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Interviews

DREW ALTMAN

*Transcript of the Maxwell School / Public Agenda
Policy Breakfast Discussion with Drew Altman,
President of the Kaiser Family Foundation.
Discussion moderated by Robert Siegel, host of
National Public Radio's All Things Considered.*

"The Path to Health Care Reform"

MAXWELL SCHOOL / PUBLIC AGENDA
POLICY BREAKFAST

Maxwell School/Public Agenda Policy Breakfast

"The Path to Health Care Reform" With Drew Altman

(From Left to Right) Drew Altman, President of the Kaiser Family Foundation. Discussion moderated by Robert Siegel, host of National Public Radio's All Things Considered.



Robert Siegel: Let's do a hypothetical, or not so hypothetical. It's January, 2009. There's a new president in the White House, and there are even more people uninsured in America than there are this month, and our national healthcare bill is still going up. We still haven't addressed what happens when the baby-boom retire and need Medicare. What is something that the President can do that's realistic, that we can afford to do, and that will have sufficiently instant effects and benefits for people, that the members of Congress, who by January, 2009, will already be running for re-election in 2010, can say, "I'm for that. Let's do that. America will welcome that move."

Drew Altman: This is where I have to make a de-personal decision about how much I want to depress all of you this morning. Deciding on that something is going to be very hard for the President because we're at one of these moments of opportunity again in the country when there's at least a possibility for bigger health reform. The question is whether you go after something smaller that would be easier to agree on, or you seize this moment and try and go after something big. You either go after "that something" big quickly, or it won't happen because there is a short window of opportunity before the next election cycle starts to close in, and then there isn't a chance to do anything big again. Let me deal with the big enchilada first. For that to happen, there are a few things to watch for. One, a new president has to make health reform, bigger health reform, an early and top priority. I think there's no chance unless that happens. The rhetoric of the campaign, notwithstanding, that will be re-visited once there is a

new president in office, and I do not think it is preordained that that occurs with the crush of all the other things that will obviously be on the agenda, especially with the economic meltdown, which I'm quite sure is affecting everybody in this room as it is my organization.

The second big obstacle will be finding the money, which relates as well to those very same concerns, as a rough rule of thumb, and it's only one aspect of health reform, but it's the one they're talking about the most. It costs about 100 billion dollars a year if you want to cover everybody, so you may not choose to try and cover everybody in your plan, but it's real money, and it will be very hard to find given the focus on the federal deficit, and the meltdown, and other priorities.

Then I think the toughest problem of all, if you've been watching anything in Washington lately, but especially any effort in health, will be bridging healthcare's huge policy and ideological divide. The one you see reflected in the very fundamentally different approaches that John McCain and Barack Obama have taken to health reform. In the old days, I used to think the big obstacles to health reform the last time around were healthcare's legendary interest groups and finding the money. I actually now believe in recent times the biggest obstacle is this fundamental ideological divide, which will be there no matter who wins, no matter what the margins are. It's still there, especially in the Congress, which is more sharply divided ideologically than the country is, than the American people are.

That's the first thing. Do they go after big health reform? If they choose not to, then the President makes a decision that looks at the question that you framed. Do we go after something more modest? Certainly, they'll be dealing with the reauthorization of the so-called Children's Health Insurance Program, so that is a place to start. There are other issues that are there, that they are going to have to deal with. There's a big issue that has to do with paying physicians under the Medicare Program, and restoring a planned cut in reimbursement for physicians, which is expensive under the Medicare Program. A big question is whether they start with those smaller steps, that are going to be there anyway on their agenda, or instead they move beyond those, and shoot for some bigger version of health reform.

I think the thing to think about is if they go small, if they go for the singles or the doubles, and there's a real chance that will happen, both because the fear of failure on big health reform, and just because those smaller things will be there on their agenda anyway, and that's how the Congress works. They never get to anything bigger because the clock runs out.

RS: I want to ask you about one of the philosophical differences that I think you're alluding to, and it's embodied in the McCain proposal, which given the likely outcome of the Congress, I think even if John McCain were elected, this doesn't seem like it's going to get off the ground. There is an idea that he's attached himself to. That if you retain insurance, employer-supplied health insurance, as a non-taxed benefit, then we never become cost-sensitive to what we are spending in the way of healthcare. It's perceived as a free good by a lot of people, so you go and get it, and we rack up more costs. Has it got a point? Is there something to that attitude?

DA: Yes, I mean he does have a point because everyone's frustrated with the employment-based health insurance system, and there is understanding on the left and the right that the current tax preference from employer-based health insurance is regressive. That is you get more, if you make more money. Look, I would put it this way. I've been actually really frustrated with the way in which the health reform debate has evolved so far and even the coverage of the debate, because I think we've been looking at the trees, and focused on the trees, and not the forest. The details of these plans, and their component parts,

and how they're going to work, when in fact, if you think about it, the one thing which is certainly true about the McCain plan and the Obama plan is that neither plan will ever be enacted into law in our country no matter who is president because, of course at best, they represent a statement of direction, and a device in a political campaign on behalf of the candidates that will then morph

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hugely as others get into the act, something called the Congress, the interest groups, when they are elected.

What is really important to focus on are not the details of what we call plans, which in truth are six, or seven, or eight pages of bullet points, not really plans, but the truly fundamental differences, including the one that you're mentioning, between the candidates on their visions for the future of healthcare, on the direction in which they would take the healthcare system, which you don't get so much by reading the bullet points in the seven pages, which were written by friends, many people in this room who are experts, but you get instead by listening to the candidates.

By the way, this is not a plug. It's just if you're interested. We have everything they've ever said on our health08.org website if you want to listen to their words on health reform, but they disagree fundamentally on so many things. One of them is the point that you raised, whether we should build

on Obama believes the employment-based system and public programs, or instead as John McCain sees it. See a future for the healthcare system in which people, many more people, buy health insurance themselves on—in the non-group, or so-called individual health insurance market. That is tied to a further vision of empowered consumers who will become prudent purchasers, and lead us to a more efficient healthcare system. We can go into that, and there's a great debate about that, but there are other even more profound, I think, differences.

That's one about how you structure the system. Another one, their basic goals; the Democrats basic goals, and Barack Obama's basic goal is to get as close to, or to, universal coverage as you possibly can. That actually isn't the base and goal of Republican plans, or John McCain's plan. I think it's actually wrong to judge Republican plans by the Democratic standard, or the liberal standard. They have a different goal. Their goal is to get to a more competitive market, oriented-efficient system to make health insurance more available, but not guarantee it, for everyone, and give some people a tax break.

They have fundamentally different basic goals. Because John McCain's vision is a vision of a system in which people are purchasing insurance themselves, that leads us directly to a debate about another fundamental difference, which is people are now out there, and they're buying insurance themselves. Do we then set rules for how that non-group, or individual health insurance system works? I'm out there now. I'm buying health insurance, and I'm all alone. They disagree fundamentally on that question, as you know.

Senator Obama believes, and most Democrats believe that you need to regulate that system so that insurance companies will take all comers. Senator McCain does not believe that. He believes in an unfettered market place, and instead would back stuff. That market place would better high risk pools and other mechanisms. Most important of all, and I think the one that gets really lost in the debate, is they actually have a fundamentally different vision of what health insurance should be in our country.

Senator Obama's vision of health insurance, and by and large, the liberals and Democrats' vision, socialist vision of health insurance in America—it is certainly not the socialist vision—is a vision of

comprehensive coverage where people have coverage for everything including preventive care. Senator McCain's vision of what health insurance should be is completely different with cost sharing, high cost sharing, high deductibles on the front end, catastrophic coverage on the back end. It is less comprehensive, or if you want plain English, skimpier health insurance, and in his ideal world, people would have these tax-preferred savings accounts, which some believe would encourage them to become more prudent purchasers of health insurance coverage.

Now there are great debates about whether that will make people more prudent purchasers of healthcare, or it won't do that at all because if you think about it, purchasing healthcare is not the same as buying a plasma screen, or a camera online because (1) we don't have good information about cost or quality, and average people really don't have much at all. (2) People don't really make the decisions. Their physicians either make it, or mostly make the decision, and (3) you're making the decisions that really count when—and that really cost money when you're really sick. I don't know about you, but that's not a time when you're really weighing the costs if you could even get the information, the costs of this MRI versus that MRI, or that surgeon versus another surgeon.

There are these basic fundamental differences in the visions of the two candidates in the directions in which the health system might go, that I actually think the American people could understand and make some judgment about. What kind of health insurance do we really think we should have in this country? Instead we're lost in this morass of the details of plans, and I think that has been a disservice, and it is meant that we have not had a real debate about the real fork in the road, what differences on health reform that are at stake in this debate.

RS: There are many studies that say that although we pay more per capita for our healthcare than anybody else in the world, the outcomes of our healthcare are not much better than many other countries and worse than quite a few. My question is: Do you think the American people, if they listen to the news enough, or read it, will hear news to that effect? Do you think Americans believe that? Do you think Americans believe that the healthcare we get as a result of all this system is, if not second rate, B+?

DA: I have a couple of semi-weasily answers to that. One of them is that this is a non-answer. It is that the debate that we're having right now is more a debate about health insurance, and this is where healthcare people have missed the boat, I think, in framing our issue in the wrong way. It's not so much about health, though certainly health insurance is fundamentally related to health, as it is the economic security of working people.

My first response is it isn't only about health, this debate that we're having, and so in our polls and surveys now, we find as many as a third of the American people truly struggling to pay their healthcare bills, and postponing care, and skipping medications because they can't pay their healthcare bills. When we ask people, you know in these polls, and they ask people, "What issues are you most worried about today? What's going to influence your vote?" They pick the economy, but noone says, "What did you mean by that?" We decided we would ask them, "Okay, what did you mean when you picked the economy?"

It turns out that a big part of what they mean when they pick the economy is paying for healthcare and health insurance. When we structure our polls the way we all do, and so you get the economy, Iraq, and healthcare, then a distant second and third, you get a misleading picture because actually what one of the things they're really about worried about when they say the economy is the cost of healthcare and health insurance. First, in the public's mind, it's about economic security, their healthcare bills, as much as anything else.

Secondly, we have one of the world's experts on exactly this issue here, Humphrey Taylor, and it has been a great service to try and push us to think more about other countries, and their healthcare systems, and Humphrey has done a lot of that. I believe my answer is we have succeeded in getting decision makers and opinion leaders to do that. I'm not so sure about the American people. I think that there is a sense of American "exceptionalism," a tendency to feel that we are just different. I'd actually thought that 9-11 would open us up to the rest of the world, but it seems to have had the opposite effect. Some of that is the impact of Bush Administration policies, so no, I don't think that it penetrates, and in fact, I think there is denialism about that on the part of the general public, but I know a lot of prominent leaders who are affected by those data, influenced by them, and think about them.

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RS: Even if, let's take one, which seems right now a very possible outcome in November, which is judging from where all the polls are, a Democrat is elected president, and the Democratic majority in the Senate rises to, who knows, 56, 57 seats and that still leaves a couple of Republicans who will often vote with Democrats; three or four of them left in the Senate. They add another 20 seats in the House perhaps. That alone you think would still make it unlikely to pass a think-big sweeping healthcare reform?

DA: I don't think it's a partisan statement to say it increases the odds, but to me, I think it's just a factual statement. No, I'm not a big believer in the democratic slam-dunk theory on health reform because I think that no matter what—who's in charge, one party control, whatever the margins—we still have a lot of moderate and conservative Democrats, Republicans, and this sharp divide in the Congress about how to proceed on health reform, this difference on how to do it, is profound and deep, and so I think the odds that something happens goes up tremendously.

Healthcare is a much higher priority frankly for Democrats than Republicans, and for the Democratic constituency than for the Republican constituency, and for Independents than the Republican constituency, so it increases the odds that something happens. My view is that divide in Washington, and in the Congress is very, very powerful. I think that it will be a centrist compromise, a centrist deal, or no deal at all. A lot

of people, close friends, get angry at me when I say those things because it's not where they want it to come out, or they just don't want people like me saying that yet, but that's where I think it comes out.

It looks something like, and this is where Massachusetts becomes important in my mind. It doesn't look like Massachusetts in its details at all, but in spirit. What they did in Massachusetts that's significant to me is that they put together a coalition and a plan that had elements that left, right, and center could buy into. Something everyone on the left, right, and center could like. It is in that sense too, to me, that the state health reform efforts is really only one comprehensive one left standing in Massachusetts. We failed in California. That would have been very significant had California succeeded, or significant because we can't reform healthcare state by state.

We can go into that if you want, but a handful of states can be pacesetters and help show the way, and in the sense that they put together a centrist deal, a broad-based, crossed ideological combination. Some call it hybrid approach. I think Massachusetts is significant as a kind of harbinger of what could be done.

RS: How do you think the whole discussion of healthcare reform is affected by the financial crisis that we're going through? Obviously, insurance companies are major players in both stories. How does it alter the discussion?

DA: I hope this doesn't sound mystical to everyone, but I think it is fundamentally affected in the following way. We in the healthcare field have tended to define our issue as an issue of access to care, and the bad outcomes that occur when people don't have health insurance, or have an adequate health insurance, delayed care, don't get it, wind up sicker, more costly in the end. That is what we direct all our research to, thousands of studies. We do them. Others do them, our rhetoric, our framing of the issue. I think it has been a fundamental error in the framing of our issue that has badly hurt the chances for health reform, but now it—an even more fundamental mistake because healthcare is not defined that way.

The problem is not being defined that way by the American people. It's being defined now as a problem of affordability, paying for care. How do I pay my healthcare bills, and pay for my health

insurance in the future? It's being defined by the American people, not as a healthcare problem, but as a pocketbook issue, and as an economic problem. The train that is leaving the station in the Congress is the economy train, and legislation related to that. Unless the issue is reframed as an economic issue, and as a pocketbook issue, I think it will get pushed aside over the next couple of years. People worry about paying their mortgage, their credit card debt, buying food, as part of that constellation of issues, and not as a separate healthcare issue, a social issue, but rather as an economic issue.

RS: On the other hand, this sum of 100 billion dollars a year, as you would say, the price tag for universal coverage sounded like an astronomical amount of money until a few weeks ago. In a way things that seemed outrageously expensive not too long ago, are conceivably back on the table at a time when now economists are saying, "Don't care so much about the deficit. We're going into a trough. Spend our way out of it."

DA: In my weaker moments, I have exactly those thoughts, but I think also where it could go is, you know, if you were going to bet, you would bet that there would be something incremental that is smaller, so you'd see a reauthorization of the Children's Insurance Program, and some other things built around it. Another way it could go is that you could see a big health reform plan, but one which is phased in over a long period of time. It wouldn't start immediately, for example. It would bank on a recovery occurring, you know, three or four years from now.

You get the political credit. You don't have to pay for it right away. It would theoretically still occur, so there still are a lots of—there are lots of ways that this could go, which are more nuanced than it all happens right away in this giant health reform plan, or it's just a little tiny S-chip renewal.

RS: I'm going to ask you another question related to the economic, the financial problems, we're having. You run a foundation. Our stock image of what's happening in the past year is people opening up their 401Ks and seeing they've lost a lot of money. I can only imagine what it's like for people with large endowments looking at what's happened. How does that affect what Kaiser can do, and what the non-profit players in this whole discussion?

DA: I think I was mentioning this to you earlier, but my days consist of trying to provide calm and clear leadership to my staff, and then you go in a closet and scream. I had dinner with a big foundation president two weeks ago, who in that early week in October when the markets lost another 20% in a week. Yes, lost a billion dollars in two days. Look, when you run an organization that is entirely dependent on endowments—we're an operating foundation. We don't make grants, and we do accept outside foundation funding just for our global work, but never for our domestic work, so when you run an organization that is almost entirely dependent on your own endowment for your operations, it's a very, very scary time. It just truly is.

For us, for grant making foundations, you really have to worry about your grantees, and for us, if we cut back, it's my staff, and my friends who are on my staff, and our operations, and our programs. Everyone is trying to decide what to do. Some people, I think, are moving too speedily, and they tend to be the foundations, you'll pardon me, with a lot business people on their boards. They're making massive, radical, and immediate cuts in their programs. Others are actually adopting the attitude. They tend to be bigger foundations who have the cushion, that now is the time to spend more because the people that we are here to do work on behalf of are hurting the most. Then there are those who are taking a kind of wait-and-see attitude.

Our own approach is that we're taking it a step at a time because we—our funds are not tied up in long-term grant commitments. We can move very quickly where it's not pretty. I'm worried about it every day, but we're able to adjust our spending up and down almost on a monthly basis, so we're adjusting to what is happening almost in real time, but it's a terrible, terrible environment. When you read the newspaper, and stuff, I don't think you think about, you know—I mean all of the non-profit organizations, the hospital who have bond-financed activities, and their interest rates, the foundations. Just a whole set of the good guys who are really hurting in this.

Others are calmer than I am. I was talking to Jim Tallon earlier who's a great friend, and runs United Hospital Fund, who's sitting right there. Jim was much calmer than I am, but he's a veteran politician.

RS: Let's take a couple of questions from the audience. We have some microphones standing here, and if you have a question for Drew Altman, please.

Audience Member (David Walker): I agree with you that the biggest challenge is the ideological divide, and it's very considerable. My question to you is if you assume that we need universal coverage at some point, as part of comprehensive healthcare reform, how do you define universal coverage in a way that is affordable and sustainable over time?

DA: I have a feeling you have your own answer to your own question. The universal coverage means everyone has health insurance coverage. I think the debate then is joined around is what is the benefit package. Yes and that's actually the tricky question ---the real question about the McCain plan. If you follow the press reports about the

McCain plan, it's this big debate about you lose your tax preference for health insurance coverage, but the tax credit will net that out for most people, but not everybody.

I don't think that's the real issue. The real issue is you've got your \$5,000 tax credit for a family, but then what kind of coverage will you be able to afford, and then is that good, or is that bad? The real issue, I think, we face as a country is we can provide more comprehensive coverage for everyone, universal coverage, which I think everyone agrees should be—I wouldn't say everyone. Most agree it should be a goal. Will we spend more as a nation, or will we provide less comprehensive coverage? We've learned in this recent period where our studies show many more people are getting skimpier coverage with higher deductibles, and now we're starting to see the studies roll in about people using less care.

They use less care when they have less insurance. They really do, so we can provide less comprehensive coverage if that is our, you'll pardon me, kind of ass-backwards way of controlling costs in the U.S., and we will spend somewhat less money as a nation on healthcare. You know that's a real decision that will never be clearly framed, and we will never clearly debate as a nation, but it is actually the fundamental decision, or a fundamental decision.

“The real issue, I think, we face as a country is can we provide more comprehensive coverage for everyone--- universal coverage--- which most agree should be a goal. Will we spend more as a nation, or will we provide less comprehensive coverage?”

RS: Should everyone, for example, have the right to the quadruple bypass if needed? Should we just assume that whatever potential high-end of surgery is possible, all Americans have a right to that when their medicals require it?

Audience Member: Drew, you’ve heard me say, “We sell healthcare. We produce healthcare and sell it as capitalists. We purchase it as very poorly organized socialists.” Now that we are officially the, as I’ve just said to you, the only remaining socialist nation in the world without national health insurance, are we prepared because the implication is that the problem is the quadruple bypass, when the underlying reality may be what we pay for the quadruple bypass because at every part of our system, the producers maximize price and volume. The insurers minimize risk, and we all, at some point of view, create the illusion that it’s the consumers driving us, but at every step in the system, we’re making money. On this two trillion dollar system, does the debate cross over into a more aggressive control approach on the production side of healthcare, and the pricing side of healthcare?

DA: You could see why he was once described as too cerebral to be governor in this state in the New York Times. You know we were there once. I mean our focus on the healthcare system in the ‘70s was on regulation and the supply side, rate setting, and we may get back to that, I think in a clearer way

than we have been in recent times when the default position in politics broadly, and in health has been a conservative position, and a market position. Certainly in the underlying polling we see it.

We behave as if regulation is out of bounds, unthinkable. There’s actually tremendous political support for it, and especially when it comes to things like the price of drugs, and forget the debate between experts. I’m talking about the public support for it. We might get back to that in a clearer way, I think. What’s your answer to that, Jim?

Audience Member: I think that if you take the assumption that we can’t control, the costs are higher. It’s really —and Humphrey’s work on the opinion side, and some of the other work that our commonwealth has supported on the international comparisons. I was with Philip Howard yesterday, and showed him the slide in which if you take the western countries, and we

start in 1980, and we are reasonably clustered as shared, GDP, and dollar purchasing power equivalent dollars, and the United States number just runs away from all of the other western industrialized countries by a huge margin. You have to step back and say, “We didn’t just get there. This isn’t the only way to run a healthcare system because there’s eight other lines in that chart showing you that there’s a different way to run a modern industrial society with a healthcare system.” The question is there is an introduction of greater societal value and enforcement into those other systems.

DA: What I find, and this is broad point, but what I find interesting about all the other systems is that they’re all different, but they all have a way, different ways, to control the total resources imperfectly, but some control that go into the system. Then they leave their medical professionals and patients, you know, largely alone to make whatever decisions they make. We, in our fragmented system, have absolutely no way, and then we micromanage everything that walks and breathes. Sometimes that micromanagement comes to you through a private insurance company, sometimes through a government agency, but to me, that’s the fundamental difference. We have no way to control the resources.

RS: In that line that we've heard described that departs from our—from other OECD countries for example, are all the components racing up? I mean is it pharmaceuticals, end pay, and we have perhaps the oddity of lawyer costs. We always hear about them. Is everything rising more than everyone else, or what is the peculiar American disease when it comes to healthcare costs?

DA: I haven't looked at that recently.

RS: Back to the audience.

Audience Member: Just sort of extending that conversation a bit in terms of intervention and some of the management, but the Medicaid/Medicare has recently announced that hospitals will be responsible for covering the cost of their mistakes. This is likely to break out into among other healthcare financing companies. Could you talk a little bit more about that because I think that extends sort of maybe this ad hoc approach to trying to grapple with what is an interlocking group of systems, not a healthcare system? I think we really should be aware of not, or wary of describing our manner of getting healthcare in this country as a single system.

DA: I think using payment as a lever is good in that way, and the public programs can lead. There's an ancient saying that dates back to the days when I worked when I was about two in the healthcare financing administration, Carter Administration, that when Medicare sneezes, healthcare catches cold, and so I believe that Medicare, in particular, can lead in that way.

Personally, so I think these are entirely positive developments, is I guess what I'm saying. On the other hand, a lifetime in this field has convinced me that there are limits to our ability to get inside the black box of medical practice from outside. I get nervous when people start to pretend that pay-for-performance guidelines are—I think these are entirely positive developments, but they are not a panacea. They are not solutions. They are what they are. A giant quality industrial complex is developing in our field, and I think we have to focus on the good parts of it, but be careful not to pretend that it will solve more than it will solve.

I've been down this road many times in my career, and I think there is also a danger in the next couple-of-year window on Capital Hill that these are the things people can agree on easily on

Capital Hill: information technology, quality interventions, some payment reforms, and so it will be easy to go there. That's all we will get. There's nothing wrong with any of these things as I've just said. They're entirely positive. For the long term we need to do them, but they don't address the immediate really big issues of coverage and costs, which is what has brought this issue back to the forefront of the national agenda.

Audience Member: I like where this conversation's going. One can't go anywhere in the healthcare system without being struck about how inefficiently it's delivered. Whether it's from defensive medicine, to privacy rules, to people doing what they can be reimbursed for, you know, all of Jack Wenberg's work, etc, and so this goes to your point of a big reform, but I worry about the idea of let's have more regulation because I do think we do need regulation, but part of the problem is piling onto this Rube Goldberg machine that's been created, both privately and publicly. Don't we need actually a sort of spring cleaning, if you will, where we try to realign incentives with regulation, but doing the hard **thing, which is** undoing what all these special interests, as Jim was saying, what all these special interests now have a vested sake in. We get reimbursed for this, and we don't want to lose that. Doesn't it require a kind of deep breath, "Okay, we're going to have to sort of begin trying to start all over?"

DA: That could be, and there's a big debate about regulation and how much versus the market and all that. I'll tell you another little mini lesson I've learned too, I think, over my career though. There are different forms of regulation, and reformers get attached to the latest one, and it's the magic one. I don't know if pay-for-performance is exactly regulation. I learned this in the DRG Movement, which was begun in New Jersey where I spent some time in government.

The little mini lesson was it isn't the magic form of regulation. It isn't how you pay. What actually saves money is how much you pay, and so at the end of the day it's about that cruel, difficult decision about how much you pay the providers, or—I don't even like that word, how these healthcare institutions and health professions more than the method of payment. They figure out a way around the method of payment. It's how much you pay them. That's just my little mini lesson from 30 years of doing this.

RS: Just as a principle, and when you approach the—I mean when you look at what we spend as a nation on healthcare. I'm thinking of discussions of the federal budget more broadly, waste, fraud, and abuse is the politicians evasion of addressing the budget deficit because when we look at debt service and entitlements where we're starting to account for much of what's going on with federal spending.

In healthcare when you hear about use, wasteful spending in our healthcare economy, is there so much of it really when you get inside the black box of medicine, that we could totally alter the equation of how much we have to spend on healthcare?

DA: I don't know, maybe. My very first job in health, when I was one, was working with Jack Wenberg in what was called the Codman Research Group, which was when we first began to document the variations in healthcare. This was in Calais, Maine, and strange little towns in Vermont, and so we have been documenting these variations in healthcare among similar populations. It seemed to be driven by the different kinds of supply in the community of physicians, and surgeons, and so forth forever.

We've had these great debates about much care is necessary and unnecessary forever. Jack has always believed that the answers we ought to push towards the mean that that must be the answer. Of course, there's no reason to believe that that's right or wrong. We do know that institutions like the Mayo Clinic can do really good work with really less care, but beyond that, I don't believe we really actually know much about. More importantly, we have no good effective mechanisms to get there, and we're working on that. That's what the quality movement is about. It's what guidelines are about. It's what pay-for-performance is about. It's a long term, 100 year agenda that the medical profession and government are working on together, but it's certainly not a short-term answer to anything.

Audience Member: Hi, Lois Aronstein from AARP. I have—AARP has been working for years just in New York State to ask the state to create a buying pool for pharmaceutical drugs, and fighting against PhARMA as the biggest lobbyist. Being out-spent by PhARMA, to a great extent defeating legislation that would allow Pennsylvania, New York, and New Jersey to purchase drugs in a bulk-buying pool, which would save, immediately save millions of dollars for the big state programs. My question

"The President does have to make it [health care] a priority, and the money's an issue, but most importantly, there has to be an interest in the Congress in coming together on some sort of a compromise."

comes back to lobbying and special interest. How do you assess the strength of, not only the pharmaceutical lobbyists, but also the insurance companies, the medical community, to defeat any kind of health reform that we might have in our country?

DA: Healthcare interest groups are incredibly strong. They always have been, but if you look at the current debate, it's mostly so far a debate about coverage and coverage expansion, so it doesn't affect them yet. We'll see if there's legislation and what form it takes, affect the interest groups so far in the way in which proposals have in the past. Now, when they get to trying to figure out how to pay for it, and raise the revenue, that could change, and that's when we could see interest group opposition like we have seen in the past, but so far the complexion of the health reform debate and proposals we've seen to date have rather than raise the opposition of interests groups, it's just been a happy party. By the way, how much money is AARP spending on those ads, which have been running month after month after month. It's quite amazing.

I think a really critical thing on the other side of the equation for health reform is the business community because the business community for as long as I've been in the field has complained appropriately and mightily about the cost of healthcare, and whined about it, but has never lent its lobbying muscle as a countervailing influence to healthcare's vested interest when legislation has pended on—when there has been legislation on Capital Hill. Leaders have been active, and they're

noticed from the business community, but they've never ever really shown up when there's been a fight. They could not have done more in the Clinton plan to pay off business, but business went the other way in the end. I think what the business community does, and its different parts, if there is a legislative debate about health reform in the next Congress, it will be a really important thing to watch. Do they really show up, or is it just rhetoric again?

RS: One more question.

Audience Member: Jim Knickman of the New York State Health Foundation. Let's see if I can get to be any more optimistic on getting over the ideological divide. I mean I have two ideas. One is are you sure the Democrats couldn't say, "We like the McCain plan. We just want to make a few changes, so we want to make those tax credits income-related. We really want to deal with the 5% of the chronically ill who are accounting for 80% of the costs, and of course, that's where the 100 billion would go to subsidize those, and do it. We'll live with doing something about the tax benefit for employers, or for people who have employer-based coverage, but just a little bit. We'll give you a little bit, but tax it 20%, or something like that. We'll make one other change. It isn't going to be an open market in the individual market, but it'll be like Medigap where there's five or six policies."

In other words, could they artfully say this is a market-driven system, but get to 80% of where they want to be? Or the other radical approach would be is there any hope of listening to Zeke Emanuel and Phil Lee, and say we should start over with the individual-based system, and coverage system, and figure it out?

DA: Yeah, I was just discussing this with Zeke Emanuel at the third presidential debate. He happened to be there. Look, I can see a million ways to compromise on this frankly, if Senator Obama wins, or if John McCain wins, and I'm not entirely pessimistic. First of all, our issue only makes it to the forefront once every 15 years, so this is as good as it gets for us, and there is a shot at this, but I do think a bunch of things have to break right, as I said earlier.

The President does have to make it a priority, and the money's an issue, but most importantly, there has to be an interest in the Congress in coming together on some sort of a compromise. There are a whole bunch of ways that they could come together on a compromise. I'm just saying I think it's going to take a willingness to do that. You could see resistance on the right, resistance on the left, but it's going to have to take a willingness to do the kind of meeting in the middle, listening that Senator Obama has been talking about on the stump for this to work.

We haven't seen a lot of that in Washington lately, but we're hoping that it will be a new day. I've almost reached a point where I think this is as much about cost as it is about coverage, but it is a national shame that we have so many people without health insurance coverage. I've almost reached a point in my career where I no longer—I know there are more and less efficient, better and worst ways to cover 47 million people, but I've almost reached a point where I don't care how we do it, just as long as we do it. I certainly do personally hope that they'll be—that the issue will be there on the agenda, and there will be a spirit of compromise, and a willingness to reach agreement on how to do it, or at least take a big bite out of the apple on this next round because we just don't get these opportunities, you know, very often.

RS: We'll be hearing from you a lot, I think, next year as this gets a little bit more real, and if not 15 years after that. Drew, thanks a lot for talking with us.☐



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