



Insights in the American Healthcare System

Interview with Theodore Marmor

Theodore (Ted) Marmor is Professor Emeritus of Public Policy and Management & Professor Emeritus of Political Science, Yale University. Professor Marmor's scholarship primarily concerns welfare state politics and policy in North America and Western Europe. He particularly emphasizes the major spending programs, which is reflected in the second edition of *The Politics of Medicare* (Aldine de Gruyter, 2000) and the book written with colleagues Mashaw and Harvey in the early 1990s, *America's Misunderstood Welfare State* (Basic Books, 1992). The author or co-author of eleven books, Marmor has published over a hundred articles in a wide range of scholarly journals, as well as being a frequent op-ed contributor to U.S. and Canadian newspapers. Ted regularly writes op-ed essays for the *Philadelphia Inquirer* with long-time Yale law colleague, Jerry Mashaw.

Welcome Professor Marmor and thank you for taking the time to share your views with the readers of "Revista Actuari@," most of whom are actuaries interested in insurance, social security, and public policy issues. Given your impressive background in welfare state politics and policy, we would like to know your opinion on the following topics:

Q - How do you see the American healthcare system evolving in the next ten years? How do you expect the interplay of interest groups (employers, providers, insurers, politicians and consumer groups) will shape the system?

A – *My view is that forecasting is about conditional predictions, depending on the mix of economic and political circumstances. The best guess for the next few years is more of the same, either some expansion of insurance ala the current congressional bills or a worsening of the non-insurance picture in the absence of legislation this spring. On either scenario, costs will increase since the United States has not had a grown-up argument about cost control (see the article on cost control in the "Annals of Internal Medicine," April 2009). From there, matters depend on the political-economic combination. If Republicans gain in the mid-terms and in 2012, then continued stalemate on cost control is likely. This is not so much interest group strength, as whether we grow out of our economic mess and what the policy/partisan balance is. Who could have predicted the 2008 outcome? And what if Kennedy had not been ill? So, contingency plays a role, but the fundamentals are a product of the political/ideological/economic environment. When that changes, the probabilities change.*

Q - Regarding universal coverage, how does the mentality of American citizens differ from that of Western Europeans, in particular British citizens? Do you believe that ideology plays a role in shaping the healthcare institutions? In this context, why is it that Americans seem to be more willing to tolerate a high number of uninsured than restrictions in healthcare (e.g., the American public opposed Managed Care, particularly Health Maintenance Organizations (HMOs))?

A – *One topic at a time. On universal coverage, the most relevant comparisons are both Canada and Australia, where you have about 10-20% of the population with libertarian views and about a third with the equivalent of our orthodox Republicans on "markets" and the argument for a more limited role of government in social policy. Our population has a similar breakdown, with about 30% so-called independents and about 35% Democrats in partisan orientation.*

You have to be careful not to go backwards from results—the logjam over universal coverage—to an explanation ideological in character. Since World War II we have had larger majorities for the same type of universal coverage that in fact showed up in Australia and Canada, but in the latter countries these majorities were parliamentary. The translation of a permissive majority in the United States into a policy is much harder, with many more veto points.

The fight in Australia and Canada was in the period between the late 1950s and the mid-1970s, exactly when we were disputing Medicare and wondering when National Health Insurance would happen. The United Kingdom, by contrast, had a fully socialist party bring in the National Health Service in 1948, an institution that finances and delivers medical care directly. A big difference.

Do not be confused by talk of managed care; it is not universal coverage but a vague and misleading umbrella term that meant to doctors constraints on what they could do and for patients limits on what doctors they could see. my most recent publication I devote a chapter about how not to think about managed care. HMOs are a marketing term for what are called Health Maintenance Organizations, most of which do not maintain health and are simply insurance firms.



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Q - What are, if any, the lessons that America could learn from other countries to improve the healthcare system that have been ignored so far?

A – *The main one is the simplest law of medical economics: a dollar of expenditure must equal the income of someone in the industry where the dollar is expended. This is the theme of the article "Hope v. Reality: Cost Control and Health Reform" in the April issue of the "Annals of Internal Medicine." The failure to understand this accounting identity allowed much nonsense to be uttered this past year about all kinds of hopes for improving medical care: research on effectiveness, Information Technology (IT), Enterprise Risk Management (ERM) and prevention. No country in the Organization for Economic Co-Operation and Development (OCDE) is fooled by such talk; they are always to make medical care potentially better, but not necessarily cheaper. Cost control must be costly to someone or it is not the control of costs.*

Q - The role of actuaries in public policy making has been minimal. Why do you think this is the case? Do you see any reason why this may change in the next five to ten years?

A – *It might if the actuarial profession focuses on the basic laws of medical economics as described above and makes realistic forecasting its contribution, replacing the silly Congressional Budget Office (CBO) "scoring" on the basis of whim and extrapolation. The CBO is utterly provincial and actuaries have counterparts abroad.*

Q - What advice can you give to healthcare actuaries interested in a career in public policy? Do you believe that, given their lack of recognition in the society, an actuarial career is a handicap to enter the realm of public policy?

A – *Actuaries play a big role in social security. It is interesting to wonder why they have lost to the economists on health financing.*

Thank you for sharing your views to our readers on themes that are vital to the medical and economic welfare of the American Society.

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