Programme OPERA – ENTRETIENS

Entretien – santé n°46

Pour citer cet entretien : Lepont, Ulrike, Entretien santé n°46, Programme OPERA (*Operationalizing Programmatic Elite Research in America*), dirigé par W. Genieys (ANR-08-BLAN-0032) (*insérer hyperlien*).

27 avril 2010

Responder: I started working for the New York City department of health and then I work in the Commission of the New York state investigating the quality of health care and nursing home. From where, I worked for the CBO and the department of public health in the department of Massachusetts. I went to Washington in 1979 and worked for the government, doing policy analysis and research, in 1980 in the Health Care Financing Administration, which became the CMS. Then I went to work for the Brookings Institution in 1984 and I was there for 12 years. Then I went to the Urban Institute, mostly because they had a very large project looking at state policy and that was my interest at that time. When that project ended, I came here and I have been here almost 7 years. So I have an experience in national, state, and local level. And for the government, I worked both for the executive and the legislative branches.

Interviewer: Is there a big difference between working for the executive branch or the congressional branch?

The work I did in the Congressional branch was in the CBO and the part of the CBO that I was in was a more academic part. It wasn't the costs estimating part. It was more general policy. My area is generating long-term care. I had to work the first paper that CBO did on long-term care in 1977.

What were the ideas that you developed in this paper?

It was a paper about financing. So we looked at arrange options to expand financing. We looked at block grants, public insurance programs, private insurance. But in 1977, it was not a lot about private insurance.

Do you thing that you personal views had an impact?

I have done a number of similar kind of studies during my career but when I was in CBO, as well as elsewhere, the CBO does not make recommendation. It is very militantly non partisan and non ideological. We will give the pros and cons, various policy options, do policies that will illustrate them but we did not make recommendation. I have view but they really did not come through. When I worked at Brookings, I did a similar but much larger project and again

it was a non ideological balanced presentation. But at the end, we made recommendation at what should be done.

What were your recommendations?

My recommendation was that we should move to social insurance programs for long-term care, public insurance. My observation was that private insurance was unlikely to play a major role. So, if you wanted to fix long-term care financing, you needed to go to a public plan.

It has always been your views about long term care?

I had quite consistent views. My view on what should be done has not changed. The environment which I believed has some changed, sometimes. I would be more pragmatic. As you now it is a big move for United States. I had more incremental recommendations along the way.

For instance, what do you think about the idea of Partnership in long-term care, from Mark Meiner?

Mark and I have debated this for a long time. I am not a big advocate of this partnership. It basically has failed market tests. Not too many people have bought these policies in the states where they are offered. I don't have huge objections to them. My objection to a lot of long term care insurance activity is that I think that it diverse attention from the public founding, which is the overwhelming source of funding for long-term care. To me, it is just spending a lot of time on something that cannot go very far. So I am not a huge fan of that.

You worked also on the state level…

Yes, I worked both for Massachusetts and New York. A lot of my research, especially in the Urban Institute, were about state activities.

But you think that the public insurance should be at the federal level?

Yes. My general view has been : financing reforms have to be primarily at the federal level; delivery system reform automatically have to be implemented at the local level or state level. When I worked on the Clinton long term care – and it is back to 1993 – we came up with providing federal financing but it provided states that have a lot of different sensibilities had to organize the delivery services.

In the last reform, you participated in a meeting organized by Mark Meiner on Capitol Hill to try to push the issue of long-term care. What do you think about this meeting? Do you think that it was influential?

Well. I was attended. It was an interesting meeting. I would be surprise if it have had a major influence. The staffers who were there were the people already interested and committed to long term care. At that time, there were already a number of provisions in health reform. I certainly served to maybe maintain momentum, to retain those provisions. I don't know what kind of conversation Mark had afterwards with Congressional staffers. For example, the

CLASS Act was already in. Kaney Gardner who was one of the speakers, I don't think that it changed because of that meeting.

In your opinion, who has been influential for the CLASS Act?

The basic Class Act was written by the Kennedy staff: Kaney Gardner. It was influenced by the work that the American Association of Home and Services for the Ageing had done, which was in part influenced by the German long-term care system, with its cash system. There was a coalition of elderly advocacy groups, lead largely by Ira Bedlane at the National Council on aging.

You, did you do something in the last reform?

I did less than in the last one (the Clinton one). It is partly do to the difference between the Brookings Institution and RTI. RTI gets 85% of its money from the federal government. So we have to be scrupulously non partisan and non ideological because we have to be founded not only during the Obama years but also during the Bush years.

So, the institution where you work matters a lot?

Yes, in terms of expectation. There are two sides of this. For instance, in Brookings, the expectation is that you will, in a kind of reasoned, rational debate-supported way, comment directly public policy proposals and comment with one of your own. In part they can do that because they have a large endowment, and in part because they have a lot of grant founding from foundations. They do very little with the money from the government. They also revenue from individuals and corporate institutions. It give them more freedom. They don't have the same constraints.

What do you prefer? To work in Brookings or in RTI?

Well, there is a trade-off between the two kinds of institutions. I very much enjoyed the policy forum at Brookings. They get a lot of press. I was on TV, interviewed by major newspapers. Because of their endowment, they haver greater freedom to decide what they want to do. On the other hand, it is not a large organization and they cover everything. So they don't have a lot of depth in one area. When I was there, I was basically the only one working on health care on a full-time basis. Henry Aaron was doing it sometimes; Joe White was doing it sometimes. It is the case for all the areas. There are only 60 or 70 senior people. That has two consequences. You don't really have colleagues who know what you are talking about. Second you can't do very large project because you can't have a large team. RTI is much larger organization. I am in charge of a team of researchers on aging disabilities and long term-care that have 25 people in it. So we have colleagues and we do much larger projects.

But it Brookings they are maybe more now, don't you think? Because the health care issue has become very visible and important in public debate.

Yes. That is true; but another issue is whether they were able to find foundings. We have a thousand people who work on health care. They have 12 or 20.

Do you think that it is difficult to get founding for health care issues?

No, getting founding on health care is probably easier than for most other areas. Because so much has been happening and the spend issue is growing up, the number of uninsured is growing up. But on the private founding side, for the last couples of years, with the crash in the economy and stark market, it has been harder to get money from the foundations because their money is in stark market. So they cut back. I don't know how Brookings has been doing.

Concerning RTI, even if it must be very neutral, is it influential? Is it connected to the political world?

There are people who have connections to political world; but not very many. What we are connected to is, just below the political level, civil servants. I am going policy development. We are more connected with the kind of ongoing policy bureaucracy at HHS.

For instance, in the case of long term care, have you done something, a report for example, that has been important for the administration, for the implementation of a law or…

Probably not…

Are you sometimes ask by them for advice?

Again, two things. In long term care, there has been less federal policy development. On Medicare side, we do a lot of work – we were recently involved []. Medicare's pays prosecute providers differently. It pays nursing home [] agencies. [] But to a substantial extend, they seem same kinds of patients . So we are doing a study for them where we assessing that the patients – and we are cutting the data on the resources that each of these kinds of patients are using. And we are using that to make recommendation for a reinforcement system for that could be used to cross the different providers. That is the kind of work that we do. We do a lot of work on [resuggessment] payment. We calculate the suggessment factors, weare doing a project on the CMS have quality measures for nursing home. We are viewing those quality measures and using new data to new measures and to revise the old ones. What we do here at RTI has a policy interest and a policy impact but it often has a more technical nature than what the Bookings Institution do.

Are your projects always ordered by the government?

As I said, 85% of our funding is from the government and most is contracts, as opposed to grants. The government would put out request for proposals, we write a proposal and there are often opposition. Then there is a review and they choose the one that they think is the best. Usually the best value for the money. So having a lower cost is an advantage but they also want a good quality. So we always have to balance these two activities. You can always do more with more money but they often don't have more money.

Do you hire external people, like consultancy people, to do the projects?

Sometimes we hire some consultants but usually we do the work. It is mostly done by regular staff.

You told me that you have view about what should be done in long-term care. During you career, did you try to push this view, to be influential, to have connections with the political world? Was is for you important or not?

Well…, yes. Obviously, when I worked in the government, I was trying to promote… The general constraints of whatever the institutions I was trying to promote my view of how long term care should be organized and financed. When I went to Brookings, I testified often before Congress and I was part of the [] from Brookings and went to the administration to work on health reform, as part of this large group of 500 people - you know?

No…

In what was criticized heavily at time and later. When President Clinton came in and made health reform a major priority, he [randed] up this large group of regular government employees but also a large number of people from the outside who became temporary government employees to help health reform design and plan. So, I took a leave from Brookings and came to this group and became a temporary government employee for three or four months. I was again within the broad constraints set up by the administration and I was trying to promote my view. You know, [drop up] my time at Brookings, well-doing [salat-research] that was balanced, neutral and not ideological, I was trying to promote my views. Since coming here, in part for the reasons that I mentioned to you. And also because, during the Bush administration, it was very difficult to influence the administration. So I was less concern to be influential and more to…(do research?)

Did you leave the administration to go the Brookings because you thought that it would be a better place to be influential?

Yes. Two things. When I was working in a policy advising job during the first Reagan administration, and I disagreed with most of the Reagan administration policies. I was not getting along personally with the political appointees, at HCFA either. Brookings was, and still is, a very prestigious organization that does very good work. The reason I went there was that a consortium of foundation had given Brookings what was not a very large grant to do work on long term care financing. They essentially had given it to Alice Rivlin. She was at Brookings and she needed somebody who… She was going to run this project but she did not know anything about long-term care. So she needed someone who knew about long-term care. That was me! The project ended but I staid around until 1996. There was a poll to go there and as far as I was concerned, that was in a great situation. It was September 1984 and it looked like that Reagan would be reelected.

Do you think that your views about long-term care were in the Clinton plan at the end? Did you succeed to push your view in this reform?

Yes. I mean, I am quite pleased with what was recommended, on the long-term care side. I think that we would have been much more [] if it had been enacted. But, like everything else, it was not. I had a pretty good hand in order to design.

It was thanks to your position in the 500 people group?

Yes.

So it was a very important place to be at the time…

Well. It was important in designing the proposal. Since the proposal was not enacted… It could have been… Obviously there were very major political consequences from that health reform. The Republican took control of Congress and a serious health reform was not discussed again for another 15 years. I don't think that the long-term care component had a major influence on the overwhole political consequences. Very few people do much about it. The overwhole effort was a failure.

Were you the only person working on long-term care in the group?

No. There were maybe 10 or 15 people. People from the Assistant secretary for Planning and evaluation, various researchers in the federal government, people in the health care financing administration. I do not remember the names now. There were other outsiders.

From?

From universities, from advocacy groups.

Which one?

Robert [] disability.

Because at this time, there were less research organization than today, maybe?

Yes. But there were a fair number. Brookings was there. The big ones were there. Were not there, some that was created some years ago, like the Center for American Progress. The big one, like the Brookings, the Heritage Foundation, the AEI, the Cato were all there.

Do you think that the failure of the Clinton reform changed your view about the role of experts in the policy-making process?

It is a good question. I think that one of the reasons… I have not thought about that for a long time… The Clinton reform was a mixed [back] and a mixed experience. On the one hand, the basic ideas, that is the managed competition, came out from very academic several people and papers. And, Ira Magaziner, who was in charge of it, relied heavily on them. I think most people would say that two of the reasons it failed is that political people was not heavily enough involved and that academic ideas proved very difficult to operation was, to figure out how it would actually work. So the bill became very complicated. I think the reform needed to be more grounded and experienced – because many of the ideas had never been tried before – and secondly that it needed more involvement by both the political world and the operation

world, who actually delivered services. There were some efforts to get these both groups involved but there were not very successful.

Do you think that, after that, the research institutes changed a little bit their way of working?

Before maybe 2 years before the election of 2008, the idea of comprehensive health reform was not… because nobody was talking about that. When Clinton was president, he would not have tried and the Republican would have not supported it. Then George Bush was certainly not interested in. I think that people worked on more incremental ideas and looked at more evaluating what had been done, promoting [preemskin]. I think that one of the big… - You would not think that it was the case – but it was under [two] the Republicans, health care reform that passed actually had broad consensus across a very broad ideological continuum in the US. That was not in many ways a consensus document. That was incredibly moderate.

Do you think it also because of this period when people focused more on incremental ideas?

It was partly that; it was partly… - I mean, many of the players, political player, who are in Congress now, were there in 1993: Henry Waxman, the other in the Finance committee. They were determant not to screw up again. So they were looking broad consensus. So you did not have for example a serious effort as you had in 1993, to have a single payer system. I mean there were certainly people who supported that… But in 1993 there was a sizeable [consortium] within the Democrat party who really wanted that and would not supported anything else. This time, we had much [record] versions and public option was there but almost everybody who supported that voted for the bill. I think – of course the Republicans would not say that - that it was a much more moderate bill. It was also more moderate – and this may come back to [hunted] - because it did not include a lot of mechanisms for costs control that most European Countries use. There was no global budget, there was no capital control, there was no cost effectiveness research to decide what to cover and not to cover, there were no strong [rite] setting. So most of these mechanisms that other countries use were here politically unacceptable.
I have a meeting in 5 minutes… But we did not have say anything about the Urban Institute… The Urban Institute is quite in the middle between Brookings and RTI in that they are less heavily dependent on government funding than we are, but more than Brookings who get their funding from foundations. So they don't generally do the kind of big proposal that Brookings does. They still try to do more balanced analysis but it is more talking about issues and options that are in a moving in, individuals []. And behind scene, some people from there were very involved in the health care reform. They would do a paper on what would happen on health care costs if you would not pass health reform. That was trying to build the case for reform.

Was your Ph.D about health issues?

Yes. It was about government regulation of nursing homes.

Was it a common subject at this time? Because I met other people who did their Ph.D on this subject?

Who? In [1981]?
I mean, among baby-boomers, there were people, like Mark Meiner, who developed an interesting expertise. But we were the first.