Health Policy in Medicine: Inside the Beltway

What I Have Learned "Inside the Beltway"

by Eugene Rich, MD, FACP

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I have now been living 5 years "Inside the Beltway." Some readers will recall this began as a sabbatical combined with the Robert Wood Johnson (RWJ) Health Policy Fellowship. When my wife Elaine and I arrived at our small apartment near Connecticut Avenue's Van Ness metro stop, little did we imagine the next five years. In the autumn of 2006 I began the program's 4 month orientation to DC where I learned critical factoids –from downtown navigation to Capitol Hill security to arcane legislative processes. We RWJ Fellows were then placed in positions in the federal government- usually in the legislative branch; my year was spent as a health policy staffer on the House Committee on Ways and Means. There my real learning began.

Just like Medicine internship. 2007 was an exciting year in the House of Representatives. Issues I had been worried about my whole career were suddenly top of the legislative agenda- problems with primary care, rising health care costs, perverse financial incentives, and unwarranted variations in practice. The very smart, tireless, and dedicated health policy staff I worked with were helping members of Congress tackle all these problems. The month of July was a critical time- we were finalizing major health legislation for debate and (hopefully) passage prior to the traditional August Congressional recess. When asked later what that month was like, I realized it was remarkably like July of my Medicine internship. I was working around the clock on challenging health problems, stretching the limits of my competence, supervised by extremely busy mentors, talking to lots of consultants, writing many pages that few others would ever read, and making the best decisions I could with the information available.

Capitol Hill is NOT an "evidence free zone." While public political discourse can seem frustratingly simplistic and unscientific, executive and legislative branch decision-makers are NOT working in an evidence vacuum. Indeed one of their biggest challenges is synthesizing the enormous amount of relevant, but inconclusive, evidence (again, not unlike internal medicine internship). The Library of Congress (LOC) is on Capitol Hill- connected by tunnels to the Senate and House office buildings and to the Capitol itself. In addition to volumes of US and international publications, the nonpartisan Congressional Research Services (CRS) is located in the LOC and generates numerous reports to inform the debate on critical topics of upcoming legislation. CRS staff also produce special reports for key Congressional committees; as a staffer on Ways and Means, I could call a CRS team to action researching a question for Chairman Stark. CRS reports are only officially available to members of Congress but some make it onto the internet. (http://opencrs.com/).

CRS and the LOC aren't the only evidence resources available to Congress. The nonpartisan Congressional Budget Office (CBO) has a cadre of smart and dedicated economists and policy analysts who monitor the financial and other economic impact of current and proposed federal legislation. These professionals are often integrally involved in the assessment of policy options. I had many meetings, and not a few middle of the night phone conversations, debating with CBO staff the evidence underlying the potential benefits (and harms) of proposed policies changes. CBO analyses are dense but thoughtful assessments for the real "policy wonk." Congressional Budget Office - Home Page The US Government Accountability Office (US GAO) (http://www.gao.gov) and the Medicare Payment Advisory Commission (Medpac Home) are two other non-partisan policy analysis resources for members of Congress, with different functions but plenty of insightful reports.

In addition to these resources, key staffers follow publications in the leading health science journals, not just *Health Affairs*, but the *NEJM*, *JAMA*, etc. Of course, the *New York Times*, *Wall Street Journal*, and *Washington Post* are required daily reading (as well as influential newspapers in the Congress member's home district). Staffers subscribe to various "clipping" services to keep them aware of important publications in their area of

focus. The *National Journal* offers an excellent (though pricey) subscription based resource. Others like *Kaiser's Health News Alerts*, are free http://www.kaiserhealthnews.org/.

Then there are the various think tanks with partisan leanings (e.g. Center for American Progress, Urban Institute, American Enterprise Institute, Heritage Foundation) and nonpartisan policy research organizations like my own Mathematica Policy Research, Rand, and the Research Triangle Institute (RTI). Of course there are also many consulting firms and independent consultants who provide their own particular brand of analysis for the innumerable health system stakeholders whose lobbyists and advocacy organizations are trying to represent their positions to elected officials and their staff. Sadly this relentless outpouring of evidence relevant to US health policy does not offer a clear path forward, and new Congressional staffers describe the situation as "trying to drink from a fire hose."

"To every complex question there is a simple answer- and it is wrong." HL Menken's blunt assessment is particularly true of the quandary that is our US health care system. I quickly came to realize this during my time on Capitol Hill, subsequently confirmed in my year as a "Senior Advisor" at the NIH, and then as a Scholar in Residence at the Association of American Medical Colleges. When I came to DC there were many simple answers I thought were obviously true, that I have since learned to be wrong. For example, I thought the low cost of administrating the Medicare program (between 3 and 4%, compared to over 15% for private health insurance) was due to the efficiencies of a single payer system. While it is true that the health care administrative cost burden in other countries is much lower than in the US, the costs of running the Medicare program are actually too low. This is because, unlike typical insurance programs (whose administration is part of the premium cost), Congress annually appropriates the money to run the Medicare program. The voters back home are usually more enthusiastic about funding for school lunch programs or cancer research than they are about better managing Medicare claims.

Another of my simple answers since proven woefully wrong-headed was the idea of having the FDA require cost effectiveness analysis (CEA) for approving new products and services. First, this idea was incredibly politically naïve. Can you ever imagine a day when a filibuster -proof 60 Senators will vote in favor of "rationing" (the political synonym for CEA)? But just as bad, this approach would be ineffective at addressing the underlying problems, and might even prove harmful. Only around 10% of our health spending is directly related to products and services regulated by the FDA. Much of the costly variations in care are related to unregulated procedures and services or off label use of approved services. So the only effect of such an FDA regulation would be to greatly increase the cost to innovators of getting promising new drugs or devices to the market. This would selectively complicate the discovery process for some interventions (drugs) over others (new surgical procedures, or venues of care). Breakthrough innovations that could ultimately be highly cost-effective would thus be delayed or even undiscovered. Various undesirable, unintended consequences could result, without really solving the underlying health system problems of rampant spending growth for relatively ineffective services.

The DC Beltway is 65 miles surrounded by reality. Yes, living and working inside the beltway is different from anywhere else I have been. And from outside (and inside) the beltway, the public discourse often seems unreasonable, even surreal. Certainly the current tone of political debate is remarkably harsh (though not unprecedented in the 200+ years of US history). The outside view of DC is also complicated by political messages aimed at relatively narrow constituencies, and the tendency for TV news to seek "sound bites" and scandals rather than explore complex solutions to difficult questions. But many serious people are dedicated to finding the right answers to these problems. Over the coming months, with the help of colleagues at Creighton's Center for Health Policy and Ethics, I will give you a glimpse inside the world of health policy research. I will describe a variety of our projects at Mathematica Policy Research and illuminate how we work with policy-makers to find ways to improve the most complex and expensive enterprise devised by humankind – the US health care system.

Eugene C. Rich MD FACP
Senior Fellow and Director
Center on Health Care Effectiveness
Mathematica Policy Research
Clinical Professor of Medicine, Creighton University School of Medicine
Contributed-Service Faculty, Center for Health Policy and Ethics
email: ERich@Mathematica-Mpr.com