ANESTHESIOLOGY

How Can Anesthesiologists Influence Policymaking? Reflections from a Year at the Council of Economic Advisers

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ABSTRACT

From September 2019 to August 2020, the author served as a senior economist on the Council of Economic Advisers, a government agency charged with providing economic analysis and advice to the President of the United States and senior government officials. Working with the Council yielded many useful lessons on how anesthesiologists can influence healthcare policy. First, because the President has wide latitude over many areas of health policy that directly impact patient care and anesthesiologists' working environment, anesthesiologists should focus their efforts on influencing policymakers within the executive branch of government in addition to influencing lawmakers. Second, policymakers are busy and typically do not have a technical background, so anesthesiologists must learn how to communicate with them succinctly and at an appropriate level. Finally, because policymakers often need analysis quickly, anesthesiologists must meet these needs even if the underlying analysis is rougher and less precise that what would normally be needed for peer review.

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Dr. Tomas Philipson, a health economist from the University of Chicago, was appointed as the acting Chairman of the Council of Economic Advisers in July 2019, and shortly after, he asked me to join the Council's staff. I accepted the invitation and served as a senior economist for the Council from September 2019 to August 2020. The Council of Economic Advisers is a government agency located within a larger agency known as the Executive Office of the President. The Executive Office of the President is led by the White House Chief of Staff and encompasses many other agencies that directly support the work of the President of the United States,[1] such as the Office of Management and Budget (the agency that produces and manages the budget) and other well known agencies such as the Office of National Drug Control Policy.

Established by President Truman in 1946, the remit of the Council of Economic Advisers is to provide the President of the United States with economic advice and analysis. The Council itself consists of three members, one of whom is also appointed as the chairperson of the Council and in this role leads the agency. The Council chairperson is also the external face of the Council and therefore interacts with the media, as well as the most senior government officials. For example, the Council chairperson directly presents the views and advice of the Council to the President of the United States, as well as other high-level government officials such as Cabinet Secretaries.

The Council chairperson is supported in their work by a staff consisting of the two other members of the Council, a chief economist, and several senior and staff economists. Generally speaking, the Council members, chief economist, and senior economists are academics on leave from their home institutions, although some senior economists are on loan from other government agencies, such as the Securities and Exchange Commission or the Department of Agriculture. The senior economists are typically chosen for their expertise in an area of interest to the Council. I was responsible for health policy, and other senior economists covered disparate areas such as trade policy and national security. While the Council members and chief economist also have their areas of expertise, their primary role is to provide guidance and supervision for the senior economists. Staff economists (colloquially known as "juniors") typically hold a masters or undergraduate degree in economics and assist the work of the senior economists. In addition, because the Council staff is highly transient—most of the senior economists and even the members and chief economist will stay for at most 2 yr—the staff economists play a vital role in providing institutional memory as well as practical knowledge of "how things work."

In many ways, the Council's functions are analogous to the way an attorney would advise and represent a client. First, there is an internal-facing role through which the Council provides advice to other agencies within the Executive Office of the President and ultimately to the President himself. In the same way attorneys should provide objective advice to their clients, even if that advice is not necessarily "good news," the responsibility of the Council for this internal-facing role is to provide objective advice even if that advice is not always popular. The Council would typically provide this advice in several settings. First, other components of the Executive Office of the President would reach out to the Council as a sounding board to assess the relative merits of a given policy. Second, for issues of high importance about which there is disagreement within the administration, a meeting will be arranged with the President and senior officials—such as the Council chairperson—to resolve the disagreement and decide on a path

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forward. In these meetings, Dr. Philipson would present the Council's perspective and analysis. Finally, the Council would generate ideas for potential policies and then reach out to other components of the Executive Office of the President to request their support in making these ideas reality. For example, in line with much of his research,[2] Dr. Philipson had a particular interest in reforming the drug development process to allow for faster drug development times and for faster approval of generic drugs. Therefore, I worked closely with staff from the Domestic Policy Council and the National Economic Council, two components of the Executive Office of the President that are tasked with the actual work of driving the President's agenda, on this subject. I would present our ideas for potential policies and also evaluate potential policies presented by the staff from these two agencies.

The second aspect of the Council's mission is external-facing, whereby it interfaces with the media and releases reports to advocate the President's economic agenda. The most notable report is the annual Economic Report of the President, which the Council is required to produce by law. The Economic Report of the President essentially reviews the previous year's economic activity and advocates for the President's economic agenda in this context. In addition to this annual report, the Council releases smaller reports or blog posts throughout the year to advocate or highlight the President's agenda on specific topics. Some examples include a report on the impact of tax cuts directed to opportunity zones,[3] as well as a report on reforming prescription drug prices in the United States.[4] Just as a lawyer is required to zealously represent their client's views within the codes of professional conduct,[5] the Council's mission for this external-facing role is to advocate for the President's policies within the standards of economic practice. Because the Council represents the views of the President, it has quite a megaphone, and these reports—although academic in nature—can receive extensive media attention and therefore influence the policy debate.

Working at the Council and the White House was similar to working in academic medicine. Both institutions are intense, fast-paced environments where much of the day-to-day work is done by a large cadre of junior people under the supervision of senior people. In addition, both institutions are rigidly hierarchical, with the White House being even more so than academic medicine. For example, at a fundamental level, my job was to support Dr. Philipson and his goals in a way that does not quite hold in academia. Similarly, depending on context, some anesthesiologists in academia might feel comfortable directly emailing the chairperson of the department of surgery; in the White House, the number of acceptable scenarios for directly emailing the head of another agency are much more limited.

Health policy is of importance and interest to many anesthesiologists, and my time at the Council provided many lessons on how to influence policy. One lesson is the importance of the executive branch in setting health policy. The common teaching is that the United States government consists of three branches: the legislative branch (Congress), the executive branch (the Presidency), and the judicial branch (the Supreme Court). In this tripartite system, the legislative branch writes the laws, the executive branch enforces the laws, and the judicial branch interprets the laws. However, in practice this teaching is overly simple. The laws Congress writes typically give the executive branch substantial discretion to establish regulations—which have the force of law—to accomplish the law's goals. Therefore, in a very real sense, the executive branch has tremendous power to essentially interpret and write law through the regulatory process.

For example, the original law that established Medicare (the U.S. public insurance program for the elderly) gives the Secretary of Health and Human Services fairly broad authority to set standards for hospitals that choose to participate in Medicare, with the only requirement being that the Secretary "finds [these standards to be] necessary in the health and safety of individuals who are furnished services in the Institution."[6] These standards, known as the Medicare Conditions of Participation, apply to all patients in the hospital, not just Medicare beneficiaries, and affect many areas that are relevant to anesthesiologists, such the requirement for a preoperative and postoperative evaluation.[7] Perhaps most importantly, until 2001, these regulations also required physician supervision of nurse anesthetists. However, in 2001, President George W. Bush modified the regulations to allow states to "opt out" of this requirement.[8] The Secretary of Health and Human Services also has broad latitude to determine how Medicare pays for anesthesia services. Whereas the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act (MACRA) moved Medicare payments toward a pay-for-quality system, crucial details of this system, such as how "quality" is defined and measured, are at the discretion of the Secretary of Health and Human Services (and implicitly, the Administrator of the Centers for Medicare and Medicaid Services). Similarly, the Center for Medicare and Medicaid Innovation has broad authority to test and launch new physician payment models.

In addition to affecting working conditions and payment for anesthesiologists, the discretion of the executive branch also has direct implications for the care of our patients. One issue that the Council provided advice on was the "Institutions of Mental Disease exclusion." The legislation that established Medicaid (the United States public insurance program for the poor) explicitly forbids it from making payments to institutions that primarily treat mental disease (such as institutions that primarily treat substance use disorders), even if the care is medically necessary. However, under the Trump administration, the Secretary of Health and Human Services used another section of the law to waive this provision for states that met certain other requirements.[9] This action was taken with the intent of improving treatment options for persons with mental illness, although whether it will ultimately be successful is an empirical question.

Ultimately then, one lesson I learned at the Council is the importance of working with the executive branch of government and not just Congress when it comes to setting policy, because of its tremendous power to affect patient care and anesthesiologists' working environment. There are many ways to engage with the executive branch. First, changing existing regulations or establishing new ones is a fairly complex

process that, by law, typically requires advance notice and a public comment period. Anesthesiologists should take advantage of this period to make their thoughts on pending regulatory changes known. By law, federal agencies must consider these comments, and I was actually fairly impressed by the detailed attention with which they did so. Second, anesthesiologists should interact directly with relevant policymakers in the executive branch to influence their decisions, and efforts to meet with these policymakers should be an important part of the agenda for the American Society of Anesthesiologists and its component societies. Finally, anesthesiologists should play a role in empirically assessing the effects of past and current regulatory changes and using these assessments to guide advocacy.

Another lesson I learned was the importance of learning how to communicate with nonexperts. At the Council, I was considered the expert in health economics. Although Dr. Philipson was also an expert in health economics, ultimately the people the Council was advising—including the President—were not. Moreover, these people—particularly the President—had many other competing demands for their time and therefore one did not have the luxury of taking several minutes for introductions and "throat clearing," as occurs often in academia. Thinking of ways to simplify complex topics for a nontechnical and time-pressed audience is important when engaging with policymakers.

Another challenge at the Council was the rapid turnaround required for many projects. When conducting a study, there are generally tradeoffs between precision, accuracy, and resource use. A large randomized trial can obtain a high degree of precision and accuracy but is costly in terms of resources and time. Academia tends to favor increased accuracy and precision and accept the concomitant cost of having more expensive and time-consuming studies. As a result, it typically takes months to years to publish a peer-reviewed study. However, the Council was the complete opposite, with time often being the most important constraint and projects needing to be completed within weeks to months and—at the height of the COVID-19 pandemic—in hours to days. The reality is that policymakers often need information and analysis quickly, even if it is not at the level of rigor required for a peer-reviewed study. An important skill I learned at the Council was determining what the necessary timeline was for a given project and then finding ways to do the best analysis possible under those timelines. When advising policymakers, sometimes "good enough" needs to be good enough.

Ultimately, working at the Council was a rewarding experience. The Council's viewpoint was always heard and respected and often made a difference in policymaking. Dr. Philipson's efforts at reforming the drug development process had some payoff, because the administration ultimately ended up rescinding the Unapproved Drugs Initiative,[10] a policy instituted by the Food and Drug Administration in 2006 that is thought to have led to price increases and shortages for many drugs including colchicine, phenylephrine, and atropine.[11] Just as important—although less noticeable—are the policies that were not adopted because of our advice. For example, in response to Council concerns about studies showing a lack of efficacy,[12] the administration delayed efforts to increase payment for a particular drug. Finally, the Council assisted many important aspects of the administration's response to COVID, such as determining how to the distribute funds from the Coronavirus Aid, Relief, and Economic Security (CARES) Act to hospitals.

Moreover, my time at the Council helped me learn about how policymaking is done and the importance of the executive branch in setting health policy. As outlined here, these are important lessons that have important implications for how anesthesiologists can influence health policy.

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Competing Interests

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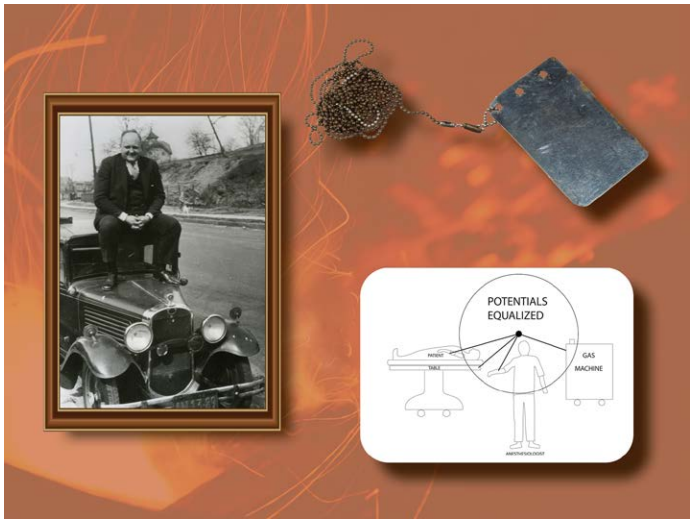
ANESTHESIOLOGY REFLECTIONS FROM THE WOOD LIBRARY-MUSEUM

Paul Wood's Grounding Plate: A Shockingly Down-to-Earth Strategy for OR Safety



Modern anesthesiologists do not think twice about "charging" their portable devices and equipment. For physicians using ether, ethylene, and cyclopropane, a "charged" device implied a shockingly different situation. Combustible anesthetics required vigilance to neutralize current leaks or static electricity sparks between conductive materials. Such discharges could ignite a flammable cloud of oxygenated volatile agent. Safety-minded anesthesiologist and Wood Library-Museum founder Dr. Paul M. Wood (1894 to 1963) used a grounding plate and chains to minimize potential differences. His personal grounding plate (*upper right*) created a low-resistance pathway that linked the anesthesiologist, patient, and operating room table to the drag chain-grounded anesthesia machine. A 1941 ASA report titled "The Hazard of Fire and Explosion in Anesthesia" encouraged such connections. Luckily, for our dapper founder, the automobile industry had already grounded the electrical components of his shockingly stylish 1938 Bantam Coupe (*left*). (Copyright © the American Society of Anesthesiologists' Wood Library-Museum of Anesthesiology.)

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