

Academics, Academies and Public Policy: The Case of the American Health Care Debate

In the British Academy Fellows Seminar on 7 January 2010, Professor Theodore Marmor FBA discussed the role that academics can play in contributing to public debate, and commended the British Academy on the recent establishment of its Policy Centre. In contrast, he provided an American perspective on the lack of any organised academic input into the debate over Obama's health care proposals.

IT HAS TAKEN ME quite a lot of effort to avoid being outraged by what has gone on in the United States in the last year. If I were British, I would still be hot under the collar after reading Iowa Senator Grassley's comments about Stephen Hawking, which are totally uninformed and wrong; or gratuitous remarks about the fate of Teddy Kennedy were he to be in an NHS hospital. Not one American newspaper chastised either Grassley or the leading Republican in the Senate, McConnell, when he repeated those remarks: there was no headline anywhere saying, 'Grassley is grotesquely mistaken – Iowa voters take notice.' The norms of American journalism, particularly the so-called mainstream, are devoted to the proposition that objectivity consists of quoting both sides of a debate, even if one side of the debate is ridiculous. It produces the amplification of nonsense, on the misbegotten thesis that truth lies halfway between two sides. As Jim Hightower, a great and wonderful head of agriculture in Texas, once said, 'The only thing in the middle of the road is a yellow line or a dead armadillo.' That confusion between balance, objectivity, and the pursuit of truth as between claims has not led to any illumination.

I want to give some illustrations of what has gone wrong, in my judgement, in the debate over the so-called overhaul of American medical care in the last year or so.

What was the debate about?

I would guess that none of you have any clear idea of what it is that President Obama is in favour of when he proposes an 'overhaul of



Figure 1. Senate Finance Committee Chairman Max Baucus talks with ranking member Senator Charles Grassley (right), ahead of the committee's vote on the health care reform legislation, 13 October 2009, Washington, DC. Photo: Chip Somodevilla/Getty Images.

American medical care'. He has been using that expression for a year to capture these aims. His overhaul is supposed to make medical care affordable to all Americans by expanding health insurance to a large proportion of the uninsured and controlling America's huge medical costs through citizen choice of insurance plan and competition among those plans. I think it is fair to conclude that 95% of Americans, when asked, would not know what it is that is actually being proposed.

This is a really important failure of a democratic debate, a debate in which the problems of American medicine have been articulated and dramatised again and again. I know them all by heart. It does not take much to remind Americans that between 46 and 47 million of them have no health insurance at any one time. Fewer people inside or outside the United States know that something close to 90 million Americans over a two-year period experience an episode of non insurance. Many have heard that medical care expenses are the second most common cause of bankruptcy in the United States; few know that 60% of those bankruptcies are for Americans who had health insurance when they became ill. This is an important failure to understand that, although non insurance is a problem, so is

under insurance – particularly for chronically ill people. Under insurance is a much surer road to the possibilities of bankruptcy.

With regard to the quality of American medical care, there is more open disagreement. But the President and a lot of his backers in the Democratic Party – and indeed a number of Republicans in the Senate and in the House – will regularly assert that 440,000 Americans allegedly, according to the Institute of Medicine, died prematurely because of failure to care for them appropriately in American hospitals and clinics.

The cost of American medical care is repeated endlessly, but people do not actually have much idea what to make of it. What does it mean to spend \$2.4 trillion on medical care? It is a little more comprehensible if you express it on average as \$21,000 for premiums for an average family of four, or \$7,500 per person in the United States. But the other way of thinking about it is that 16–17 cents of every dollar of national income in the United States goes to medical care. Compare that to 14 cents in 2000, about 11 cents in 1990, about 9 cents in 1980, and a little over 7 cents of every dollar in 1970. We spend a lot and we feel bad about it.

That is the conventional diagnosis. But there is nothing in the description of these

problems that tells you anything about a remedy. The gap between the problems stated and the remedies offered is huge, and has been huge throughout the reform debate. Here we are in January 2010. The Senate has passed a bill. The House has passed a bill. The respective legislative leaders are going to come together, although it is uncertain as of last week whether or not the House is actually going to agree to go into a joint committee, where they work out their differences. That is the traditional way: the two bills come together, and the dominant figures from each institution choose members of the conference committee, and they do a lot of 'horse-trading' across the differences between the two.

Academic contribution to the debate

No commentator would deny the state of confusion and misunderstanding of what the policy debate is about. Nor would they deny that the problems are serious, that the suggested remedies are highly controversial, and that there is very little consensus about what would count as a useful, appropriate and affordable intervention. What I want to say instead is that no academic contribution to that debate has been significant. Most

importantly, the American Academy of Arts and Sciences, the Institute of Medicine (of which I am a member), the National Academy of Social Insurance (of which I am one of the founding members) – none of those institutions has played any role whatsoever in disciplining any aspect of the debate. I think this is to our great loss.

In an article I wrote 18 months ago, on the basis of my earlier experience with the Clinton reform in 1992–3, I claimed it 'is obvious that there is problem consensus, but there is not consensus on the severity of the problems, and there is certainly no consensus whatsoever on what to do about it. We have no idea what will emerge from the sausage-making factory that we have got.' So I suggested that we find some American or republican (with a small 'r') form of consultation with informed, deliberate and serious people, to produce a guide to what would be the likely effects of four or five of the most prominent policies that were proposed. Not to choose among them; not to decide which ones to vote for; but to inform the democratic debate by reasoned claims about what the best understanding would be. If you tried to do policy x, what would it be like in practice? And what would be the

range of ameliorative interventions if you were going to implement a given policy that would be responsive to acknowledged vulnerabilities? I identified the four options. I suggested as participants the sort of people that you would find in the British Academy: not just experts in the policy, but also competent people who would in the presence of information be able to come to a judgement about what a citizen would make of this or that proposal – an informed and thoughtful judgement.

The fate of my particular proposal was not something to gloat over. My email got cluttered, but, then, I sent the article to lots of people. As far as I can tell, the impact of all that was modest. Here, I thought, was a profound policy 'output', but negligible practical consequences – other than for those students who could not escape listening to

Figure 2. In the run up to the crucial Congress vote, the Health Care Reform Package has continued to polarise American opinion.

Left: clinic workers express support, 17 March 2010, Oakland, California. Photo: Justin Sullivan/Getty Images.

Right: opponents hold a 'Code Red' rally, sponsored by the American Grass Roots Coalition and the Tea Party Express, 16 March 2010, Washington, DC. Photo: Chip Somodevilla/Getty Images.



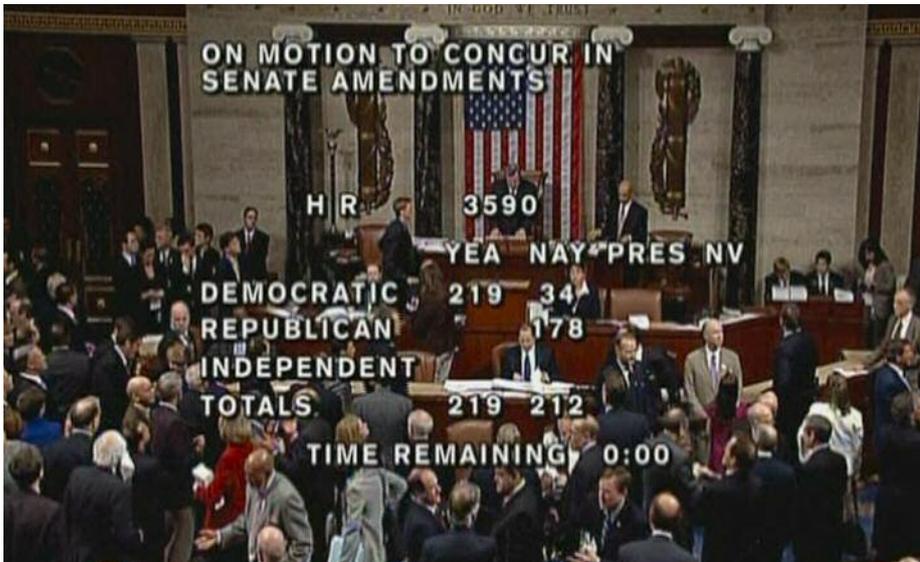


Figure 3. An overall view of the US House of Representatives chamber, after the House voted to give approval to the health care overhaul, 21 March 2010. Photo: Reuters/House TV/Handout.

me. The talk and the article did have one effect: it increased the number of speeches I was asked to give, because no one else was giving a speech quite like this. But the serious point is that neither disciplinary groups of scholars nor any of the scholarly academies, which justify their existence by their contribution to an understanding of the social order, made any attempt whatsoever to enter in this debate. They were scared to death. I think this was largely because they feared the impact in their capacity as grantees, if things went badly.

Evidence from the Netherlands and Switzerland

Here is an example of how evidence has been ignored in the debate. Obama's concept of cost control – controlling costs through patient choice of insurance plan and competition among private insurance firms – has no empirical basis whatsoever. It is theoretically possible. But the two instances that have been invoked by the advocates of this particular view are the experiences of the Netherlands from 2006 and of Switzerland from 1996. Both countries mandate that their citizens have health insurance and pay for it, with subsidies going to lower income citizens. Both have an extensive set of regulations to prevent private health insurance firms from engaging in exactly what you would think private health insurance firms would do – namely to try to select the less sick and

benefit from a disproportionate share of the healthy and the wealthy.

Without going into great detail, let me just say that in the pre-existing period in the Netherlands, that is 2004–5, 1% of the Dutch were uninsured; 99% were insured. That is in the face of a situation in which only 60% of the population were compulsorily insured, the lowest 60% of the income distribution. It was up to the remaining 40% to choose whether to buy health insurance. The Dutch are very inclined in general to purchase insurance, and all but 1% had bought health coverage. Since the law was passed, the level of non-insurance has increased to 3%, despite the fact that there is a legal requirement to do so. It does not take very much to figure out what happens. People's lives are disordered at the bottom of the income distribution: you have got a lot of people for whom the choice between paying any premiums at all and taking risks leads them into behaviour in which they could be threatened with fines, indeed imprisonment. But no Dutch government would ever agree to do that, so they bribe the insurance companies to keep people on, by paying *ex post* for the premium.

The Dutch and Swiss contexts are quite unlike the US. The behaviour of their insurance firms is partly conditioned by the laws that regulate their conduct. In addition, 50 or 60 years of experience with public

regulation of private health insurance have produced social norms about not cherry picking. Conduct that would be called cherry picking is actually treated as a subject of regulatory investigation. Both the Netherlands and Switzerland now experience considerably more non insurance than they did before they universalised it through mandates. And, beyond that, both nations have experienced increased rates of medical inflation after universal coverage was legislated.

In short, the empirical evidence from countries that have tried to do what the Obama platform calls for actually provides no empirical support for the reform proposition at all. You would have thought such a finding would have been a decisive element in the debate. Instead it was an argument made by almost no one, other than a small cadre of people at Yale University who have been urged by me to use comparative evidence for the last 30 years.

I leave you with this reflection. Here is a huge issue in American life – on the public agenda for the last two and a half years, most sharply in the presidential primary fight between Obama and Hillary Clinton. Yet academics as disciplinary representatives and academics in academies have made no organised contribution to eliminating or reducing falsehoods, pointing out truths, or in any way bordering the arguments over this reform topic. Instead they are observers, watching as the country is engaged in a debate that is misleading, is dominated by myths about what the facts are, and includes an extraordinary degree of ignorance about just how disappointing the 'it' is going to be that is going to emerge in the next few weeks or months.

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