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BOOK REVIEW

BOOK REVIEW: *CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH-CARE CRISIS*

THEODORE R. MARMOR*

In the beginning of 2009, there were compelling reasons to review—and take very seriously—former Senator Tom Daschle’s 2008 book about the reform of American medical care.¹ Then, Daschle was both Secretary-designate of the Department of Health and Human Services and President Obama’s choice to lead a White House office devoted to advancing the Administration’s reform plans. What is more, Daschle’s co-author of the book under review, Jeanne Lambrew, had already been appointed the deputy director of the White House reform office and many others close to Daschle had positions at the Department of Health and Human Services.² Following Obama’s presidential victory, news reporters regularly described Daschle as the incoming “Czar” of health reform.³ Between November 2008 and January 2009 there were reports of bookstores selling out their copies of the book Daschle had published to much less notice in the summer of 2008.⁴ The book’s sub-title was clear about its subject, “What We Can Do About the Health-Care Crisis,” and Daschle’s close relationship to President Obama further justified serious attention.

That much was prologue. Then there was the abrupt transformation of Daschle’s future: his widely reported tax problems, initial expressions of support from President Obama and promi-

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1. TOM DASCHLE WITH SCOTT S. GREENBERGER & JEANNE M. LAMBREW, *CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH-CARE CRISIS* (2008).

2. Robert Pear, *Health Care Policy is in Hands of an Ex-Senator*, N.Y. TIMES, Dec. 11, 2008, at A28.

3. See, e.g., Peter Baker, *Reshaping White House with a Domestic Focus*, N.Y. TIMES, Dec. 20 2008, at A13.

4. See *Bestsellers in Books for January 2009*, AMAZON (Jan. 2009), http://www.amazon.com/gp/bestsellers/2009-01/books/ref=zg_bsar_cal_ye#4 (listing *CRITICAL* at number 74).

nent Senate Democrats, followed by Daschle's apology to his former Senate colleagues on February 2, and his quick withdrawal on February 3.⁵ For a few days, it was a leading story in American journalism.

Does Daschle's demise as a central figure in the Obama Cabinet lessen interest in this book? It might, but it should not. *Critical* is an invaluable guide to the thinking of many in the Obama Administration who have been central to its health reform efforts. Kathleen Sebelius, now Secretary of the Department of Health and Human Services, echoed Daschle's views on health reform when questioned on her nomination by congressional committees.⁶ By the end of February 2009, President Obama had held his Health Reform Summit, reinforcing similar ideas. He set aside in his budget plan more than \$600 billion (over ten years) to fund complex steps towards universal health insurance, to improve the quality of American medical care, and to secure better value for our medical expenditures.⁷ Few outsiders had any clear idea of *how* the Obama Administration would pursue those goals. The insiders, however, many of whom had been in the Obama health team during the presidential race, were well versed in the Daschle/Obama approach. That makes *Critical* an unusually helpful primer on the assumptions from which the Obama Administration proceeded during its efforts to reform American medical care.

The book sets out those assumptions on three crucial topics. First, what did Democrats like Daschle (and Obama) regard as the fundamental problems of American medical care? Second, how did they understand the history of failed attempts at universal health insurance for American citizens and what lessons from the past had they learned, especially from the ill-fated reform attempt of the Clinton Administration in 1993–94? Third, and most important, what conception of reform was taken for granted as both desirable and doable—or in the language of this book—politically feasible and administratively workable?

5. Jeff Zeleny, *Daschle Ends Bid for Post; Obama Concedes Mistake*, N.Y. TIMES, Feb. 4, 2009, at A1.

6. The suggestion here is that Daschle's book represented a widely shared set of ideas, not that he created the ideas. As such, it was no surprise that a new Cabinet appointee would reflect what was understood to be the Obama position on health reform.

7. Robert Pear, *Obama Offers Broad Plan to Revamp Health Care*, N.Y. TIMES, Feb. 27, 2009, at A17.

I. THE FUNDAMENTAL PROBLEMS

The troubles contemporary Americans face with medical care dominated the opening of Daschle's portrait. "Our [health care] system is fundamentally broken," he states bluntly. "Millions of Americans go without medical care because they cannot afford it, and many others are mired in debt because they can't pay their medical bills."⁸ He reviews the familiar statistics describing the number of uninsured and underinsured—estimated as 47 million and 16 million, respectively, in 2008.⁹ But he goes beyond these numbers to report the miseries of individual families drawn from both his long political career and the research for this book. The resulting account of American medical care is bleak. It costs an enormous amount, whether measured in per capita terms or as a proportion of national income: roughly seven thousand dollars per person, over sixteen percent of GNP, or more than two trillion dollars in total as of 2007.¹⁰ These costs have been "skyrocketing"¹¹ even as the number of insured Americans has "steadily declined" over time.¹² To make matters worse, Daschle concludes, "[w]e're paying top dollar for mediocre results."¹³ Our health status, according to many informed commentators, does not justify claims that we have the "best health care in the world."¹⁴ The quality of care varies greatly, mental health is given "short shrift,"¹⁵ and, while we "take great pride in our high-tech medical equipment," American medicine's use of information systems is "incredibly primitive."¹⁶

As is common in American political commentary, the language of despair and crisis takes over quickly. "Indisputably," Daschle writes, "the American public is dissatisfied with the current health-care system."¹⁷ An "overwhelming majority," according to the 2007 polls he cites, said American medical care "needs fundamental change or total reorganization."¹⁸ Anything requiring "fundamental change" would appear to justify reform action. But Daschle here introduces an historical caution that distin-

8. DASCHLE, *supra* note 1, at xiv.

9. *Id.* at 3.

10. *Id.* at 4.

11. *Id.* at 9.

12. *Id.* at 21.

13. *Id.* at 38.

14. *Id.* at 32.

15. *Id.* at 35.

16. *Id.*

17. *Id.* at 41.

18. *Id.*

guishes his jeremiad from most critiques of contemporary American medicine. He emphasizes the “similar poll results in the early 1990s” when the Clinton debacle took place.¹⁹ Reminding readers that “prominent business leaders [then] expressed support for the idea of universal insurance,” Daschle rightly wondered how one can make sure that today’s reform movement “doesn’t fall victim to the forces that doomed the previous” efforts.²⁰

There are two other features of this diagnosis worth special attention. One is that the problems cited were given no particular priority. There is trouble everywhere in American medical care. That generates the expectations of “fundamental change,” which in turn means a fight over what that means. That fight involves an industry making up one-sixth of the American economy, the “medical industrial complex.”²¹ It is flush with pressure groups, and organizations with both the resources and habit of protecting their interests quite apart from those of the overall system.²² These realities shaped (and narrowed) the American health reform debate, as is evident in Daschle’s firm rejection of options like expanding Medicare to the population as a whole. *Critical*, published in the early summer of 2008, could not have taken into account the deepening recession and the extraordinary actions of the federal government in 2009 to loosen the credit markets, stimulate demand, and cushion unemployment. It is noteworthy that the Obama Administration remained faithful to a diagnosis crafted in 2007–08 about what to do in the radically altered fiscal and social circumstances of 2009–10.

The second diagnostic feature is equally consequential. The country has had decades of experience with failed reforms of American medical care, Daschle emphasizes, and he devotes a large share of the book to those disappointments. On that premise, the critical task for the reviewer is to understand what Daschle (and others) learned from what went wrong before and what would make it right this time.

II. LEARNING FROM THE PAST

Critical devotes close to a third of its pages to “what went wrong” in past efforts to legislate universal health insurance. For “almost a century,” he writes, “we have tried to reform our

19. *Id.*

20. *Id.* at 41–42.

21. See ARNOLD S. RELMAN, A SECOND OPINION: RESCUING AMERICA’S HEALTH CARE 26 (2010).

22. *Id.* at 28.

healthcare system [and] [d]espite the best efforts of skilled lawmakers, passionate advocates, and presidents from Truman to Clinton, we've failed."²³ Ideological differences, the details of the reform proposals themselves, and the timing and tactics of reformers contributed to, but did not determine, failure. For Daschle, it is the "exceptional" nature of medical care and the "political process we've followed in trying to" reform it that is central.²⁴ The stakes are high, the interest groups are many and wealthy, the issues are "incredibly complex," and "[p]owerful and pervasive myths about the 'success' of our system have helped reinforce the status quo."²⁵ From these premises, *Critical* provides an extended discussion of the Clinton Administration's failure in 1993–94 and what central lessons Daschle, and others, drew from that particularly disappointing episode.

Daschle, as with many others who supported Obama's reform strategy, concentrated on the Clinton failure and virtually ignored the strategy that culminated in the Medicare legislation of 1965. The lessons Daschle emphasized are those especially important in explaining the Clinton experience. The reasoning proceeds in the following steps:

Everybody was in favor of health-care reform [in 1992–94]. Everybody agreed that the system had to change. But when it came down to details, few groups were willing to tolerate provisions that might harm them, to swallow new regulations, or to sacrifice some profits for the greater good. [E]ach stakeholder focused on its own narrow interests and dug in for battle. The result is that the great health-care debate of the early 1990s expired with barely a whimper.²⁶

To avoid that, Daschle concludes, reformers must unite around a common message, avoid factional fights over appealing for more controversial reforms, and, above all, celebrate the role of choice and competition among private and public insurers to avoid an ideological battle with pro-market ideologues.²⁷

23. DASCHLE, *supra* note 1, at 22.

24. *Id.* at 107–08.

25. *Id.* at 108.

26. *Id.* at 99–100.

27. *Id.* at 42, 198. Another lesson from the Clinton experience addresses how to deal with interested parties inside and outside the government. Daschle is particularly insistent that consultation with Congressional committees is important and, as of 2009, that clearly became the Obama Administration's practice. *See id.* at 134–35; *see, e.g.*, Robert Pear & David M. Herszenhorn, *Democrats Grow Weary as Health Bill Advances*, N.Y. TIMES, Jul. 18, 2009, at A1 (reporting that "the five Congressional committees working on legislation to reinvent

III. THE WAY FORWARD

From this reading of history comes *Critical's* reform strategy for our time. The Obama Administration—a gleam in Daschle's eye when writing his book—had to overcome the many “barriers to reform.”²⁸ The most obvious for Daschle was an ideological battle over ‘government medicine,’ in American politics, the derisive term orthodox Republicans use to criticize so-called single payer plans like Medicare for all. Daschle, like most of the Washington establishment, rejected such straightforward forms of universal health insurance as politically unrealistic.²⁹ He regarded them as appealing in theory, but impossible to enact in practice. To avoid such useless ideological battles, Daschle believed feasible reform must be a public/private hybrid. His hybrid approach to universal health insurance builds upon public programs already in place—expansions of Medicaid, the Child Health Insurance Program (CHIP), Medicare, and the Veterans Administration.³⁰ It relies on private employers either to finance health insurance for their employees or to contribute to a pool of funds that would pay for their workers' choices among private and public health insurance plans.³¹ This requirement of employer financing is itself a replay of the “pay or play” option that was the official Democratic Party Platform position in 1992.³²

The form of a public insurance plan could, according to Daschle, resemble the options available to government workers under the Federal Employees Health Benefits Program. The appeal is to create competition between the private and public health insurance plans.³³ He adds that such competition requires detailed public regulation to make it fair and at the same time to avoid the danger of firms competing to avoid the less healthy.³⁴ This vision of a hybrid plan—with a choice between public and private plans—is Daschle's proposed way to move towards universal health insurance without forcing those content with their current health insurance to change plans.

the nation's health care system delivered bills this week along the lines proposed by President Obama.”).

28. *Id.* at 109.

29. *Id.* at 144.

30. *Id.* at 145.

31. *Id.* at 146.

32. *Id.* at 77–78.

33. *Id.* at 146.

34. *Id.* at 171.

This strategy—advanced by all three of the leading Democratic presidential candidates in 2006–08³⁵—reflects a widely shared understanding (particularly in Washington, D.C.) of the Clinton debacle: Clinton's reform failed, according to what has become conventional Democratic Party wisdom, because it threatened too many Americans with the loss of their employer-provided health insurance.

This interpretation of the Clinton failure largely explains the appeal of Daschle's reform strategy. Instead of a single plan for everyone, he celebrates multiple plans. He notes that countries like Germany and Japan have reached universal coverage with many non-profit plans that adhere to common rules.³⁶ Extending this model to both public and private insurance organizations requires, in Daschle's formulation, a regulatory overhaul of American health insurance.³⁷ To assist that effort, he promotes a Federal Health Board modeled on the structure of the nation's Federal Reserve Board.³⁸ *Critical* devotes more space to this idea than any other topic. For Daschle, it is the answer both to the frustrating debates over what procedures universal health insurance should fund and to the partisan and ideological battles that earlier reform struggles have ignited. Experts on such a board would, as celebrated in the Progressive literature of the early 20th century,³⁹ bring disinterested and specialized competence to sort out what is and is not worth paying for in the changing world of modern medical care.

IV. THE OBAMA APPROACH

The approach to reform adopted by the Obama Administration—and foreshadowed by Daschle's book—is readily understandable, if not fully convincing. To substantiate that skepticism requires discussion of the arguments for a hybrid model of expanding health insurance coverage as well as the approach to cost control that Daschle and the Obama Administration have favored.

35. See Jonathan Oberlander & Theodore R. Marmor, *The Health Bill Explained at Last*, N.Y. REV. BOOKS, Aug. 19, 2010, at 61, 61.

36. DASCHLE, *supra* note 1, at 128.

37. *Id.* at 136.

38. *Id.* at 129.

39. See, e.g., Joseph B. Eastman, *The Place of the Independent Commission*, 12 CONST. REV. 95, 101 (1928) (describing the Progressive era view of agency officials as “nonpartisan in their makeup, and party policies do not enter into their activities except to the extent that such policies may be definitely registered in the statutes which they are sworn to enforce”).

The case for a public-private hybrid—rather than a single plan of coverage for the country's citizens—is rooted in Daschle's own bitter experience of frustrated reform. He had good reasons to want to avoid a battle over the dangers of "socialized medicine," or what is now more commonly called "government medicine." And it is surely understandable that reformers like Daschle would be concerned about avoiding inflammatory labels. The national media, following the journalistic norm of quoting both sides to assure what is called balance, are indeed likely to repeat familiar ideological charges against plans modeled on either Canada's single plan or the expansion of Medicare. A hybrid, then, is a defensive tactic above all.

The mistake, however, was to believe that a hybrid favored by a Democratic Administration would escape the familiar ideological charges about enacting a new governmental insurance plan. The crucial lesson of the Clinton debacle was not that it was complicated and unfamiliar, though it certainly was both. Rather, it was that the Clinton reform, while using the language of market competition, generated many of the same objections that earlier versions of more straightforward national health insurance had awakened. The critics of Democratic plans anticipated where reform was headed, not simply what labels the reformers used. In this respect, trying to avoid a fight by changing their rhetorical message seemed earnestly hopeful, but historically misguided. Appeals to the dangers of socialism and the wonders of the American way are always present in debates over the government's role in providing, financing, and regulating American health insurance. Denials do not hush these familiar charges. Competing and compelling counter-symbols are required instead.

Moreover, the commitment to choice and competition among many insurance plans brings with it substantial administrative challenges. It is true that countries like Germany have for decades managed to regulate large numbers of non-profit sickness funds in ways that restrained both total expenditures and efforts to 'game' the system's insurance rules. But the United States depends on states to regulate insurance and cannot rely on a history of favorable national experience in regulating the behavior of commercial health insurance firms.

The hybrid reform's reliance on expanding means-tested programs—like Medicaid and CHIP—entails other predictable and serious problems. When eligibility ends with the addition of one additional dollar of income, a program suffers what is some-

times described as falling off a financial “cliff.”⁴⁰ And adjusting subsidies to the changing income of families is both administratively complex and costly. Keeping track of who is eligible for what level of subsidies, as the Dutch have learned since 2006, requires expanding their income tax staffs.⁴¹ Mandates, it turns out as well, are hard to enforce.

There is a further question about hybrid reforms. What kind of public plan satisfies the aspiration for ‘fair competition’ among the private and public participants? The insistence of a powerful public plan prompted intense objections from the private health insurance industry. Any promotion of a public insurance option shifts the debate to what advantages the public plan should or should not be permitted to have. One can reasonably claim an effective public insurance option requires the same—or nearly as much—political commitment to the values of social insurance that Medicare for all represents. But the Obama Administration began with the hybrid plan as its most liberal position rather than treating it as one among other possibilities. That, in turn, truncated the debate sharply, leaving the defenders of simpler and less costly versions of universal health insurance frustrated at being excluded from the range of options under serious consideration.

Finally, the vision of a hybrid form of universal health insurance in America rested on problematic claims about how the competition envisaged would work out in practice. The appeal to a hybrid plan was itself almost unworkably vague. Almost any form of universal health insurance short of government ownership of hospitals, drug firms, and physician practices would mix governmental, non-profit, and for-profit organizations. So what was held up as a virtue created multiple versions of reform, which required numerous defenses and operating features.

Even more important, the hybrid plan favored by the Obama Administration depended—for its claims of controlling costs—on theoretical arguments, and not practical experience. Where Medicare has subsidized competition among insurance

40. Oberlander & Marmor, *supra* note 35, at 61 (describing the edge of the “cliff” as being those “who earn less than 133 percent of the federal poverty level,” or \$10,830 in 2009, upon which any additional income causes them to lose their benefit).

41. See Wynand P.M.M. van de Ven & Frederik T. Schut, *Universal Mandatory Health Insurance in the Netherlands: A Model for the United States?*, 27 HEALTH AFF. 771, 774–79 (2008) (discussing direct government subsidies to Dutch citizens, the burdens of determining who is violating the insurance mandate, and the difficulties of determining how to allocate risk through equalization).

firms, the experience was so frustratingly expensive that the Obama Administration promised to sharply reduce the payments to Medicare Advantage plans. Furthermore, the limited experience among wealthy democracies with mandated health insurance and competing private insurers does not support the claims that competition is effective at controlling costs.

The approach to cost control—for both Daschle and the Obama Administration—was not convincing on other grounds. They treated cost control as a technical matter of improving medical practices. There were persistent claims of cost savings from better prevention, the spread of health information technology, increased research on the comparative effectiveness of medical interventions, or paying for performance (P4P). The embrace of widely supported goals, including better population health and improved quality of medical care, has obvious political appeal. In theory, these reforms—more research, more preventive screenings, and better-organized patient data—sound like benign devices to moderate medical spending. For many purposes, such reforms are substantively very desirable. But these reforms are ineffective as substantial cost control measures.⁴² If the United States is to control health care costs, it will have to follow the lead of other industrialized nations and embrace price restraints, spending targets, and insurance regulation. Such credible cost controls are, in the language of politics, a tough sell because they threaten the medical industry's income. The illusion of painless savings, however, confuses our national debate on health reform and has made the acceptance of cost control's realities all the more difficult.⁴³

EPILOGUE: THE 2010 HEALTH REFORM: PATCHING UP THE PATCHWORK

The patchwork features of American health care are crucial in understanding the complex character and broad scope of the health reform enacted in March of 2010, the Patient Protection and Affordable Care Act (PPACA).⁴⁴ That law, hugely controversial and enacted after a bitter ideological debate, can be

42. Theodore Marmor, Jonathan Oberlander & Joseph White, *The Obama Administration's Options for Health Care Cost Control: Hope Versus Reality*, 150 ANNALS INTERNAL MED. 485, 485 (2009).

43. *Id.* at 488.

44. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 25 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.). The PPACA was immediately amended through a reconciliation bill. See Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

regarded as a patch on a patchwork, with four major elements.⁴⁵ First is the expansion of health insurance to the uninsured, using mandates to buy insurance as the regulatory stick, and means-tested subsidies as the financial carrot. This reform, as Daschle anticipated, borrowed substantially from the Massachusetts reform of 2006 and brought with it a commitment to regulating the behavior of private health insurance firms in the individual and small group market.⁴⁶ The second feature—extensive regulation to prevent insurance firms from practices characteristic of profit-seeking commercial health insurance—was the expected companion to the expansion of insurance coverage. According to the Congressional Budget Office estimates, roughly two thirds of the 50 million uninsured Americans would be insured by 2014 if the reform were implemented as designed.⁴⁷ The third feature of the reform worth notice is its unconvincing cost control strategy. The PPACA proposes reliance on instruments that are exceedingly unlikely to make much difference to America's medical care expenditures: increased attention to prevention, expanded research on the comparative effectiveness of medical innovations, and expanded use of electronic medical records and information technology generally. No doubt helpful in improving the quality of medical care decision-making and provision, none of these measures confront medical inflation seriously (some predictions of lower rates of increase in Medicare payments were included in the legislation, but the history of such projected savings does not support relying on them). The fourth and most profound feature of the reform is its political strategy and its implications with the law's implementation. Briefly put, the 2010 reform reflects more the value preferences of Republican commentators on health insurance than traditional Democratic formulations of what universal health insurance should be. The new law takes for granted the patchwork of present arrangements as the starting point. It builds upon them rather than transforms them. In that sense, the 2010 reform is a "mosaic" of reform, to use Carolyn Tuohy's more elegant expression for what Daschle called a hybrid.⁴⁸ There is no single overarching model of medical care financing and provision. Rather, the reform

45. Oberlander & Marmor, *supra* note 35, at 61–63 (describing reforms related to subsidies, mandates, regulations, and programs).

46. *Id.* at 61.

47. *Id.* at 61–62.

48. Carolyn Tuohy, *The Dynamics of Policy Change: Big Bangs, Blueprints, Mosaics, and Increments in Health Policy in Four Advanced Nations*, THE UNIV. OF B.C. (Mar. 10, 2011), http://www.politics.ubc.ca/index.php?id=11086&backPID=2327&tt_news=2318.

holds out the aim of universal insurance coverage over time, coverage that is catastrophic in character (leaving considerable financial risks to families in the form of high deductibles and copayments). The reform thus tolerates great differences in how the care of similarly ill Americans will be provided, financed, and regulated.

The irony is that, while reflecting Republican preferences to buttress the present world of private health insurance, the reform failed to secure a single Republican vote in the Senate. So, to explain the reform rather than describe or evaluate it requires understanding the institutional structure of American politics and its substantial status quo bias. Dispersion of authority marks American politics, especially prominent in the sharing of power among the executive, the Congress, and the courts at the national level. Added to that are rules—like the filibuster in the Senate—that permit minorities within Congress (forty-one votes in the Senate) to block legislation. Facing that context, the Obama Administration decided to pursue additions to America's medical system rather than attempt to rationalize it with, for example, extending Medicare for all. It did so because of political realities and the decision to try in the first term to make a major change. A major change did occur, one that almost did not happen when one Senator, the well-known advocate of national health insurance, Ted Kennedy, died in late 2009. Looking back on the final form of the PPACA, what emerged after the long debate was largely foreshadowed by the book Tom Daschle wrote in 2007–08.