.

Interviewer: And the same question, please?

Responder 1: I became first influenced in public health, and then when I was in public health school, I became interested in policy, and there was a former Assistant Secretary who was one of my teachers, so I was impressed with his stories about working in the government, and then I became more and more interested, and I ended up actually working for him in the summers doing some research projects, so I became more and more interested in policy, and so-- but I didn't feel ready to go into the world of work, so I discovered that Columbia had a--

I didn't have a background in political science, so I went to Columbia where they had this special program where I could still stay in health and study political science and government and so then, I-- so, after that, it was sort of obvious to come to Washington, you know, if you wanted to come to policy, you needed to be at the center of things.

Interviewer: Yes, it's the center of the world.

Responder 1: Yeah, but, I mean, it's interesting that I've gone back and forth to the National Academy of Sciences, because some of the powers also outside in terms of-- that's the sort of, I think, the focal point for sort of the academic leadership input into the government to get advice from--

Interviewer: And why did you go back and forth and not stay in the same place?

Responder 1: Partly because at various points, the government became less interesting, because of either a change in the party, partly it was ideology, I think. There were times when the government was shrinking and we were doing less and less and it was sort of more interesting to--

Interviewer: So you left?

Responder 1: So I left, but still could work kind of closely on those issues. The National Academy has-- it's a prestigious place to work, and that's where-- for example, one of the committees I was the director of had the President of Princeton and a former Secretary of Labor, and an ex-Congressman on it, so it's sort of a place to sort of work with sort of important people who have an influence.

And then the studies have an influence on policy.

Interviewer: Okay, and would you consider that you are important people? Would you consider that you are influences on the healthcare policy and healthcare reforms?

Responder 2: Not healthcare reform as such, but the sphere of influence we have, which is health professions workforce, is one of the things we deal with. We provide grants for training of physicians and nurses and that sort of thing, and we run with what we call the safety net, which is community health centers that we fund, and they basically provide care, particularly to uninsured people, low-income people.

So, within that sphere, I would say that we certainly can affect policy. For the actual healthcare reform piece legislation, less so. That was at a very high level.

Responder 1: Let me give you-- I'll give you a political science answer. So, it's a sixth of the economy, healthcare, and so it's-- there's a lot of interest groups that have a high stake in it. The government is big-- our department is bigger than most countries in terms of the budget. So, any one individual at any one point in time, you know, you're a tiny little cog in a very complicated machine, and so, I think you quickly learn-- you know, whatever dreams you might have of influencing policy when you're, you know, a student, you sort of quickly realize that it's very complex, and it's slow moving, and so-- and there are two parts to the policy, at least, there's the sort of legislative-- what we're doing now is, we're at an

interesting point in time, because we're moving from the time in which the legislative developments were happening to the point of implementation of it.

So, the political process doesn't stop at that, and important decisions are made, and, I mean, the Department now is writing regulations to sort of interpret the law and how it's actually going to work on the ground.

Interviewer: So, now, the role of the Department will increase?

Responder 1: Yeah, it's different.

Responder 2: Different.

Responder 1: It becomes different. It becomes-- goes from the sort of legislative deliberation piece to the politics of implementation, and the interest groups are now focused on how that-- you know, how these regulations are written, so, what's going to be the actual definition of a business with 100 employees, for example.

Responder 2: The legislation will say one line, but that could turn into 40 pages of regulations about how to interpret that, so that's sort of the stage we're at now, where we're getting into--

Responder 1: So, there are many, many committees that are sort of put together from different parts of the department, and so you may have an idea that you get into this system, but it spins out in a very complex web of (inaudible).

Interviewer: In your view, what actor will be the main during the most powerful and most powerful influence in the process of implementation? Is there any actor that will be more influential?

Responder 1: I mean, I think it's a combination. I think a lot of it starts-- the combination of the White House Staff and the Secretary and the people directly around the Secretary. That's where I think the tough decisions are made. The nature of the options may come up from the bottom as, you know, here's a decision that needs to be made, here are three options, and the final decision will be made probably by a combination of the White House and the Department staff in consultation, back again, with the Congress.

Responder 2: Yeah, we're already getting reaction from the Congress. I mean, they passed the legislation, but now that we're starting to write regulations and rules about how to do it, they want people to come up there and brief them about what we're thinking and how we're going to interpret it, and then it will get sort of a second shot at how we're interpreting what they wrote.

So, sometimes, even when they wrote it a certain way, they're saying, "No, that's not what we meant, we want to go this way a little bit," so there's a very heavy sort of back-and-forth, even at this stage, of how to interpret what they wrote.

Responder 1: And the impact-- and you can't, as you know, you can't sort of underestimate the importance of the interest groups who have a stake in how these--

Interviewer: So, you have a relationship with interest groups? Do you have some relation with them?

Responder 1: Yeah, I think for us, it's-- since we have those community health centers and the medical schools and those things, that's-- those are the interest groups that we would most likely deal with.

Responder 2: Like, we would not interact, say, with the American Hospital Association. That would be more Medicare and Medicaid, would interact with them, but we would deal with, say, the American Nurses' Association or the (inaudible).

[crosstalk]

Responder 2: Association of Academic Medical Centers, we would interact with them, because we are giving them grants to, you know, create medical schools, and to do that kind of thing.

Responder 1: Yeah, the health reform was not just about giving insurance, it also had other parts, and, I mean, it's a very long bill and it has all sorts of other things, so they're worried that there won't be enough permanent-care physicians to meet the increased demand. That's one sort of worry, and they're worried about-- there has always been-- I mean, I'll-- a geographic distribution problem, where physicians locate, so that's why our health centers often were created to work in the poorer neighborhoods where there are fewer physicians, so that's being built up again because I think there will be more demand for service as a result of that.

Interviewer: I'm sorry-- to come back to my first question, because I had one that was pretty important, and mine was one that (inaudible)-- it's still about your personal lives, and-- during your career, did you have a special contact, someone that was very important in your career, maybe because it helped you to progress or inspire you or whatever? Was there someone very important in your career?

Responder 2: Yeah. I've had a couple of bosses along the way who were-- really taught me sort of what program analysis is and how the healthcare field worked and sort of sent me in certain directions, to training to help you along. So, yeah, I mean, there has certainly been a couple of them along the way who have been very good in that sense.

Interviewer: But a person that we can identify that inspired you or made you progress in the (inaudible) administration, or did you do it by yourself, or--

Responder 2: No, you certainly don't do it by yourself. You have the fellow you like. He'd make a good example.

Responder 1: Yeah, at Columbia University, my sort of mentor and sponsor was a very famous economist-- health economist named Eli Ginzberg.

Interviewer: Yes, I know his name.

Responder 1: Yeah, and he was-- he had been advisor to-- from Eisenhower through-- you know, he retired probably during the Bush years, first Bush years. So, and I was fairly close to him, and sort of got to watch him in action and work for him for-- I worked at Columbia on the faculty, did research after I got my degree, and so I think he really shaped me, and how I think about, you know, policy very much.

Then, there were people in the government-- there were people in the government and the National Academy of Sciences, obviously.

Interviewer: Like who?

Responder 1: Well, one was-- at the National Academy of Sciences, there was my boss there, who was there from the beginning, and his name is Karl Yordy, and he had a big job in the government, and then left the government to help set up the Institute of Medicine, and so he was very experienced in policy, intellectually. So, I think he was a big influence on me, and then the fellow that we-- I wouldn't say Ron was-- he was a big influence on you, too, the previous-- his predecessor.

Responder 2: Ron Carlson, he ran the planning and evaluation here for about 16 years, a fair chunk of time.

Responder 1: And he had similar jobs, and he was purely a government-- worked his way up through the government, but when we were coming along, there were people-- the older people in the career were people who were here kind of at the beginning, when the department really sort of grew in size, and there were just more and more programs and legislation, the beginnings of Medicare and the beginnings of Medicaid.

So, these were people who saw the whole thing grow up and were there at the sort of policy point, yeah.

Interviewer: You tell me that the department is growing in size, but people that we met with my colleague before you, usually they tell her that the HHS is less powerful than it was maybe 20 years ago. Do you agree with that point of view?

Responder 1: No.

Responder 2: No, I don't think so. I wouldn't say that, either.

Interviewer: Maybe because you are more involved in the implementation process?

Responder 1: I guess it depends on what you mean by power, you know.

Interviewer: Yeah, the question we asked was on the issue of decision-making and implementation, so, of course, they told us that Congress is more important and the White House, but this is weird for the French, because the French administration has-- the central administration has a lot of power in the negotiation process, and it comes from the administration, and here it's-- it looks different, because it looks-- it appears that it comes from whether Congress or the White House. Is it really like that?

Responder 2: I think a lot depends on which administration it is.

Responder 1: And who is in control. See, we have a parliamentary process, so you can have a party in charge of the legislative process that's not in charge of the administrative process because of the separation of powers.

Responder 2: I was thinking, like, during the Clinton years, the healthcare reform effort really came out of the White House, and Hillary Clinton was really running the whole show, and HHS, at that point, was really a secondary player, whereas this time around, I think Secretary Sebelius played a much stronger role in negotiation with the Congress and trying to get pieces put together.

Responder 1: And the Reform Office was located in the department.

Responder 2: Yeah, so, I think, at least for this administration, it has been stronger than it was certainly during the Clinton-- and--

Responder 1: It's hard to say, because I worked on Hillary Clinton's task force, and the plan-- the legislation that was submitted to Congress was developed by bureaucrats, really, with a few outside people, and this time we had no sort of participation in the design. It was all sort of staff, at the staff level.

Responder 2: Yeah, I was thinking about Secretary Shalala didn't play much of a role in that whole thing. As I recall, she was sort of marginalized. It was more White House dealing directly with the people they wanted to work on.

Responder 1: Yeah, although when-- once it was written, she played a big role.

Responder 2: Yeah.

Responder 1: Yeah, but that was the-- they thought they learned something from the Congress, because we worked-- the bureaucrats worked away and created this bill and this infrastructure and all this sort of stuff, and they did really work, then they presented it to Congress as legislation, and that's when it all started to fall apart.

They couldn't pass it, because they hadn't brought along everybody, so what they thought they learned this time was, instead of presenting them with a fully-developed sort of completely worked-out plan, they would let the Congressional deliberation process unfold, and for a while, it looked like that wasn't going to work, because it wasn't sure that the leadership was really-- had it in hand, but, in the end, they did, and partly because they had a big legislative mandate, because there was--

Responder 2: Big majority.

Responder 1: Yeah, they had a big majority, though less of a majority than Clinton had, so they were trying to learn from the lesson of the past and do it a different way, which had its own problems-- ran into its own problems, because Congress is-- doesn't do things necessarily in a coherent way because there are so many of them and there are all these interest groups that are trying to--

Interviewer: Politics.

Responder 1: Yeah. And interest groups are in every type of government, they just operate differently, so, I think that was-- I think there is an interesting comparison to be made between the two processes, but, I mean, the key thing here in the U.S. is the separation of powers, so you have the process in Congress, the legislative process, which the administration tries to influence and participate in, but it is its own thing, and that's a contrast with European (inaudible) where the party who wins the most seats really pretty much runs the bureaucracy, and so whether you have more-- an easier sort of way of sort of voting in the process unless you're in Britain today.

Responder 2: Yeah, that coalition just seems kind of strange, kind of two heads.

Responder 1: The other thing that's different here is the power of the states and the role of the states.

Responder 2: Yeah, the states are much more powerful here than I think they are in any--

Responder 1: Any, yeah--

Responder 2: Any of the British-- or, any of the European countries.

Responder 1: So, pieces of the legislation are going to depend on state implementation. So, a good example is-- a good example for us to look at, actually, is to sort of-- the-- one of the immediate parts of the healthcare reform is developing high-risk rules at the state level, and the law is written so that if a state-- the state can get money from the federal government to set up their own risk pool under sort of-- certain guidelines, and if the state doesn't want to do that, the federal government will then step in and set it up for them.

So, you're having the politics of individual states deciding whether they're going to do this or not, and mostly a lot of the Republican governors don't want to have anything to do with an Obama program, so they're saying, "No, we're not going to play in this."

Interviewer: Do they-- can they do anything?

Responder 1: In some of the states, Attorney Generals are actually challenging the legislation in the courts. That's the third piece-- that's the third piece of policy in the U.S., is the court system. So, those who are opposed to the legislation are now trying to undermine the legislation by challenging certain pieces of it in the courts. The particular tactic-- target is whether it's constitutional to require people to buy insurance, which it would be called the mandate.

So, you really see the standard American political science-- we have the three sort of branches of government and then the powers of the state, and then the interest groups influencing.

Interviewer: So, would you say that the power of the states has increased in the past 20 years, because of the reforms, or on the contrary, decreased, compared to the federal government?

Responder 2: I think this is another thing that shifts back and forth depending on who is in the White House. When President Reagan was in the White House, he deliberately pushed more things to the states, more control, gave them more flexibility, and then when the Democrats-- usually when the Democrats come in, they try and reverse that.

Responder 1: Yeah, centralize.

Responder 2: And bring the power back into Washington. So, it sort of flows back and forth depending on who-- which power-- which group is in charge.

Responder 1: It has always been-- it's complicated, because a lot of the programs work through the states, even though they are financed through the federal government, and they are required to put in their own share of the money. So, Medicaid, the program for the poor, is a shared responsibility, and so-- and it varies, you know, the level of the entitlement varies wildly across the states, depending on how much money they have to put into the system, and what they feel is the right level. It's a total lack of social solidarity here.

Responder 2: Thanks for that.

Interviewer: I ask that question because it's one of our hypothesis, there's two, that reforms during the past 20 or 30 years reinforced the power of central states in the EU and the U.S., so we are sure of this in the EU, but it looks more complicated here, as you said, it's back-and-forth, and so--

Responder 1: I mean, partly-- I think partly it's because of the fragmentation of our system. It's hard to grab a hold of something where-- that's set up structurally to share power and money, and, you know, where the money goes, if you look at where the money is, so it's very hard to grab a hold of the system, because some of it is-- in comparison to, I think, Europe, where a big chunk of it is in the private sector and a big chunk of it is state control and a big chunk of it is federal control, and the fact that it varies, you know, all over the United States.

So, I think that's probably-- that's the big difference. When you have-- if you set up a system where everybody's in the same system, you can sort of grab control, and you can make decisions that, you know, kind of stick. You may get pushback from the providers and have to negotiate with a physicians' union or something like that, but it's-- they are all together and you're all together, and there's an obvious negotiation process.

Here, it's very fragmented, and lots of people have their fingers in the pot.

Responder 2: And it makes for a lot of differences in the level of services that people are going to get. Because, like, New York, under their Medicaid program, will set their threshold at, like, 300% of poverty, and everybody under that can get into Medicaid, but if you go down south into Texas or Mississippi or Alabama, they will set it at 100% of poverty or even below, and so--

Interviewer: Big difference.

Responder 2: Yes. In New York, they have set it so high that people who work for the post office are eligible for Medicaid, whereas in Texas, you have to be really dirt poor to get into the system, and some of that has to do with the immigration issues down there, that there are so many immigrants that they don't want to pay for--

Responder 1: And just social-- socio-cultural views of the role of government. So, again, there's no one sort of sense of social solidarity of-- this is the sort of bottom line, that we're willing to let all sorts of conditions exist and sort of tolerate it, basically.

I mean, the other piece of this is, communities also have varying amounts of public services (inaudible), so in New York City, there's a big public hospital system and a very active public health department, and in other places, it's just sort of charity care from the private institutions.

Interviewer: And so we cannot talk about the EU, but in the states in the U.S., but--

Responder 1: And also, we don't run-- we don't own the hospitals. The hospitals are not government hospitals, for the most part.

Interviewer: Government hospitals, yeah.

Responder 1: I mean, at least, I know, you know, I think in France, most of the-- aren't most of the hospitals-- except for a few of the private hospitals, but most of them are government-owned, aren't they?

Interviewer: Yes. Approximately all of them.

Responder 1: I guess there's a few private hospitals, right?

Interviewer: Very few.

Responder 1: Yeah. So, there's more ability to control than there is here.

Interviewer: Yeah.

Responder 1: Where you have-- even our public hospitals are usually city or county hospitals, and so--

Responder 2: There are very few federal hospitals, there's only-- most of them are very specialized.

Responder 1: Veterans.

Responder 2: Yeah, veterans and rehabilitation, that kind of stuff. Drug rehabilitation kind of things.

Responder 1: Yeah.

Interviewer: Interesting.

Responder 1: I mean, I think that's sort of-- you have to look at the way our system is structured, which, obviously, is related to the political system we have, but that gets back-- that fragmentation and sort of variation makes the question of who controls and who makes the decisions much more diffuse and complicated.

Interviewer: Yeah.

Responder 1: Yeah.

Interviewer: And I am-- the same question for organized groups, like professional associations? Do they play a huge role in the implementation process and in the negotiation process here?

Responder 2: I think they play a stronger role with the Congress. I mean, the very-- they have a pretty strong voice in the Congress as far as locking things or pushing certain things. Once it gets through the Congress, it seems to me their role decreases somewhat, because the government agencies try to avoid being influenced too much by particular interest groups, whereas in the Congress, that's just sort of normal business.

Responder 1: Yeah, but, they give them their contributions-- their campaign contributions.

Responder 2: I mean, we'll certainly talk to these folks and tell them what we're thinking and get some reaction, but it's not like they could block something if they wanted to. It's much more of a communication thing.

Responder 1: A good example in the history of this is, for most of the history of trying to get healthcare reform legislated, national health insurance legislation, back in the '50s, '60s, '70s, '80s, the American Medical Association was the key group that blocked most of that legislation, because they were concerned about government sort of controlling their practice and influence, and they were essentially conservative people, higher-income people.

In this environment, they basically came out early and supported the healthcare reform, and their-- but their main focus has been-- and what they have been bargaining for is the-- basically a salary-- an income one. So, there have been these automatic cuts built into the Medicare legislation for physician payment, and each year, Congress has sort of put aside the cuts that were supposed to happen, and now it has gotten to, like, a huge percent, and their main focus in their lobbying has been to get rid of those sort of projected cuts and have a permanent sort of-- so, their focus has been much more narrow on the sort of economic-- direct economic influence.

In the earlier days, health insurance was not a profitable business. Mostly, they were life insurance companies that happened to have health insurance policies in order to sell life insurance, and they didn't care that much. Over time, it has become a huge business, and a profitable business. They were the principle opponents to health care reform this time. They weren't much of an interest group back then, and with the growth of their business and them being into more managed care, they had a higher stake and more powerful influence, so-- and the same thing with the drug companies. They sort of, early on, made a deal. They would

give discounts in order to make the bill affordable, because they saw an opportunity for more customers with insurance.

Interviewer: Yes, this was different with Clinton's plan, because anything-- I'm sorry, direct companies were supported in this one and not the former one, Clinton's one.

Responder 1: Yeah, they started to be an influence back in Clinton's period, but when Medicare was being deliberated in the '60s and when national health insurance came about in the '70s, they weren't much of an influence. They started to be an influence with Clinton, and it has gotten even stronger since that time.

So, I think they were-- some of them were-- they were probably-- they were probably one of the important reasons that the Clinton plan didn't pass.

Interviewer: So, there was an evolution in the way the interest groups (inaudible) in a way, and insurance and drug companies have increased their influence, but professional associations decreased. Why?

Responder 1: I think their focus became more narrow, and they didn't see-- since there's so much government payment now, they didn't see it as much of a threat to control as the occupation as they once did when there was very little government.

Interviewer: And for the Hospital Association, that we were talking about a few minutes ago, how did they react to this reform?

Responder 2: They seem to be less of a player.

Responder 1: Again, they are more narrowly focused on what the reimbursement is going to look like for them.

Responder 2: Yeah. In this last round, they seemed to be less of a player than a lot of the other groups, which sort of surprised me.

Responder 1: Yeah. I think they focused on particular issues, and, again, it's mostly on payment policies.

Responder 2: Mainly, protecting their source of income. They seem to be that-- that was their basic interest.

Responder 1: There's less of a-- those interest groups have less of an ideological position than they used to in terms of-- in the past, it was all about government control. I mean, physicians did very well, financially, after Medicare passed, so it was in their economic interest to have Medicare pass in '65, but they were still more worried about the government sort of having a great deal of influence in how they practiced.

Interviewer: They preferred independence to money?

Responder 1: Right.

Interviewer: And it changed?

Responder 1: I think it has changed over-- they still want money, they still want money, but they're used to-- the government-- even without health insurance reform, the government still pays about 50% of the bill. So-- and fewer physicians are in sort of single-- a lot, still, are in solo practice, but fewer of them are smaller business, and more and more are working for large groups, like Kaiser.

Responder 2: It's sort of-- the independent practitioner is sort of a declining field, smaller, smaller, and smaller. The only way they can survive is to have groups of 6, 8, 10, 20 physicians, and, you know, get the--

Responder 1: There's still-- it's amazing, there's still-- the small offices are still a big percentage of the whole-- so it's less-- the other thing is, there's been a lot in the literature about the nature of the interest group itself has changed, and that of course is because in the beginning, it was all family practitioners, general practitioners. They all belonged to the AMA, so the AMA was very powerful.

With the growth of specialties, which had their own specialty societies, the power got more fragmented, and there was more interest in protecting the interest of those specialties. So, that kind of fragmented the power of the AMA.

Interviewer: Okay, interesting. I have a lot of books to read about the U.S. system.

Responder 1: Yeah, the AMA has been, like-- that's been a big focus of political science literature has been on sort of the-- as the classic interest group.

Responder 2: One of the things we were going to give you is, I don't know if you are familiar with the Journal of Health Affairs.

Interviewer: No, I'm not.

Responder 2: It's really sort of the premiere health journal, but they just came out with an issue on reinventing primary care, which is a lot of good articles in here, but there's one in particular that we focused on, which is this one here, primary care, current problems and proposed solutions, and this is a very good summary of the whole primary care issue in the U.S., and where the problems are and how they might fix them kind of thing, but it's a really good article.

Interviewer: Excellent.

Responder 1: That's the other part of-- the healthcare reform was not just about providing insurance coverage. There's a big piece of it about trying to redesign the system to control costs and improve value and quality. So, you have many pieces of that are around. So, that's partly what the politics are about, too, is a growing percentage of the GNP were-- that's growing much faster than general cost of living, I mean, that's part of the larger political issues, the whole sort of-- it's the same as is going on in Europe, it's the sort of-- the entitlements as a percentage of the budget, how do we control the costs?

So, part of it is-- part of the belief, and related to that article is, we don't have enough primary care physicians versus specialists, and our proportions are wildly different than in Europe, so that's part of the belief of how-- of why our costs are higher, and there's all sorts of efforts to try to think about-- pay people for performance and comparative effectiveness, research in order to sort of try to get-- you know, try to control over-utilization and unnecessary use of things.

Responder 2: Yeah, instead of paying for procedure by procedure, trying to pay sort of a set fee for a physician to take care of the patient for a whole episode of care, so you get so much for the whole episode, rather than $200 for an x-ray, $300 for a CAT scan, $400 to do a blood test and just keep piling up these charges, which is pretty much the way it works now, they just pile one charge on top of another.

Interviewer: Do you think that this solution will cost less than what exists now?

Responder 2: Yeah, if they can pull it off.

Responder 1: I think it's hard. I mean, everybody is struggling. Europe is struggling with the same thing, is sort of-- how do you pay people for-- how do you incorporate performance into sort of how people get rewarded or reimbursed? So, you have the sort of comparative effectiveness, like NICE, in England, where they are trying to compare alternative treatments under the guise of quality, but they would really like it to be about cost.

But the big sort of cultural thing here is the crazy fear of rationing. It's like--

Responder 2: Socialism.

Responder 1: I mean, it's just, I mean, that's the sort of-- that's the big issue.

Interviewer: Still now?

Responder 1: Yeah, I think it's-- underlying it all is the notion. We would rather have indirect rationing-- I mean, we have been rationing, obviously, because we have been paying for people-- for many people who can't afford insurance and who don't work for large employers. I mean, there's all sorts of rationing that goes on, but we're more comfortable with that than we are with any sort of explicit rationing scheme.

Responder 2: Any time they want to scare people they talk about Britain, where if you're over 55, you won't get dialysis or a kidney transplant, and they say, "See, that's what you're going to do. You're going to stop everybody from getting a kidney," so it's a little bit of that.

Responder 1: So, it's really-- that's partly what the ideology-- the ideological arguments are about is sort of really, what sort of rationing do you find acceptable.

Interviewer: So, healthcare here is an ideological issue?

Responder 1: It is, yeah. I think it's-- it's both about the role of government, I mean, it's ultimately about the role-- what's the legitimate role of the government in sort of influencing how care is delivered.

So, I mean, the system that we have, I mean, the new reform, I mean, looks insane from a European point of view. There are so many--

Interviewer: No, I won't say anything.

Responder 1: No, it's just-- everybody is in, like, different parts of the system, and they get their insurance in different ways. They pay different amounts, they-- sometimes the employer contributes, sometimes not, it's a total screwy way, and the reform has made it a whole lot more complicated.

Responder 2: But it's probably the bets we can do where we are politically. That's about as far as we can get.

Interviewer: Because of ideology?

Responder 1: What's interesting is that Medicare is sort of closer to-- Medicare is sort of a payroll tax, and you get it one way from the central government and-- you know, that sort of follows the European model, but--

Responder 2: And it may be that 15, 20 years out, you know, they will be able to take it closer to a whole payment kind of system, but it certainly is going to be at least a 15, 20-year deal.

Responder 1: And our administrative expenses are so much more than other countries, because of the complicated business of how you get insurance and insurance companies, market people, and employers, and you get it from so many different ways, and the reimbursement processes are different.

Interviewer: And what is necessary to produce this change in 20, 15 years?

Responder 2: I think part of it is, assuming this whole thing can get implemented and people can get used to it, and they see that they're not going to have death panels, they're not going to have rationing as such, if people get used to that model, then I think they can start incrementally, you know--

Interviewer: Step by step.

Responder 2: Start rationalizing the system.

Responder 1: Because so much depends on the employer role on this, and if employers start leaving, deciding they don't want to be in this business, they have mixed feelings about it. It's really strange, so, I mean, it has become a bigger and bigger part of the cost of doing business, and then on the other hand, they don't want to give it up to the government.

Interviewer: Still because of ideology?

Responder 1: Ideology and the way that they have always done stuff. You know, they sort of bargained on the-- it's foregone wage increases, you know.

Responder 2: Typically, the big unions, like for General Motors, Ford, they spent years trying to build up these health insurance policies that are very rich, and they don't want to give that up. They are much richer than the government plan would be. They even call it the "Cadillac Plan," because they are worth about $23,000, $25,000 a year in terms of insurance, which is pretty high.

Responder 1: Yeah, so it's partly a-- I mean, yours, too, the employers are involved in the European systems as well, so--

Interviewer: May I ask you maybe one last question because I don't want to--

Responder 1: We're fine, whatever you want. Whatever you need from me. It's Friday afternoon.

Responder 2: Yeah, a little longer.

[crosstalk]

Interviewer: So, it's almost the weekend.

Responder 1: So, we're fine.

Interviewer: There is a holiday on Monday, no?

Responder 1: A week from Monday.

Responder 2: May 31.

Interviewer: Okay, so just a small weekend.

Responder 2: (inaudible)

Interviewer: When you need expertise to develop your own policies here, to whom do you rely on? Do you contact entities or specific institutions or actors like the NIH, for instance? Do you have specific links with someone?

Responder 2: I mean, a lot of it is with the academic health centers, in our case, since so much of our work is geared around health professionals training and that kind of thing, we have a lot of link with the academic health centers, which usually have a medical school and a nursing school and a hospital.

So, I think there's a lot of reliance on the people out there. As a matter of fact, we even fund, in the case of, for example, Rural Health, they fund six research centers out in academic health centers, and they rely on those people to write policy papers and send us ideas on how to improve the healthcare system, that kind of thing.

So, there's quite a bit of support for--

Responder 1: I would say that, yeah. I think they come from two sources, mostly. One is the academic institutions, where they have health policy and various kinds of research out there, and the other is, we do a lot of contracting with consulting firms, and a lot of that has to do with-- I would say sort of evaluations of our programs. We tend not to do that kind of thing with the staff inside. We would sort of do a contract and manage the contract with sort of--

So, a lot of studies and policies sort of get, you know, work through sort of the research part of those, kept on through consulting firms, and, like, the Department, for example, all the projections to do, you know, how much healthcare reform was going to cost, they were economists at universities, for the most part.

Interviewer: You externalize your evaluation on costs?

Responder 1: Yes.

Interviewer: And in the universities and academic institutions and consulting firms, sorry, do you have some privileged relationships with some academic institution or some consulting firms, or does it depend on the subject, issues, or--

Responder 1: We have-- with the consulting firms, we have a lot of rules about competition for-- there's a lot of regulations governing how you do contracts, so you put a proposal, you put a request for proposals out, and then they sort of write proposals and bid and you have a selection process.

There have always been, both on Congress and in the Administration, there is always particular economists that have been advisers through the campaign, and continue to-- the fellow that they're proposing to head the Medicare/Medicaid program, Donald Berwick, he is basically an academic who has done all sorts of work on quality measurement and quality improvement, and so he has advised a lot of Congress.

So, often, they will go out to somebody like that to bring into the government or that have a key role. Well, actually, I think there's something also to understand about the bureaucracy is that there are people like us who are civil servants who like to stay in the government, but there are also positions at the top which are called political appointments, and so those are people that have a relationship with whoever has been elected, and some of them have to be confirmed by Congress, but others can just be hired directly.

Interviewer: It brings me to another question, because we met someone yesterday, I can't tell you the name, and this person told us that she had been appointed by the White House into the HHS, and she was paid by the HHS, but she actually worked for the White House. Is it sort of--

Responder 1: (inaudible).

Interviewer: No, I can, it was Mira (ph) (inaudible).

Responder 1: Yeah, I've worked with Mira on some things.

Responder 2: She's the one who reviews all of the issue papers.

Responder 1: Mira left, I think.

Responder 2: Did she leave?

Responder 1: She left the government, yeah.

Interviewer: Yes, no, she is at the Center for American Progress.

Responder 2: She is the one who-- when a lot of the research papers were done sort of justifying health insurance and how we might fix the system, she was the one who actually reviewed the papers before they got put into the formal part of the Obama program kind of thing. So, yes, she played a very influential role and she was sort of the screen of what was coming out of the bureaucracy and turning it into a political document, so she played that kind of a role, it was very--

Responder 1: It's really all part of what I just described as-- there is the civil service, and people like us, who are-- who go across, and then there is this level of political appointees who can either be located in the White House's staff or can be located in the different departments as staff, and they are the-- that's the link between the elected leaders and the bureaucracy, so the leadership. I mean, it may have sounded kind of funny, but, you know, there's all sorts of sort of things about how things look. They don't want the White House staff to look too giant and big, because it looks like a big bureaucracy, so they might locate people who might be normally working in the White House, you know, in offices in the White House, have them work in the agencies.

So, I mean, it's nothing. I know it sounds kind of shady or something phony, but it's built up to be that there is this sort of-- just the way the Ministers in England and their immediate staff are whatever party is in power, and then the standing civil service, it's the same kind of-- our boss, the head of our agency, is an administrator, she had an appointment.

So, she is political and she, you know, talks directly to the other political folks.

Interviewer: She is the in-between.

Responder 1: Yeah, but the top leadership of most agencies is a political leadership with connections back into, you know, the White House and the White House staff.

Interviewer: Okay, and do you think that these people that are political appointees, so they stay here less longer than you, for instance--

Responder 2: The political appointees stay less than us. Shorter.

Interviewer: Shorter, yes, that's what I wanted to say.

Responder 2: Yeah.

Interviewer: It's very common for political science to say that the administrations are sometimes stronger than political actors because they stay in the same position for years

and years, and so they are very experienced, and they know everybody, and they know how to play. Is it something that you could stay here, that political actors in the health field may be less powerful than the administration because of changes or time?

Responder 2: I think that's less true than in Britain. I mean, in Britain, the long-term bureaucrats really do control a lot of the process. Here, I think, more of the politicals really do get pretty much control of the bureaucracy and push it whichever way you want to.

Interviewer: So, it's more toned-down, then?

Responder 1: Yeah, I think the ethos here is-- not just in-- it's supposed to be in England, is to get the sort of-- is to try to figure out what they want, how to-- you quickly adopt the notion of how to further the goals of the administration.

What political-- and this is the same thing, I think, this is part of the dynamics, is especially if they come from outside of government, if they don't understand how slow it is to move the battleship--

Responder 2: Turn the battleship.

Responder 1: And why-- that you can't just sort of declare something and that suddenly it's-- you know, and that there's all these rules about contracts and grants, and-- so, reality sets in, in terms of what's feasible in the real world, and also, they learn to-- you can avoid making mistakes if you don't sort of listen to the bureaucracy.

But, generally-- as examples, I mean, after many years of Democrats, when Nixon came in and Reagan came in, you had a much more liberal bureaucracy that didn't want to go along with all the changes. Generally, I think that the bureaucracy, especially in health, maybe not in the defense department is more liberal than Republicans, so--

Interviewer: Can bureaucracy oppose-- oppose is maybe too strong a term, but may the bureaucracy oppose to Republicans when the White House is Republican or the Congress is-- any leverage for the bureaucracy?

Responder 1: I mean, I think-- I'm not-- I don't think-- it depends on the issue. I think, generally, there is a limit to what the bureaucracy can do other than point out reality in terms of stuff, but, I mean, everybody is beholden to the interest groups, and so-- and I think the other thing is, when you're so big and you've been around for a while, it's hard to change things, because it's so complicated.

So, that's everybody's problem, is that it's expensive-- we're spending lots of money, it's expensive, and there's lots of interest groups out there. There's--

Responder 2: Yeah, every time you want to change something, somebody is going to get hurt out there, and they immediately object to it. Doesn't matter who it is, I mean, you know, could be the Durable Medical Equipment manufacturers who are selling scooters to everybody in Miami. You know, but if you want to change the rule, they will say, "Oh, those poor people down there they can't get a scooter."

Interviewer: Change isn't easy.

Responder 1: Change is hard in general, and I don't think we-- we don't have-- it's hard to do the radical kinds of changes you can sometimes have in Europe when you have a clearer change, and I'm not sure actually that the-- while the ideologies may be very different, the sort of realities-- the two parties aren't all that-- when it comes actual sort of, the everyday aspects of running the government, they aren't that wildly different.

Interviewer: Okay, thank you. Just the last question. What are your top priorities here for the next year in terms of policy or activity?

Responder 2: Well, for us, it's implementation of the healthcare reform legislation. I mean, there's so much-- there's so many pieces of that bill--

Responder 1: With very short time.

Responder 2: Some of the timeframes are four months, two months, four months, six months out, we're supposed to be doing something. For example, one of the pieces in there, we designate what are called "health professional shortage areas," that are supposed to be the area around the country that have the most severe shortages of practitioners, current-care practitioners, and the legislation requires that we do this, actually they say we're supposed to do this by July, which is impossible, because it takes about a year, but I mean-- so, we've extended it out about a year, but even with that, it's going to take a massive amount of work to redo this whole system of designating all these shortage areas.

So, I mean, huge amounts of staff time going into how do we announce this to the public, how do we get feedback, how do we get the data together. So, that kind of thing is just going to eat up huge amounts of time for the staff.

Interviewer: Are there other examples of such issues, or--

Responder 2: There is also, in this bill, automatic appropriations. You can-- you know, usually, we authorize programs to say they exist, and then we appropriate year-by-year, but in this bill, what they did was sort of pre-appropriate money for the health centers, so what is now a $2 billion program is almost automatically going to become a $3 billion, so we are going to have to expand by 50% in very short time frames. So, there is going to have to be a huge process of getting out application guidance and then reviewing applications, getting the money all spent, and that-- there's pieces of that throughout this legislation. It's just going to create a huge workload.

Responder 1: Yeah, I think that people don't-- at first blush, you don't, unless you look at the legislation, you don't realize how many millions of little pieces there are to this. It's not just about giving insurance to people. There's all sorts of-- to everybody-- whatever idea anybody has ever had has been thrown into this legislation, so there's provisions to do this that and the other thing that they thought were good things to do.

Responder 2: You may have some of this stuff already, but these are two pieces that sort of summarize the whole healthcare reform bill, just good background stuff, you know, to dig out if you want some of the specifics of what's in the bills.

Interviewer: Oh, can I keep it?

Responder 2: Yeah, you can keep it.

Interviewer: Thank you.

Responder 2: But, the bill-- I don't know if you've seen this thing being printed, but--

Interviewer: It's (inaudible).

Responder 2: Two books. That's the bill.

Interviewer: And did you read it?

Responder 2: I've ready several copies of it, actually. But, I mean, it's just huge.

Responder 1: Goes on and on and on.

Interviewer: So, I'm sorry I told you that it was the last question, but it's not. I just have another one, maybe only for you because of your special career. Would you say that you have different influence when you were outside the administration, in the NIH, or inside the administration on the implementation or decision-making?

Responder 1: It's sort of-- the place I worked was the National Academy of Sciences. Issues that are-- like, difficult issues that have like a technical side and a political side, we go there, and they put together a group of efforts to sort of look at the science and then look at the policy and make recommendations to the government, so it was those kinds of issues that are sort of-- they don't get really into the nitty-gritty, the detail of implementing things in the government. They are sort of high-level policy kinds of things.

So, it's a different kind of issue then, I think, what it is. I mean, sometimes, there will be a report from the National Academy of Sciences, and we'll have to figure out what to do with these recommendations, and there will be sort of options papers and things.

Responder 2: They tend to be fairly narrow, like, they will do a very deep study about the Emergency Medical System, and how that works and what needs to be fixed, so it's not really broad policy in many cases, it's just to take one slice and then go very deep about how to fix it.

So, at least in those particular areas they have a lot of influence, but it's really more whatever the slice is.

Responder 1: Yeah, it kind of depends.

Responder 2: They did a study on the Pacific Basin, you know, we have six jurisdictions out there, and in general, they have pretty poor healthcare, and they did a pretty deep study on how to try and fix what we do on those islands out there in the Pacific.

Responder 1: So, I'm not getting-- tell me what your hypothesis is, and I'll tell you whether it's right or not.

Interviewer: Sorry, I did not--

Responder 1: Tell me about-- you have a hypothesis about inside versus outside the government? A theory about how things work? I could probably give you an example that meets what you're trying to demonstrate.

Interviewer: I'm not trying to demonstrate anything, I'm just trying to have information. We don't have-- okay, no, we do have a theory we're trying to test. Some of our colleagues have demonstrated that, in France and Spain and in Germany, and less in the UK, so a bit less, there was a strong elite, a strong group of elites that made, in fact, actually, their health reforms for 20 years, and this elite is composed of civil servants, but, actually, did politics. They wrote the papers and drafted, and then negotiated. We're trying to compare with the U.S. to know if it's similar here or if the decision comes from politics, political actors, and not from the administration.

And it looks different.

Responder 2: Here, it's much more the political actors than it is the long-term bureaucrats.

Responder 1: I think, again, it depends on-- I think there's less direct sort of formulating of the policy and stuff like that, but an idea will develop outside in the academic community, the academic elites, which may take hold and shape a policymaker's-- so, yeah, out of that whole sort of-- there's a whole group of people at Dartmouth who have been doing these studies of variation in cost and quality across the United States. They have done all these studies to demonstrate that, you know, can you get just as much quality with less cost, and maybe even better quality.

So, that's a concept, I think, that has sort of taken hold, and then this fellow Berwick that I was telling you about is, you know, is being recommended as the new head of Medicare and Medicaid, so he will try to incorporate these ideas about the appropriate way to-- so, that's how that comes.

So, I think ideas, and some of them have ideological components out there, I mean, each of the parties has its own group of academic elites that they look to to sort of guide-- but I think it's more of a broad guidance of policy as opposed to any single small group sort of determining how the system works, because, again, I just think it's so fragmented you can't make the kinds of decisions here that you can make, because there's less central control, and because it's just the way it's structured.

So, I mean, I think, you know, the history of Political Science in the United States is full of examples of where there was what they call the Iron Triangle, where there, you know, maybe the oil industry or something like that really had people who were just-- had the same philosophy, the same interest, the same-- and you did have a lot of sort of control. I think healthcare is just, like, too big and too complicated and too difficult for that to go on.

Do you agree with what I'm saying?

Responder 2: Yes.

Interviewer: So, I will ask you to write the paper.

Responder 2: I tell you, you invite us to Toulouse for the summer, and we'll do it.

Responder 1: Where are you based?

Interviewer: I'm based in Rennes, it's in Western France.

Responder 1: Spell that?

Interviewer: R-e-n-n-e-s, but my school, it's a French national-- sorry, I'm tired, it's the French National School of Public Health, and it's based on Rennes and Paris, just across from Notre Dame.

Responder 2: Across from Notre Dame?

Interviewer: Yes, just in front, but my office is in Rennes, I'm lucky. This study is-- the leadership of this study is in Montpellier, the University of Montpellier, and the next meeting of the team is in Montpellier, if you want to come, at the beginning of July.

Responder 2: We spent about three days there in Montpellier, it's a very nice town.

Responder 1: What's it near?

Responder 2: It's down in the southern part, fairly close to Marseilles, or?

Interviewer: Northern Spain.

Responder 2: Oh, Northern Spain, that's right.

Responder 1: Yeah, I've never been there.

Interviewer: Yes, but it's in the south, and not on the right, but on the west coast.

Responder 1: Yeah, I have never been that far west.

Responder 2: They have a big central square in the middle with I think almost a circus kind of thing, with restaurants and that kind of stuff.

Interviewer: Very old city. It's nice. But you can come to Paris as well. Well, thank you for this interview and all the information you gave me.

Responder 1: Oh, it's fun. Actually, I thought we were just going to be talking about-- trying to explain healthcare reform, but it's fun thinking about the political science questions.

Interviewer: It reminds you of--

Responder 1: Yeah.

Interviewer: Maybe I can give you my card.

Responder 1: Sure. Let me go get my card in case we--