Interview

The Surprising Optimist: Why Tom Daschle Believes That The Country Is Ready For Comprehensive Health Reform

For the former Democratic leader, it's not a question of "if" but of "when" the United States will embark on a path toward change.

by Robert Galvin

ABSTRACT: When Tom Daschle was last a private citizen, Jimmy Carter was president, and the country was embroiled in a debate about how to control health care costs. After a distinguished twenty-six-year career in Congress, Daschle has a lot to say about not only health care costs but overall system reform. With his deep understanding of the inner workings of Congress, Daschle breaks from the prevailing belief that incrementalism is the right approach; comments on the novel use of budget reconciliation to pass reform; and argues that the country, including some business leaders, is ready for comprehensive change with a bigger role for government. [*Health Affairs* 25 (2006): w26–w33 (published online 31 January 2006); 10.1377/hlthaff.25 .w26)]

Bob Galvin: As you know, our health care system is in need of substantial reform. Where do you think this issue is going to sit on the agenda of the 2008 presidential election?

Tom Daschle: I think it's going to be a high priority for both parties in the '08 elections. I say that, in part, because all the demographic trends and polling asking the American people what concerns them suggest that the cost of health care is driving the political debate. I think there's a great deal of frustration.

I was surprised, when I ran my last campaign, how many people came to me to tell me how concerned they were about their own personal circumstances. Obviously, cost, access, and quality are usually what drive issues, but, clearly, people are increasingly concerned about costs. Moreover, I think it's going to become a bigger business issue.

So, as a result of trends, both economic and sociological, you're going to see increasing pressure on Congress and on future presidential candidates to address the problems associated with health care.

Galvin: As a non-Beltway person, I hear that prediction every four years, but more often than not, defense and the economy squeeze out health care. Given what's happening with our military and the threat of increasing inflation, why will health care make the grade this time?

Daschle: Well, I'm not going to say it definitively. I would say that the prospects of it being a top issue are greater than they've been at any

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one time. We're reaching a series of tipping points. By 2008 there is a real prospect that, according to one forecast, health costs will exceed the profits of Fortune 500 companies. By that time, there is the real possibility that we will have crossed the fifty-million-person threshold in terms of the uninsured. We've already seen, in the last five years, wages go up 15 percent, while health care premiums have gone up 73 percent. So, if trends continue, cost and access issues are going to be far greater than they've ever been before.

At some point, you reach a point when the American people say, How are you going to fix this? They're going to demand that Congress and presidential candidates come up with solutions beyond what you've seen so far.

Now, there have been times when we've come close. Six times in the last century we tried to do this, and on a couple of occasions we actually came closer than most people realize. So, this, in my view, is not a question of "if." It's really a question of "when."

Galvin: Assuming health care does make the grade, what do you think the top issue will be? Will it be covering the uninsured or controlling costs and ensuring access for the middle class?

Daschle: Because they're interrelated, it's a hard question to answer. But, if I were forced to pick one, I would say cost, more than anything else, will drive the issue. It certainly is driving the issue politically in the business sector today. Since there are nearly three hundred million Americans, and only forty-six million who are uninsured, I think it's going to be cost more than access, although access is becoming a bigger issue—and, as a result, so are the economic issues associated with it.

Almost 16 percent of GDP [gross domestic product] spent on health care, I think, is too much. How else could our money be spent to more effectively make our country better than it is today? Our other competitors around the world do a lot more with a lot less than we do, and they get better results. So, I don't think we're getting what we're paying for today. We're still ranked by the World Health Organization as thirty-seventh in the world with regard to overall health system performance. I would expect the American people to say, at some point, that's unacceptable.

It's also affecting our competitiveness. When an American company has to spend $8,200 per employee for health care, and they're competing against a company in Canada that doesn't have to directly spend on health care, that puts the American company at a distinct disadvantage.

> **"Health care costs are hurting our competitiveness and are affecting our overall decisions about where we allocate resources in this country."**

Look at the auto industry. The auto industry in America is virtually collapsing. Our auto industry is doing pretty well in other parts of the world. The problem is not solely because of health care costs. But if you talk to officials in most of the auto manufacturing corporations in this country, they're going to tell you that it's a huge factor. Health care costs are hurting our competitiveness and are affecting our overall decisions about where we allocate resources in this country.

Comprehensive Reform

Galvin: What kind of reforms would you recommend?

Daschle: It's a complex issue that has to be addressed in many ways. First of all, I don't think you can do it incrementally. We have attempted, at various times, to address the issue incrementally. And I don't think it will work until we deal with it comprehensively. So you start with whether you do it piecemeal or whether you do it wholesale.

Look at what South Korea and Taiwan did in the 1990s. They came to the conclusion they couldn't do it incrementally, either, and ultimately passed comprehensive health care reform that created a new paradigm for health care. I think that two things would have to be present here for that to occur.

First, the circumstances would have to be such as I've described, which would allow these forces to be demanding far more than they're getting today. Second, you have to have leadership. You have to have a president and a Congress who say, Look, the time has come for us to deal with this. And, as I say, I think that time will be sooner, rather than later.

Now, what would I do? I believe that you could run our health care system in a way similar to our federal reserve system. Our federal reserve system works, in large measure, through the private sector but is governed by decisions made within a federal governmental infrastructure. I think you could do the same thing in health policy. Already, over half the people obtain their health care in this country from a public or publicly funded source. So, we have, in some ways, the same circumstances in health care that we have in our monetary system.

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I would like to see a framework that begins with a recognition that there has to be an infrastructure in place that allows for the public sector to be able to set in motion a politically insulated decision-making process that would allow us more collectively to make decisions about cost and financing. If we could fix our financing system, I think we could fix a lot of the other problems involved with our health care system today.

I also think that we have to recognize that the problem of uninsurance has a cost-shifting repercussion that must be addressed. By making health care universal, we can at least begin to address this cost-shifting issue. There have been estimates that each uninsured person costs the average health insurance holder about $900 a year that they wouldn't be paying if everybody were insured. So, ending cost shifting would be a big part of it.

We should have a best-practice incentive system, or some process by which we would adopt a successful system used here and in other industrialized countries. And, I think, we have to incorporate technology. Technology, especially, with regard to information, could be readily adapted. The Department of Veterans Affairs [VA] has already demonstrated, very effectively, what the implications of a technological application in information and administration management can do.

So, there's a series of steps, all interrelated, that have to be dealt with in a comprehensive manner for us to get to a point where I'd feel confident that we'd accomplished what we'd set out to do.

Galvin: Senator, your call for comprehensive reform flies in the face of the current belief that only incremental change is possible. Although you refer to other countries' experiences, I'm not sure that comparing the U.S. to other countries matters a great deal. It seems to me that our differences outweigh our similarities. For example, we are far larger and more heterogeneous than any of the countries you mentioned. And Americans seem to place a much higher value on individual choice.

Daschle: But I think that the models still hold, Bob.

Galvin: Well, I don't disagree at a 50,000 foot level. Your diagnosis about waste and inefficiency is correct, and most policy experts would agree with you. The glide path from that recognition to addressing financing in this country is what's so difficult. I don't believe it's failed six times over the past three-quarters of a century because we didn't have very smart people trying very hard to get it done. I believe that there are some fundamental obstacles, and frankly I do not see what's different today.

Daschle: I agree with you, in part. I think you had very smart people who didn't want the change, who benefited from the current system substantially. That's to be understood and not necessarily criticized. If I were one of those who benefited from the current system, why would it be in my interest, at least in the short term, to be a participant in this effort to

change the system?

And, in that context, I would list some physicians—specialists, in particular. I would list insurance companies. I would list many of the major players in our current health care system who are only doing what most humans do. They protect their own individual best interests. That's what happens in a republic. And, every single time, those who have had the resources and the ability have stopped or obstructed the effort to try to bring about meaningful reform.

Galvin: Why would that be different today? One person's cost is another person's revenue. I would argue, if anything, that the difficulty is greater today. So, again, why now?

Daschle: You have every reason to be cynical. I would say that I think that the biggest reason I am encouraged is because I believe that the landscape, politically, is changing. I hope and expect that businesses will become much more proactive than they have been in the past.

In the past, in large measure, business has sat on the sidelines in the health care debate. I can't think of a single instance where a company was a significant player in a health care debate—outside of, of course, the logical drug company or insurance company participants over the course of the last fifteen years. By and large they've sat on the sidelines. I'm not sure that's going to happen this time.

And, it isn't just businesses. There are other professional organizations that have not always seen this as their issue or their concern, but this is changing, too. You're also seeing a change in the landscape politically that could have huge consequences in bringing about the catalytic forces that could make this the time when this could actually be done.

Public And Private Sectors

Galvin: What are the respective roles of government and the market, in your view?

Daschle: I'll go back to my banking paradigm, in which the Federal Reserve system really directs the policy, in macroeconomic ways, and leaves to business and the banking system the financial tools and institutions to respond to the challenges we're facing within our economy. I would like to see that same model applied to health care, where business continues to provide the innovation, but the federal government provides the framework for that innovation to happen. I don't think investment alone ought to be private. I think it needs to be, as it has been, public and private. That could be the case in a new health care system, as well.

Galvin: So, what would be the role of this Federal Reserve in health care?

Daschle: The role would be much like we see today through our Medicare system, where a framework is created with which the private sector would continue to provide most services. The framework would involve cost containment as well as some degree of transparency with regard to the system itself. I think there needs to be more transparency, frankly, than there is. And only the federal government can ensure it.

In other words, I don't think it has to be a single-payer system. You could have large blocs of people or industrial sectors who pool their resources and collectively purchase the insurance within this framework, just as Citigroup and Chase and Morgan Stanley all function as large groups who pool their financial resources to provide financial lending services.

Galvin: It sounds like there's a lot of government involved. Hasn't government involvement to the degree you're recommending been rejected multiple times before, and aren't Americans more resistant to government solutions than ever?

Daschle: Well, first of all, I hope that ideology doesn't become so much a part of the future debate on health care that people are not prepared to think differently than they have in the past about the private/public mix and the right way in which to address these issues. I think it's critical.

If you compare the pension systems in the public and private sectors today, I'd take the government record on pension systems almost across the board, and I'd argue that they did a better job. I also think you could argue that there are a lot of governmental functions that

have worked far better than they have in the private sector, because they're better designed to do that.

I'm not suggesting, in this case, that we adopt a system like, for example, the VA, but I do think that there is that kind of partnership, almost by necessity, that we need to work through and not be hindered by ideological concerns, about either the private sector or the public sector.

Role Of Consumerism

Galvin: Let me tell you how private-sector employers are thinking today, and get your impressions. The belief among private-sector employers is that even if you had the proper financing and structure to cover the uninsured, you still are going to have the issue of how to motivate providers—physicians and hospitals—to change. And history shows us that it's very difficult for government to do that, as evidenced by the variations in quality and gaps in safety that occur under the sponsorship of the Medicare program.

The idea is that you inject consumerism in health care. The view is that if you give consumers proper incentives, give them information and choice, and make them more financially responsible for their health care, you'll stimulate forces that have been very effective in driving value in other sectors.

Daschle: I don't think that there's a great deal of evidence to suggest that that works in health care. I would cite the models internationally that do work as part of my evidence. I do acknowledge that the mentality, the psyche, of Americans is different than it might be in Europe, or in Asia, or in other parts of the world. So I readily accept the notion that we have unique circumstances here. But I often talk to people who are content simply to get the care that they do because of their personal relationship with a physician or a particular institution. In many cases, like most in my state of South Dakota, you don't have the luxury of choice to begin with. You don't have the luxury of selecting from many specialists. You might have one if you have any at all.

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My point is that oftentimes you don't have competitive consumer choices in health care in so many parts of the country, nor do patients or potential consumers of that health care have the sophistication to make these choices as successfully as they might in other fields. In fact, if anything, I think more people are confused today than they are content or confident. I would cite Medicare Part D as the perfect example of that. My mother had seventy-three choices in her array of options as she considered which drug benefit to choose from last fall. That hasn't made the health care system more value oriented, in my opinion.

Galvin: We've had a lot of experience in the employer world with trying to educate and motivate employees. Most of us believe that unless you engage people financially, it's difficult to transform education into action. That's one of the reasons high-deductible plans were created. I'm interested in your opinion of these plans.

Daschle: I must say, I just don't think that the evidence supports these plans working. I think we probably just have to agree to disagree on that. I'm reluctant to cite, again, models from other countries, because I realize that with all of the qualifications, those models don't always apply, but I just don't believe that with high deductibles, we're accomplishing good prevention and wellness promotion. How do you ensure that all the other things we want to accomplish can be achieved with high-deductible designs?

I think we should be making our system as simple as it can be, and deductibles play against that, because you're going to have different payers and different levels and thresholds. At the same time, if we really want to incent wellness, making people pay the first-dollar costs of all wellness, up to a certain point, doesn't make a lot of sense to me.

Galvin: I think you have to look at high-deductible plans, like any product in a dy-

namic market, as evolving. Most high-deductible plans now provide prevention services either for free or for a minimal copay. The broader concept is for people to have a sufficient financial stake in their decisions that they're motivated to stay healthy and avoid services that they really don't need—and that they end up choosing the doctors and hospitals that are going to give them better care at a better price.

Daschle: There's a lot about what you just said that I completely agree with. I just don't feel that when it comes to health, patients are always in the best position to make that judgment, especially given the lack of transparency that we have today. I don't think that we have empowered our patients with the information to make the choices that you, arguably, could persuade me are necessary.

Galvin: I think that it's a "chicken and egg" situation. Many people who favor market-based solutions feel that it's the very fact that people have been shielded from information about price and quality that has led them to be the uninformed consumers that they are. In fact, a threshold change in incentives and transparency is what's necessary to transform Americans into very effective and savvy health care consumers.

Cost Control

Galvin: I want to get into more detail about how your plan would control costs, because that issue is so central in every health system. We know that if we put controls on prices, whether it's through better purchasing or even administrative pricing, the real culprit is utilization: how many services get used. How would you get a handle on this issue?

Daschle: First of all, I'd end the cost shifting. Second, I would try to wring out as much efficiency through technology and our administration and information systems. There are plenty of ideas of how to do that effectively. The third thing is to ensure greater transparency than we have today. And, fourth, there has to be leverage. There has to be ability on the part of organizations to pool resources—to leverage negotiated prices and costs that are not occurring today. I don't think that a system of individuals, in the health care system's current context, will ever allow for the leverage necessary to get the job done.

Galvin: I don't disagree with any of your ideas, but neither do I see how they address overall cost in any way that is likely to be effective. I think there's a fundamental issue that every country is facing, which has to do with physician practice patterns. That's where some of the ideas about using consumerism and consumer activation come in.

Daschle: I agree mostly with what you're saying. But it's pretty hard to inject consumerism when you're on the operating table and you're trying to decide whether you want that third or fourth test. It's pretty hard to inject consumerism at so many stages through the health care delivery process. I can see, up front, at the very beginning, you ask a doctor what's your price for this or that. And I suppose you could argue that that is an appropriate question to decide, ultimately, in who the provider's going to be. But once that process starts, how is a patient in a position to ask questions that would allow him or her, then, to make a choice? Now, the only exception that I'm aware of is when it comes to oral medications—the choice between generics and name brands ought to be more a part of this process. But on the operating table, or in the process of treatment, I think it's awfully hard to inject consumerism.

Galvin: Consumer activation does not work in every situation and is not the only answer. But I think there's a way of thinking about consumerism that goes beyond individual choices that any given consumer makes. The theory of the case is that there is a multiplier effect by which providers, knowing that their results are going to be public and knowing that consumers have choice and incentives to choose, will be motivated to change. The early research is showing that you need only a little bit of consumer movement to create a great degree of motivation for improvement among doctors and hospitals.

Daschle: That's where I think you and I agree. We've talked about transparency, and we've talked about pooling resources. But going to

the question of personal responsibility, which I think is one of the most important ones, I don't think that Americans are nearly as personally responsible for their own health care as they need to be. I don't think, as a nation, we have put much effort into prevention and wellness. I think that physical fitness, diet, and personal responsibility aren't getting the attention they deserve. Better education and better incenting people to take more personal responsibility in making those choices have to be an integral part of what we are doing.

Galvin: I believe that we need substantial financial incentives for consumers to have transparency result in an improved health care system. We see it in other sectors.

Daschle: Again, we probably will agree to disagree. That assumes a level of sophistication with regard to tests and medical practice and many applications in health care that exceeds the capacity of most ordinary Americans.

Galvin: I would agree with that in today's world. But I also believe that a true consumer market will create intermediaries who can do a lot of the explaining to people. Companies are already forming whose role it is to be the advocate and the guide for employees and consumers as they move through the health care system.

Daschle: I think that that's why you need government.

Achieving Political Consensus

Galvin: Let's shift topics and talk about the politics of health reform. Let me start by getting your impression of the following irony: Despite the fact that health care has been traditionally a Democratic issue, the biggest change in Medicare in the past forty years was delivered by the Republicans.

Daschle: Well, in some ways, that makes one of my earlier points. Why did it happen? It happened because seniors and other organizations—labor and others—who were demanding something be done, ultimately convinced people on both sides of the aisle that inaction was not an option.

I said some time ago in the interview that two things are required for major policy change: circumstances and leadership. You've had the circumstances for some time. And, I will say, you had a willingness on the part of the Democrats to provide the leadership for some time as well. But it was a big difference and a change in position for the Republicans to say, We're now going to provide that leadership. And they took this bill in a direction, of course, in which I wouldn't have gone. But, nonetheless, I have to begrudgingly give them credit for showing the leadership to address the issue, although that's as far as I can credit them. You've got to have the leadership to go with the circumstances to bring about the political environment to pass the legislation.

> **"Democrats need to say that health reform will be one of our highest priorities if we are back in the majority."**

Galvin: Senator, you're going to need people like me, who represent employers, and people on the other side of the aisle from you to reach a compromise. How are you going to get this done?

Daschle: It depends partly on who's in the majority. If the Republicans are in the majority, obviously, the circumstances are dramatically different than if the Democrats are. Something has happened in the process of passing legislation that is very relevant here but that may be very arcane and somewhat in the weeds for even *Health Affairs* readers. It has to do with budget reconciliation. Reconciliation has always been a vehicle that is viewed as 95 percent budget and 5 percent policy. But over the course of the last ten years, that has changed dramatically. Reconciliation is now viewed as a policy vehicle as well as a budget vehicle.

The most recent illustration of that—and I'm still dumbfounded to think we could still pull this off—is that we might change the laws on the Alaskan National Wildlife Refuge in reconciliation. What that means is that, instead of the requirement for sixty votes, which forces a much higher threshold level for pas-

sage, you now only need fifty-one votes. It's how this administration passed its tax cuts. It's how it is now passing controversial legislation.

Having said that, my dream is still that you'd pass a bill by eighty votes. But, my point in talking about this change in the reconciliation process is that if we had only needed fifty-one votes in the early 1990s, we would have passed health reform. We didn't have sixty, but we had more than fifty-one. And that is where, I think, ultimately health reform will happen. It's going to be in reconciliation in the future.

Galvin: So you think that maybe the only way to get this done in this country, because it's so difficult to get a compromise otherwise, is to do it with fifty-one votes and maybe at the eleventh hour?

Daschle: No. I wouldn't want anybody to think that this ought to be the strategy up front. The strategy ought to be how to get it done with the largest percentage of votes that we can get, because on something of this magnitude, there ought to be a supermajority. But I will say that at the end of the day, if all we had was fifty-one votes, I'd take it if it meant passing comprehensive health reform for the first time in American history.

Advice To Democrats

Galvin: What's your advice to the Democrats about how they should position themselves as the election starts to heat up next year, both for the congressional midterm elections and for the presidency?

Daschle: I think two things. First, I think we need to say that health reform will be one of our highest priorities if we are back in the majority. And, number two, I wouldn't be wedded to specifics at this point. It's counterintuitive, maybe, but I would say we don't claim to have all the answers. But we're committed to sitting down and working with our Republican friends and everybody who cares enough about this issue to get the result.

Galvin: Is the inclination to avoid a detailed plan at the outset a lesson from the Clinton failure and the Republican success with Medicare Part D?

Daschle: Right.

Galvin: Senator, a final question. What's your political future? Are we going to see you visiting Iowa and New Hampshire and talking about these health policy issues with a different intention?

Daschle: I have no plans to run for political office. But you never say never. I'm not being coy. I really don't have any plans. But I love public policy. I'm grateful to have had the opportunity to be involved with public service. We'll just see what the future holds.