Programme OPERA – ENTRETIENS

Entretien – santé n°9

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Responder: You'll have to tell me to slow down, too, because I tend to talk fast.

Interviewer: Okay. So, maybe just a few words about me and the reason why I'm here.

Absolutely.

I'm Sebastien Guigner, and I'm Assistant-- Associate Professor of Political Science in the French School of Public Health, which is called EHSP, but it's the French national school of public health.

It's national?

Yes. We train all the directors of hospitals, all the career people from France in the healthcare system, and I'm a member of a project. I can give you my card.

Oh, thank you.

I am a member of a research project involving Denver University here, American University and, in France, Rennes, Paris and Montpellier University.

Okay.

And we work on healthcare reforms on the U.S. and in the EU, in some countries in the European Union, like France, Germany, Spain and there was another one. U.K., and we focus on actors and ideas. We try to identify who are the actors involved, what are their profiles, and where do they derive their ideas, and there is another question on the power in the healthcare field.

We try to understand how the different reforms in this field change the power between actors. I mean, maybe federal, states, and states and political actors, Congress, the White House.

And over what period of time?

Thirty years.

Thirty years. Wow. That's how you got my name, right, yeah.

Yes. Since the late '80s.

Okay, late '80s.

So, we are about 15 researchers in this project, and we compare with another field, which is the defense.

I see, and is this-- just for my background, this research has been ongoing for many years, and it compares U.S. to France and also to other countries, or just looking at the--

We began two years ago, and studied European countries, the four ones that I told you, and now we compare our results with the US case.

Okay, okay. And does this result in a book or articles or the whole gamut?

The whole-- but only in French, for the moment. The next one will be in English, we hope so.

Okay.

But I don't know, if you read French, I can send it to you.

Yeah, no. I used to, but I-- I studied French in-- I guess in high school, but I'm not-- I don't remember very much of it.

So, we'll speak English, or try to.

Yeah.

I would like to begin with your career and a few questions about your career.

Absolutely.

I saw on your CV that you hold a PhD-- not a PhD, but a Master's Degree in Public Health, so how did you arrive in the Maryland State after your degree? Because you worked for the Maryland state?

Yeah, well, I actually worked at the federal level first, so right after-- so, this-- yeah, see, this is a summary, so it doesn't-- you know what, should I give my more lengthy one? Would that help you?

Oh, if you want, that would be great.

That would be helpful instead of the more lengthier resume, yeah, yeah, sorry about that. That's just the short one. So, I actually-- I got my Master's of Public Health in 19-- when did I get that, 1987 is when I graduated, and then I came immediately to DC, and I was a Presidential Fellow, which I don't know what the-- a Presidential Management Fellow, I think, is what they call it now. It's a two-year program with the federal government where you can, you know, do federal health policy working in different agencies, and getting a broad experience, and then after that experience, I ended up working for six years in the Senate-- in the Senate Finance Committee for Senator Riegle, from Michigan.

Okay, I see that.

Yeah, I did that for six years, and then I came on board to work for Bruce Vladek, and was the Director of Legislation and Policy at HCFA from-- you know, I'm not sure I've got all these dates. Probably from like '94 through '99, so, about five years there, and then I was the Medicaid and Child Health Director for Maryland from '99 to 2000-- the end of 2003, or something like that.

Then, one year I was with the National Academy of Health Policy doing Medicaid stuff, and then I've been at my current job in 2004 ever since, so for almost seven years. Does that help there? So, how I came to be a Medicaid director is that when I was the legislation and policy person at HCFA, I did that-- you may not know this, but during a very intense period. '94, '96, '97 was a very intense budget period, you know, with the Balanced Budget Act, there was a lot of controversy between the Republicans and the Democrats. It was kind of a tough-- Congress had just changed over from being all-Democratic, right, with Clinton to being Republican, and so it was a very contentious time period.

In the end, we were successful in passing what is called the Balanced Budget Act of 1997. That created a program called the State Children's Health Insurance Program, and I was the first director of that from 1997 to 1999.

Okay.

At that level, I started working a lot-- closely with states, and really liked doing work at the state level, and so I really decided to move from the federal level and become the Medicaid/CHIP director, the Deputy Secretary in Maryland. Does that help?

Yes.

And it was because I really-- you know, I had been at the federal level for 13 years, and you get to do great policy thinking, right? And it's great thinking and all that, but you don't get a lot done. You know, it's always-- issues keep going and going, and you just-- so, I really loved working at the state level, because if I had a great idea, I could implement it.

So, that's why I started getting involved in state work, and then, this job, I'm very much involved in working in Delaware and Florida. The reason I was late was because we are starting a new program in Florida. So, you know, I guess in terms of translating ideas into action, I have found that doing it at the state level, for me, at least, is a little more rewarding because you can actually do things.

At the federal government you can do things, too, especially with the Obama Administration, especially now. It's-- the process is different, right? I mean, it's this big, huge melting pot of different ideas, and I just find working at the state level, maybe it was the positions I was in, I was in authoritative positions, I could, you know, make an impact more, you know, for people.

So, that's why I started working at the state and community level is probably one of your questions, right?

It was.

Also, in terms of innovations, your idea-- the thing about policy ideas.

Oh, you do remember the (inaudible)

Well, you sent me some of them, and some of them don't really apply to me, of course, but some of them do. I really found that-- so, you know, I'm always leading things to think about different ideas, different ways that I can get things done or different programs that have some evidence or science behind it that can improve the lives of people.

Children-- now my total focus is on children, at Nemours. So, I have found that working at the community and state level, you can take an idea and you can implement it, so that has, just for me, has been rewarding.

Okay. I will come back these two ideas just a little bit later.

Yeah, go ahead-- yeah.

Just to continue your career, or did you arrive here in Nemours?

Actually, you know, Nemours is French--

Yes, it sounds French.

I probably won't say it right, but A.I. du Pont was a relative of Pierre du Pont, from back, you know, in the 1700s, when we first came here, I mean-- so, he came over in the early years and there's a whole history about the Du Ponts. Alfred I. du Pont was a relative, and he created this foundation called Nemours based on, I guess, the area in France. There's an area-- or his home in France was called Nemours?

So, there's a whole-- in fact, if you--

There's a city close to Paris, no?

Yeah, I'm not sure where, and--

I'm not sure, too, yeah, but it reminds me of something, actually.

Yeah. There's a French connection. So-- what happened? How did I get to Nemours? Well, what happened was, I guess in my career, people have seen that, oh, I like to implement new things, or I'm good at implementing new ideas and things, and so when Nemours, the place I am now, we're an operating foundation that focuses on children's health and well-being in Delaware and Florida, but now also nationally.

They were interested in creating a new program. They have a huge clinical operation, they are really interested in prevention, the social determinants of health, the other things that impact health, not just clinical care. Not to say that clinical care isn't important, it is important, but prevention is also important.

So, they wanted to build this new way of treating children, or helping children through community-based prevention and through clinical care, so they hired me to start the new program. So, my first five years, I did start the new program, and now it's part of our everyday operations, and so it's doing well in Delaware, and now they want me to take the learnings from Delaware and apply them to Florida, who also-- we are focused on the Florida region, and to take our learnings and try to improve things nationally through federal policy, either administrative or legislative.

So, it's a sort of bottoms-up approach?

Correct. It's a bottom-up approach. Well, it's interesting. It's a bottom-up approach, but in my thinking about innovation, right, I end up bringing ideas from here to help improve what we do in Delaware. So, it does kind of go both ways.

And why Florida and Delaware?

Why? Yeah. So, A.I. du Pont, as you may know, settled in Delaware, so the Du Pont family there, they're all in the Delaware Valley. He retired in Florida. He actually retired in the Jacksonville area, so we have a presence, and actually our home office is in Jacksonville, Florida, and I actually work for the foundation, so, actually, my home base is actually in Florida, and we operate in three areas, Jacksonville, a place called Pensacola, which is near the panhandle, and then Orlando.

Orlando is our newest area. We are about to build-- we are in the process of building a huge, new state-of-the-art children's hospital, and so I was just on a phone call to start implementing some of our great work in Delaware on prevention in Florida. Does that help you?

Okay, that's very clear. Just another question of CHIP. Why were you director? Why you?

Why me?

Because you were the best, probably?

Well, I think I was at the right place in the right time. There was the Balanced Budget Act, which created, right, in 1997, in August, that created SCHIP. They needed somebody to implement the program, and they needed someone to do it quickly, and so I was looking for a change, because I wanted to get my hands more into direct programming, and so they-- a

woman named Secretary Shalala, who was the secretary at the time, worked for Clinton, she put together a team from what was then called HCFA, which is where I was, now called CMS, and from HRSA, and so I co-chaired that team, and then it made sense for me to be the first director.

So, I actually co-chaired the implementation of that program as it was being first developed.

But you had some experience on child healthcare?

Yeah, child healthcare, where does that come from? Well, when I was working for Senator Riegle-- I've always been interested in children's health issues, even in my program studies, so my studies at the University of Michigan, my thesis was on comparing Head Start, in terms of cost and benefits, to primary care prevention, and so I've always been interested in maternal and child health, and so-- and always been interested in Medicaid, which is a program for low-income children-- low-income families and, mostly, children.

So, I have always been interested in those programs, and so people have always known that I have been interested in children's health, and then in the Senate, when I was working for Senator Riegle, I ended up doing a lot of work on children's health. In fact, one of the last things I did was an Amendment in the Senate Finance Committee on healthcare reform that passed. You probably have looked at the history on that.

There were very few amendments that got bipartisan support because it was very challenging at the time, and the children's-- I had-- we were trying to save healthcare reform, and we proposed an amendment that would cover all of children, and I don't even remember the exact amendment, now, but-- so, that's why I always had kind of a-- people have known that I have always been interested in children's health, so I guess, maybe, it seemed logical at the time or something.

So, we can say that you are an expert on child health?

Yeah, child health. Yeah, yeah. And, I also knew-- maybe it's important to say-- is the right way to pronounce your name Sebastien?

Yes.

I just wanted to make sure I was pronouncing correctly.

Perfect.

I think you can also say that, at the time, 1997, when we were implementing the new SCHIP program, it was very controversial, and so they wanted-- I think they also wanted somebody who kind of knew the politics, who knew the Republican Senate, the Republican/Democrat dynamic, and so it seemed like I was the right person, I think, although no one said that explicitly, but I always felt like because I had that background--

Politics and expertise?

And the policy, right, I could navigate that. I had good relationships with Republicans and Democrats, and I think people could sense that, you know, she would be a good person to implement this, because she knows the history in the House and the Senate, she is well-liked by people, and she also knows how to get things done, so I think all of those things, in combination, kind of helped.

So, you participated to the direct-- and bargaining of CHIP?

Right, so it's never by yourself when you work in an administration, as you know, so I was a part of the Clinton Administration. I was part of the team that worked on the SCHIP law, originally. Is that what you mean?

Yeah, and I was a lead person in that I was the policy-- I was the Office of Legislation Director for HCFA, and I worked for Bruce Vladek. So, yeah, but it's never-- you never do it alone, it's always with a gazillion other people. You know, you have to coordinate with the White House, OMB, HHS. It's a very coordinated effort. Is that what you mean?

That's what I meant. But were there any persons-- individuals important during this process?

Are you talking about for SCHIP?

Yes.

You know, I forgot to ask you-- is this all of healthcare reform, or is it just only children?

No, it's about all the healthcare reform.

You just want to talk to me about children?

You can talk about healthcare reform if you have the information.

No, it's okay. I was involved in the Clinton years. At this level, the one that just passed, I was involved more in-- our office was more involved in prevention, trying to establish the Wellness Trust Fund.

But, back to the children's issue, who else was involved, who else were key players? Democrats? Republicans? Or you mean in the Congress, or do you mean in the Administration?

Everywhere, but maybe in the Administration, because it's easier to identify key players in the Congress. It's not so easy in the Administration.

Yeah, on children's health?

On children's health, yeah.

Well, it's interesting you got to me.

It was you?

Yeah, it was me on that. Yeah, yeah, but everything-- it is a team effort, I don't want to-- so, the other person was Dr. Earl Fox. He was my co-chair of what was called HRSA, H-R-S-A, Dr. Earl Fox, but I was the main person at HCFA, and then, you know, in the administration, you never do anything alone, you know, so it's-- there's a lot of people involved.

We had a steering committee that was formed. It had a lot of key people. Trying to-- you want names of the people on the steering committee?

If you've got them.

There was a guy named Gary Claxton, there was a guy named Gary-- yeah-- and there was Jeanne Lambrew, who you probably have been talking to now, because she's involved in health reform now. Who else was there? Nancy-Ann. At the time, I worked for Nancy-Ann Min DeParle. That's somebody you probably need to-- but you probably already are talking to hear about--

Not yet, she's difficult to reach.

Yeah, well, she's-- you're going to have a-- right now they are just swamped with implementation.

We will probably contact her next year.

Yeah. At the White House, there was a guy named Chris Jennings, who was kind of the version of Nancy-Ann for the Clinton Administration, so Nancy-Ann is Obama, and Chris was Clinton. I'm trying to think of other-- oh, man. Those are the main folks, I mean, but the whole purpose of the steering committee was to involve a lot of people, because-- to gather peoples' ideas, get them to actually think about ideas, to get other people's ideas to come up with the best thinking.

And how did you choose the people consulted by this team?

So, the Secretary set up-- the committee was co-chaired by HCFA and HRSA, and then it had representatives on it from all the major agencies, so from the Secretary's office, people like ASPE, which is the Assistant Secretary for Planning and Evaluation, what-- you see what I'm saying? They were cross-cutting HRSA, CDC was on it, AHRQ was on it, the Agency for Healthcare Quality and Research. Lots of people, of course, under HCFA were a part of it. I had a whole--

And it was only people from the health administration, or also from the treasury, or other (inaudible)?

It was-- no, it was mostly HHS. It was mostly HHS, but then once HHS came up with its position, we worked with the White House and OMB, so Chris Jennings, and who did we work with at OMB? It might have been Mark Miller, but I can't-- yeah.

I can check.

Yeah, I think-- most of my interaction was with Chris, and at the time, Jeanne Lambrew worked for Chris. I should say that-- I'm sorry, she worked-- Jeanne actually worked for Chris at the time. I don't know if you knew about that, but Jeanne used to work for Chris.

Okay. Could you just spell me her name? Jeanne Lambrew?

It's-- I'm spelling it myself. Here it is. There, does that--

Okay.

Can I go get my water really quick? I'll be right back, I just want to get my water.

Do you need a refill?

So, that's fine, thank you. Just another question about this steering committee. Did you consulted-- did you consult, sorry, experts from the academic world, or-- where did you draw ideas (inaudible)?

Yeah, that's a good question. Well, there was a lot of people internally. There were-- there were-- there was a lot of meetings with people externally, so we met with state groups, like NGA, the National Governor's Association and NCSL, which is the National Association for State-- National Council for State Legislators. So-- but there were a lot of children's groups that we worked with, like the Academy of Pediatrics, (inaudible) Child Health Programs, I mean, there were just-- children's hospitals. There was just a whole range of children's groups.

Now, you're asking me a different question, I think, which is academic expertise?

In particular.

So, you know, it's interesting. Early on, we convened a meeting with child health experts, you know, talk to me about the bill and getting input from them, but I will tell you that it didn't work out quite right, because they had, like, their academic agenda items that they were focused on, you know, and we-- we couldn't find the right match. I mean, I needed to implement the program right away.

What I did do was, I said to them, “Five years from now, it would really help if you did research on looking at the impact of cost-sharing on child health utilization and outcomes,” and some of-- I don't know if they really did that, you know what I mean? I tried to help them think about-- in five years, when this program is reauthorized, what is it that you need to be researching that would help me figure out how the programs operate.

I have to tell you, it didn't work. Just something about the interest didn't quite mesh, you know? It's hard to get researchers to focus on programmatic aspects, you know? They're interested in their kind of territory of stuff. There are a few of them that are, like, the woman who wrote the article with me, Genevieve Kenney? Did you-- there was that article in 2004 written about SCHIP?

She was more interested in that. Have you seen that article? You should look at it.

No.

Oh, yeah, yeah, yeah. Not sure when it came out. I think it was June 2004 in the policy-- let me see, there's a policy journal called Health Affairs. I'm just trying to think--

Yes, I know it.

Yeah, you know it. There is a whole article on child health, a whole issue on child health, and actually you can learn a lot about the program and my thoughts about it from that article, but we tried to look at the research, and there wasn't-- I was a little disappointed that there wasn't as much research as I had hoped.

So, maybe you can check the research done in France about that.

Yeah.

So, did you arrive to implement (inaudible) or in the fact, your own ideas that you had, maybe-- your theories, or--

Yeah, yeah. Well, you know, that's a good question.

And there is another question linked with this one, which is, "Did you change your mind during the whole process?" Did you still have one idea of what you wanted to do?

Just on that point, I was very open to different ideas. Basically, because of the steering committee, all of the people had different ideas. My responsibility was trying to-- I was always guided by the law, because the law is pretty clear about what is needed. In cases that the law wasn't clear, then I would meet with the Democrats and Republicans and get their input, but-- so, my basic bible was the law itself in terms of implementation, and there were certain timeframes that had to be met, that you can't-- you know, you've got to meet those timeframes, so the work was kind of, in a sense, laid out for me, because of some of these timetables, so, for example, I talked about this in an article, the bill was passed and signed into law in August, 1997.

By October 1st, right, the money became available for states to draw down on, so we had to have all the programmed guidance ready in two months, which is-- usually takes years, so we were working our butts off trying-- working very hard trying to get the program guidance out, and we ended up using Deer State Medicaid Letters as a way of doing that, so we had this committee, and the goal of the committee was for me to raise key policy issues and get everyone to sign off at HHS, and then I had to meet with the Secretary, or this guy named Kevin Thurm, who was her deputy, and then we would meet with the White House and OMB.

So, all of the policies had to go through first me and the committee, right? Getting clarity? And then up to the Secretary, and then over to the White House and OMB. Along that process, people did have different ideas, and so I wasn't-- where the law was clear, you have to follow the law. Where there was flexibility, my job-- I felt like my job was to lay out the options and to make-- to make a recommendation based on input from others.

So, yeah, so, I mean, and maybe you're-- maybe the-- not sure the question-- so, in implementing SCHIP, I was always looking to-- using the expertise from people and trying to figure out what's the best way to reach resolution on a policy.

But you did not have a global view of what should be the health policies?

Yeah, so, I had, like, a general framework, but I wouldn't call it-- I mean, it was a general framework, and a general framework-- I'm trying to remember the three parts of the general-- it had four parts, oh, geez Louise, I'm trying to-- there were-- the first two parts of the framework had to deal with program operations, like how does the program run on the ground, right? And SCHIP was very clear that this was coverage in addition to what was-- building about Medicaid.

So, already, that framework was set by law, and so that was the framework I tried to implement, so there was a basic framework kind of-- in the statute was the program operations, but then I needed to come up with how did that get implemented in the states, right? So, there was kind of like a federal, programmatic part and then there was a state operational piece, which included our regional offices, it included a kind of opportunity for input at the state level, so I was always trying to get input from states, too, as well as others.

The third piece was quality. I wanted to make sure that there were quality in health outcomes, because I knew that in ten years or five years, whenever the-- people would come back and say, “What did this program accomplish,” so I wanted to have a set of measures that I could go back to and say, “Well, we covered this many kids, they got this improved coverage, they got these services.” So, I wanted to, in a sense, prepare for defending the program, so I was really into developing a framework about quality and health outcomes, and the fourth thing I was really interested in was coordination with evaluation and research.

So, I really thought it was important to have a rich body of evaluation and research, and that's why I had this meeting with all these child health experts, because I really thought-- first, we had to evaluate the program, but we also needed to make sure that researchers were also evaluating the program, so we had-- again, we all had information about how is this program working, so that when it gets reauthorized, which it just did, right? So, is that what you mean by the framework?

Yes.

So, that was my general framework, sort of the four, the-- kind of the federal programmatic, the state operations, and then quality and health outcomes and measures and then evaluation and research.

So, I did stick to that framework, but how that got operationalized, I was really open to how that got operationalized.

Okay, and did the law, the bill, when it passes, satisfy you? Because you probably had your own ideas of children's health before the law.

Yeah, did it satisfy me?

It didn't?

It was the best we could do at the time, given the politics. That's all-- it was a contentious time period between the Republicans and the Democrats, you know, Newt Gingrich was around. It was the best we could do. It basically, you know, built on the current Medicaid system, and it did make it more complicated, right? Because you-- it would have been easier, perhaps for the family, if there was one program for kids.

You know, now we have all these-- we had Medicaid, we had CHIP, we have private insurance, right? It continues this-- it's confusing for the families, actually, but people are-- to the credit of states, they are working around these things. In the end, they are developing programs that are easier for families to access, and that was-- you know, that was another principle.

You know, I think that-- I don't know where they are anymore, but I did have some other principles. So, one of the things was-- in that framework of four, I wanted the program-- I wanted to increase enrollment, right? So that more children were covered, and the goal was 5 million kids.

I wanted to-- so, enrollment increases was one thing. I wanted the program to be more accessible, so that-- because there were a lot of people who were eligible, but not enrolled, and partly-- the great thing about CHIP was, they developed simplified application forms, one-page forms.

You know, prior to CHIP, it was really complicated to get eligible for the program, and so one thing I think-- one of the positive things about CHIP was we always thought about-- you know, how do we make this easier to get enrolled. That, then, had a positive impact on Medicaid being-- as well, you know? So, I did have some other principles that I can't quite remember now, but--

So, I read this morning in a (inaudible)-- just a few weeks ago, (inaudible)

I didn't see that.

There is a few words about CHIP, and they say that maybe its main problem is it's too complicated for families to understand how it works.

See, I don't know if that's-- this just got published?

Sorry?

This just got published?

Yeah.

Okay, well, I haven't looked at it yet. Well, you know, let me just say it this way. Yes, the system is complicated. It's also true that the states can design it in a way that is simple for families. So, one thing we learned in-- now, see, I wasn't sure if this was just about SCHIP or

what it was about, so I got-- you're just getting my brain storming now, so before I read this, I was thinking more about prevention, you know? But I was--

That's fine.

But-- there were states that, when they implemented SCHIP, they made it invisible to the family as to whether-- how they got it. They came up with one application for Medicaid and SCHIP, so all the person needed to do was fill out that one-page application, and then they would get into a program, so states could design it, and many did, in a way to get rid of that systematic, you know, complication, so to speak.

States do have the flexibility to do that, and actually, states want to do that. Generally, states want to provide coverage for-- and services for people who live in their states, you know?

And do they do it?

Some do it well, and some don't do it as well, and it depends on the budgets, right? Some states have a history, like in Minnesota, right? They have a huge history. Massachusetts, a history of-- you know, Rhode Island. They have a history of doing a great job. Other states in the South, like Mississippi, they don't have as good a reputation. It just-- it varies, I think.

Did I answer the question?

You did. And do these-- the states like Minnesota or Massachusetts, inspired you or the team on CHIP?

Well, I would say-- Vermont was another one. I will say that when CHIP was being developed, right? In the Congress, there were some model programs out there. Dr. Dinosaur in-- I'm just remembering this now.

Dr. Dinosaur?

Dr. Dinosaur, in Vermont, was a kids-only-- a kids program. Minnesota had a program, oh, geez, I can't remember all the-- but those were the ones that kind of stand out to me that-- see, some of these programs had already existed prior to SCHIP, and so those were really looked at as models.

So, I will say that both in health reform and in CHIP, there were model programs in communities and states that did inspire people. First of all, they showed it could be done, you know, because people are always saying, "Oh, it can't be done, it can't be done." Well, these guys did it, so it can be done.

And then, some of these programs were very innovative in terms of how they did their enrollment and how they-- so, these programs that-- I guess it is true that, as a-- I've always looked at what other states are doing, to say, "Oh, what are they doing that's innovative," that I can adopt in either the state that I'm in, or, you know, in this case, for national policy.

So, yeah, these model programs do tend to be-- that's a good question. They do tend to be-- I guess they do tend to be inspirational, because they are making a difference for their families,

and there's-- you can see it, and so, actually, part of why I went to Maryland was I wanted to be one of those model programs, and when I went to Delaware, I had this huge opportunity to create a model program.

So, you're right, that does kind of attract me, now that I think about it. They do inspire me, yeah.

But does this program inspire people from other states or federal levels?

Yeah.

And nobody from those states try to upload their own program at the federal level?

Oh, they do.

Yeah?

Yeah. Dr. Dinosaur, in Vermont-- the governor at that time was a guy named Howard Dean, who is now a big player, as you know, he's a doctor. Oh, yeah, states are always coming in to talk about the innovation, and that happened during this time, too, in health reform, I think. I mean, everyone was looking at Massachusetts, right? People were inspired by Massachusetts.

So, I think the states do-- I mean, the-- there's kind of a little-- how should I say this-- there's kind of a healthy competition that states have with each other about who can be the most innovative.

(inaudible) in the (inaudible) book, healthy competition.

Who did this?

I like this expression, "healthy competition," for health. It's good. I'll put it to copyright or (inaudible). So, we were talking about states, and I obviously have some questions about this, and there is a question from the research project, and this is about the power of states and, in particular, the power of the federal government, and we wonder if healthcare reform for 30 years, now, has increased the power of the federal level, the federal government in healthcare? Would you say that, or no?

Because some people tell us, "Yes, it did," and some people tell us that, "No, because of states--"

Yeah, they're implementing it. Well, I have to say it. To me, it's always about a federal/state partnership, and so you're asking me, so, to me, it's always going to be a partnership, right? Then, the issue is, right now, is it more-- just seems to me-- now, I haven't been as involved in this current, you know, set of issues, but even there, it seems like it's going to be a real mix. Yes, there's more federal guidelines, but there's so much flexibility for states that implement it, right?

So, I mean, they get to choose whether they have a health exchange or-- I mean--

There is both.

There is both.

Both more federal and more flexibility of states?

Yeah, I think for me, it's both. I guess that doesn't add up to the whole-- well, maybe it does, maybe the pie got bigger or something. The whole system pie got bigger, and in doing so, both increased.

Yes.

I get-- but maybe I'm not the right person to ask on this one, Sebastien, because I haven't been as involved in what happened this--

Yes, but it's good to have your own point of view on this.

Yeah, yeah.

Another question-- we met about 100, 150 people, now, hear in the US, many in the Congress, and there is-- I am not clear about the role of the HHS and its different agencies. A lot of people, especially in the Congress, told us that the HHS is not so important, that it's only here to implement, but it does not decide anything.

The people we met in the HHS told us that, no, we are involved since the beginning of the process, and we have an impact on laws and bills and-- so, who is right, or who was right for SCHIP, since you know it.

Yeah, right. I think they're both right. I actually think both are involved. I-- well, let me separate the issues out a little bit, because I think it does depend on the administration.

So, when SCHIP was being done, at least what I saw, because I was right in there, right? There was a lot of interaction between Congress and the HHS, and the White House. Now, HHS and the White House, we often work-- we work as a team, because we have to be on the same page, right? But there was a lot of interaction between HHS, the White House, and Congress, about, you know, what is your position on various aspects?

I will say that sometimes, HHS can be a source of some ideas, right? Ultimately, because they involve laws, and they involve politics, Congress kind of ended up deciding the structure, right? The structure for SCHIP turned out to be the ultimate compromise. You can choose-- a state can choose to go the Medicaid route, because that was on the House side, or you can go the separate-program route, because that was on the Senate side, so they ended up merging it.

So, I guess what I would say is that some of the big framework issues, I think Congress makes the decision, right?

But for the details--

Yeah, but the details are important. I don't want to minimize the details. The details can be really important in terms of how the program is actually implemented, and now that I'm thinking out loud with you, so, I think for SCHIP, I think the broad program structure, you know, the state got to choose to either go the Medicaid route or the state health insurance-- you know, the new state program route or a combination-- that was decided by Congress, because it was pure politics, right? House, Senate, they compromised, and also, let's face it, Congress has the power of the purse, so-- you may not remember this.

The purse? What?

The financing. They came up with the money, because at one point, when SCHIP was just a little-- you know, was just a little concept, it wasn't until Senator Hatch and Senator Kennedy used the tobacco tax to fund a $10 billion program that it became real, you know what I mean? So, Congress has a lot of power over the basic structure and the financing mechanism, and HHS can have some input into that, but they kind of finally decide that, but once that happens, those are just important framework questions, right? But the actual details, I really think HHS ends up deciding, you know?

Okay.

But it's true-- now that I think about it, maybe let me take my statement back. Maybe in the area of overall program structure and financing, Congress has more power. In the area of programmatic details and implementation, then, I think, HHS may have more power, and actually, now that I think about it, in this recent health reform situation, right? The same thing happened, right? But in part, that was because Obama made a strategic decision not to get involved in the details. Remember, he didn't want to make the same mistake that Clinton made.

So, he purposefully did not provide input early. Remember, Clinton had come up with an 1100-page bill and everybody was upset that there wasn't more buy-in, all that stuff.

Yes, I heard about that.

You heard all about that. So, I will say that, in this administration, they really-- well, they also let Congress do a lot more, but Congress decided about the public option, right? One of the most important decisions made was whether to go with the public option or not, and Congress decided that, it wasn't the administration.

Now, in part, maybe, Obama let them decide, there is that issue, too. So, I think what I said earlier actually also applies to this-- you know. I will say also, though, that even when HHS is implementing the program, like the programmatic details, right? There is a lot of micromanagement by Congress.

How do they do that?

Well, they-- because they have the basic law, they feel like they also have say over the-- how it's being implemented, so there is-- there are checks and balances. I think maybe that's the way to think about it, right? Because I guess if Clinton-- if there were things that Obama or Clinton said, “These are deal breakers for me, I will not accept a bill that comes to me with

that in it," if they don't listen to him-- so, they do have that check on Congress, but they don't use it-- I mean, they use it very judiciously, and the check that Congress has on HHS is that they then say, "I don't like the way you're implementing this."

Now, they don't do it a lot either, but they will do that. So, a good example is what happened in the last couple of months with the pre-existing conditions for children, did you follow that?

No.

You should look at that, it's very interesting, because what happened was, somebody, I don't know how it started, the health insurers, some of the health insurance plans were saying that the prohibition on pre-existing conditions does not apply to children. The children's groups immediately got upset about that and said, "Yes, it does apply to children," and they got Congress all upset about it, and Congress sent a big letter to HHS, which HHS happened to agree with, because the Democrats are all-- was that this does apply for children.

So, you should look at that case, because it's a good example of checks and balances, where in implementation, Congress did get involved, because they felt strongly. It's the-- whether or not pre-existing conditions apply to children, the prohibition against it, right? You don't want to have--

When did it happen?

It happened just this year. After-- when the bill was passed in, I guess, what signed March 22nd? Somewhere between march 22nd and the end of April, there was a big controversy about whether the prohibition on pre-existing conditions applied to children.

Yeah, I will check that out.

Because it's kind of interesting about the checks and balances.

Absolutely, right. Tell me if you're--

Yeah, yeah.

Just maybe a last question about the White House-- what were the relations between the White House and the HHS when you were there?

There was a lot of collaboration, and I would say oversight, meaning that the White House was-- they were very interested in what we were doing and how we were doing it.

So, just a little-- no flexibility for the HHS? No--

Well--

It was supervised by the White House?

Well, I mean, that's a good question. There was-- the White House was very involved, I guess I should say it that way. They were very involved with the various policy options and the

direction we went to. I mean, they were very involved in policy decision making. So, you know, look, I mentioned earlier, if we did an options paper, we might come up with what we recommended HHS, well, they would look at that and make sure that they felt comfortable with that, and OMB, too.

So, don't underestimate-- when you mean the White House, do you just mean the White House? Because there's OMB, too. There's like two of them. They are different, but they both have a lot of power, OMB and-- was also really part of that triangle, too. It was OMB, HHS and the White House, and OMB and the White House had a lot of-- we would make a recommendation, you know, they would-- you know.

Say yes or no?

Yeah. So, it really involved a lot of-- that's what I'm telling you, it really involved a lot of collaboration. You really had to work well with people.

Okay.

Because it is, in part, about your relationships. It's not only about that, but-- everyone always focuses on the substance, and the substance is really important, but it's also about, you know, your relationship with people.

Yes. Okay, I don't want to be too long, so, I can stop here. You gave me a lot of information.

Was it helpful? I hope so.

Yes, oh, yes.

Can I say one thing about health reform this time around? Because I do think it's really important.

Tell me.

The new idea that was put on the table, actually, this was from Obama, was that we don't just want a system that helps sick people, we want the system to be transformed to focus on prevention and wellness, and that was a framing issue that Obama brought in early and stuck with that framing, and so that's why the eventual bill has a major-- what's called the Prevention and Wellness Trust Fund, so we're-- that's something that I'm working on a lot now, and it does involve innovation, and I do get a lot of my ideas from experts, that we need to change our system from one that focuses on sick treatment to one that focuses more on prevention.

And for children, it's helping them grow healthy in all of the places they spend their time, not just in clinical care, but in childcare centers, in schools, and in the community. So, that has kind of just-- to me, that's innovation, and trying to get people-- I have to say-- I'm not sure this is for quotation, but it's very challenging to get the Washington community to focus on prevention.

They are very focused on clinical, on coverage.

Yes, that's everywhere, around the world.

From what I hear, the European countries are much better around that.

Maybe Northern European countries, like Denmark, Sweden, Norway.

Yeah.

The WHO is more and more focused on prevention.

Who is?

The WHO, the World Health Organization.

Exactly, they have the definition. So, I do want to point out that in healthcare reform this time, there is at least the beginnings of a shift in, maybe, the paradigm, from just sickness to prevention and wellness.

How do we explain this shift?

How do we explain it?

Is it because of money? Because we say that prevention is less costly than healthcare, or--

Well, first of all, they did create this Prevention Trust Fund, so, early on, Obama did have his four-- his pillars, and his pillars included prevention in it, and I do think that helped, that he and others, Harkin and Daschle, at the time, when Daschle was in a more leading role, they all focused on prevention. I did think that had an impact on the final bill.

And the thing is-- and this is where it's really more intuitive, when you tell people, "Oh, why don't you keep people healthy so they don't need healthcare, they don't go to the hospital, which is-- you might get great care at the hospital, but you're not liking it while you're in there. Most people don't like to be in the hospital."

When you talk to people about it, it seems like common sense. The database, you may know this, the evidence base on whether it actually saves money in the long run is, you know, it's not clear, but it is the right thing to do, and so I think it does appeal to peoples' basic senses. You know, from-- if the Democrats feel like, "Gosh, we ought to be investing in more prevention," the reason the Republicans might support it is because it's more individual-based-- there philosophy is all on the individual, and the individual should-- some Republicans, I'm sorry, believe that the individual has a responsibility, and so the individual is responsibility for his or her own-- for preventing illness.

So, I think it appeals to both, you know? I think it does help that it appeals to both sides, for various reasons. But, I mean, I will say that I was worried whether that prevention trust fund would stay in, especially when they were hunting for all that money, when they were trying to

finance the healthcare bill, in the last few months before it was passed, I was kind of worried on what it-- because it was a pot of money. It's like $10 billion, or $15 billion, and so people could have taken that money and used it for something else, you know?

So, I do think that's a significant change you ought to explore, because it is also-- I don't know if the word is "innovation," but it is a new paradigm, right? And so there's something there about that, and we can always set up another call to talk about it, but I do think it's significant.

Are those-- are there some Republican think-tanks or lobbies, maybe, can we call them lobbies, saying that this policy is-- these prevention policies are against freedom, a way to lose some freedom in your own habits?

It depends on how you do it.

I agree, but can you explain that Republicans agree with this new paradigm?

Well, remember, here, how it's done is that the money goes to the states, and the states develop community and other prevention programs. So, you're right, it wasn't that-- they were not-- it wasn't a set of mandatory requirements. It wasn't that. It was more-- it created a stream of funding to support prevention, and so-- there's a group called Trust for America's Health, and a guy named Jeff Levi who was really involved in this, Jeff L-e-v-i.

Where is he?

He's at-- it's called the Trust for America's Health.

But where is it based?

It's here, in DC. The acronym is TFAH, TFAH.

Okay.

TFAH, yeah, that's what it is, but they did a lot of work on getting the prevention to be a part of it.

I'll try to meet him.

You might-- you've got a lot of people to meet, so I don't know.

No, it's (inaudible).

I say that because you're-- where do new ideas come from.

Maybe from there?

No, it wasn't just from there. I really do think Obama kind of laid out--

(inaudible)

Yeah, I think Obama kind of first laid out the focus on prevention. It's actually kind of interesting. I don't know where it first came from, but I do remember it was significant to me, at least, when Obama was also talking about prevention.

Okay.

The other one is Senator Daschle. That's another one-- this is before-- I mean, remember when he was-- he was supposed to be the HHS secretary when he got into tax problems, but he was a big proponent of prevention, so if you look at his book, he did a book with Jeanne Lambrew, this woman. You have that book, right? That book has prevention in it, I think.

So, somehow, that idea started percolating that you needed, you know, coverage, prevention, quality and cost. People used to always talk about, you know, coverage, quality, and cost, right? And then people started adding prevention as kind of the fourth pillar, but I'm not actually sure when it happened.

Very interesting. For my own research on the EU-- I work on EU policy and--

But see, ours is different, ours isn't like mandates, it's more like give money to states and have them create programs.

It's exactly the same for in the European Union, when you have policy to just give money to-- promote policies and promote more and more prevention policies, rather than care, so that's interesting.

But is it-- you were saying that they have the same problem, that people don't want to fund it.

It's probably more easy in Europe than it is here.

Everything's a lot easier there.

I wouldn't say that, but thank you very much. It was very interesting.

Oh, thank you. I was delighted to do this.

It was really interesting. I liked it, thank you very much.

Will you be quoting directly from me, and could you at least share with me if you do? I just don't want to get me into trouble.

Okay, but if you want, I won't quote you, it's no problem.

No, you can quote me, it's fine, but do you just mind checking with me? Or is that too hard to do?

No, I don't think so. If we do, I'll just send you before--

No, no, I know it actually helps to have quotes. You can have-- I just don't want-- just be careful on some of that stuff.

I absolutely understand.

Because I was pretty open on the call.

No problem, I will (inaudible). Thanks a lot. May I ask you for just your CV or--

Yeah, yeah, can I e-mail that to you? Because I-- I don't have it just handy, but should I-- is that alright to just e-mail you?

That's perfect.

So, I'll just e-mail you at this-- the gmail one? Okay.

Yes, I prefer this one. I have one at the HSP, but I use gmail.

Okay. So, when are you going back, because your colleague has already gone back, right?

Yes, she went one week ago. In three weeks. I stay here.

Gosh, you have a lot of time left.

I have a lot of interviews to do, books to read.

Are you getting interviews with some of the key people, or is it just hard to get? I know it's hard to get one with Nancy-Ann. You-- there's no way to get her.

We didn't try to get one with Nancy-Ann. We will wait maybe one year or two, because we know she has a lot of work. We-- I will maybe have an interview with Tommy Thompson. We tried to reach Shalala, but she did not answer, so we'll try again.

Yes, yes.

(inaudible) to interview.

So you're kind of taking it first-- you're doing Clinton-era, and then you'll come to this one?

We try-- depends on who answers, you replies to our requests.

Yeah, yeah. Well, that's interesting. Good luck to you.

Thank you very much.

Sure, sure, and I'll e-mail the CV. May take me a couple of days.

Okay, and maybe I'll send you an e-mail if I don't see you.

If you don't, yes, absolutely. Absolutely. I don't mind getting e-mails, just know that I can't always get back-- I just can't always get back to them right away. Well, thank you very much.