Politics, Health, and Health Care

“The health of the people is really the foundation upon which all their happiness and all their powers as a state depend.”
—Benjamin Disraeli, 1804–1881

It is no surprise that this section contains the largest number of essays in the book. Health and health care are inevitably intertwined with politics, for two reasons: money and ideology.

As the annual bill for health care in the US has soared into multiple trillions of dollars, it has become both a big business and a budgetary nightmare. As a result, everything related to health is now viewed through the prism of costs, and everyone is in the business of delivering cost-effective care—if we can just figure out what that is.

Political (as well as religious) ideology also affects how people see health and health care. Is there a right to health care? Should we allocate resources to cover the entire population, or focus on paying for unlimited care for older Americans? Are condoms a way to prevent pregnancy and disease or a moral abomination? The answers all depend on what you believe.

When Pope Benedict XVI gave an interview on his way to Africa that seemed to dismiss the effectiveness of condoms in preventing the spread of HIV and other diseases, the public health community was in an uproar. I wrote a column calling for a compromise solution—permitting condom use for disease prevention purposes, if not for contraception. Subsequently there was a hint that the Catholic Church might just consider such an option.

During the election campaign of 2008, I searched the health platforms of all the major candidates—Democrats and Republicans—looking in vain for a plank supporting the importance and central role of primary care medicine in a reformed health care system. I couldn’t find it anywhere, so I wrote a column about it. Similarly, none of the candidates had pledged to reverse the Bush administration’s blatantly political distortion of politically inconvenient scientific and medical research findings. I thought that deserved mention as well. Finally, there were several instances in which the US surgeon general
was muzzled for trying to give scientifically sound public health advice. That, and what I considered to be the wrong-headed criteria being used to select a new surgeon general, also led to commentaries.

Prominent individuals also play a role in the politics of health care, of course, and I have profiled three of them in separate commentaries. Elizabeth Edwards, sadly now deceased, first came to public attention as the wife of a senator and presidential candidate, but then became a political figure in her own right as she battled cancer in a very public way. Thomas Daschle, a former senator and consummate political insider, was odds-on favorite to become President Obama’s health secretary before he withdrew because of financial improprieties. Donald Berwick, an internationally respected pediatrician and health quality guru, has been pilloried inappropriately for promoting—gasp—rationing of health care, as he serves a congressionally shortened term running the US Medicare program. All of their stories provide interesting lessons in the politics of health care.

This section also focuses on major public health issues. Tobacco remains the leading cause of death in the US, but funds to help decrease tobacco use are being crowded out by an even more urgent epidemic, obesity. I wrote about whether or not this should be an either-or situation. A great example of the influence of political pressure on public health is the saga of taxes on sugar-sweetened beverages. I told the story of how the strong intervention of the beverage industry stopped an almost sure-fire way to help slow the obesity epidemic. Finally, some people do not consider gun control to be a public health issue. I think that when demonstrably mentally ill persons have ready access to semiautomatic weapons with high-capacity bullet clips, something needs to be done.

These many discussions about what the best public health approaches are for improving health status, however, may all be for naught. Look at the first essay I wrote for the BMJ, in 2007, which begins this section. In it I bemoaned that fact that much of what doctors do, and even most of what the health system does, pale in comparison to the individual attribute that has the strongest correlation with longevity: years of education.
Today’s doctors’ dilemma

The secret to a longer life is nothing we can do anything about in health care

To George Bernard Shaw in his play *The Doctor’s Dilemma*, the dilemma doctors faced was choosing between helping patients and helping themselves to lucrative fees. Today’s doctors’ dilemma is that what we do doesn’t make much difference.

As a young man disillusioned by the politics of the late 1960s, I sought refuge in medicine. I thought that the government and politics were making things worse. The only hope I saw was helping one patient at a time. I would work as a family doctor, my patients would feel better, and thus I would make the world a better place. The answer was medical.

I was wrong. After working in a health center in an economically deprived neighborhood only a short time, even I figured out that I couldn’t “fix” much of what was wrong with my patients. Sure, I could prescribe pills and insulin for my diabetic patients, but many of them had neither the means to buy healthy foods nor access to well-stocked stores from which to purchase them. I could refer patients to dietitians to learn about healthy eating, but many couldn’t read the leaflets they were given. I could immunize children against an increasing number of illnesses, but many fell victim to epidemics we didn’t have shots to prevent: drugs, tobacco, and violence. The answer was societal, not medical.

Twenty years later, Michael McGinnis and William Foege published data showing that the leading causes of death in the United States were not the heart disease, cancers, and strokes I was treating. Medically, we knew what to do about them. Instead, tobacco, bad diet, physical inactivity, and alcohol were actually what was killing people. This was an unconventional conclusion, even among public health types. I certainly hadn’t spent much time learning about any of these problems in medical school or residency. The answer must be preventive medicine. Knowing what the problems are and doing something about them are two different things, however.
Ten years later, America is still doing a rotten job of delivering preventive care. The Agency for Healthcare Research and Quality has just published its annual *National Healthcare Quality Report*. Their conclusion? “The use of proven prevention strategies lags significantly behind other gains in health care.” Only half of adults over 50 get screened for colorectal cancer. A third of smokers don’t receive advice to quit. Less than 60 percent of elderly people have ever had pneumococcal vaccine. Twenty percent of children under the age of 3 have not received all recommended immunizations.

One solution to this problem is to pay doctors to do preventive care. The current experience in the United Kingdom’s National Health Service is instructive here. Shaw would have loved learning that at least some of today’s British general practitioners are getting rich not by doing unneeded surgeries but by doing thousands of Pap smears and flu shots. The US Medicare program says doctors will soon be able to increase their reimbursement also if they deliver better care to the elderly, some of which will no doubt be defined as more preventive care.

But we have a long way to go. In America we are much more interested in finding the next new blockbuster (or even “me-too”) drug than in what Steven Woolf calls “fidelity of existing interventions.” We spend billions of dollars inventing and testing new drugs that only marginally extend the benefits of those they replace, rather than putting resources into better delivery of existing effective services. Woolf and his colleague Robert Johnson have shown, for example, that heroic searches for better cholesterol-lowering and antiplatelet drugs cost more and result in less population health gain than would the delivery of today’s statins and aspirin to all those who could benefit from them.

Much of this is not rocket science. If there is a budget for it, we can improve health care quality, including the quality of preventive care, with known tools: evidence-based guidelines, reminder systems, computerized physician order entry systems, and electronic medical records. It would be nice if future years’ national quality reports found great leaps of progress rather than what they admit are now only modest and uneven gains. This must be the answer.

But it is not. What is the single factor that best predicts longevity? It is not smoking, diet, or receipt of appropriate preventive care. It is not race or wealth. Recently, British GP Iona Heath argued elegantly that we should
focus on treating the sick rather than treating risk factors that we have
turned into diseases; but that too would have little or no effect on lifespan. In
fact, the secret to a longer life is nothing we can do anything about in health
care.

That is today’s doctors’ dilemma. It is not the conflict between what
is good for our patients and what is good for our pocketbook. It is not
choosing between sickness care and prevention, or between medical
care and public health services. Most authorities are now convinced that
education—years in school—has the most direct causal effect on how long
people live. We can work around the margins with our statins and nicotine
replacement patches and mammograms. We can relieve suffering and
tend to the sick. But for every extra year spent in school, life expectancy is
extended 18 months. Even bleeding heart liberals like me don’t think that it
is a doctor’s job to get kids to stay in school.
The cancer diagnosis that has gripped America

The unpredictability of cancer may help explain media obsession with a presidential candidate’s wife

I have been surprised by the extensive and continuing media coverage of the announcement that Elizabeth Edwards, wife of the US presidential candidate John Edwards, has recurrent breast cancer. It was front page news when it was announced. The Edwards’s decision to continue his campaign despite the cancer was then analyzed and discussed endlessly, with multiple follow-up stories and interviews in the newspapers, on the network news programs, and in the blogosphere. Why all the fuss?

First, a bit of background. John Edwards, a former US senator, ran for president in 2004 and was beaten by John Kerry, who then picked him as his vice presidential running mate. On election day 2004, Mrs. Edwards found out that she had breast cancer. She subsequently had surgery and radiation therapy and was pronounced cured. John Edwards is running again for president in the 2008 election and generally has been third in public opinion polls, after Hillary Rodham Clinton and Barack Obama.

Further relevant background. The Edwardses had two teenage children. Their 16-year-old son died in 1996 in a car crash. In her late 40s Elizabeth Edwards then had two more children, who are now aged 6 and 8.

On March 22, Elizabeth and John Edwards held a press conference to announce that her breast cancer had returned. It has metastasized to her bones and possibly to internal organs as well. Although the cancer is stage IV and incurable, her cancer burden is small, and her doctors told her that it is “completely treatable.” She said that she feels well, is planning to undergo unspecified treatments to control her cancer, and that she and her husband had jointly decided to press on with his campaign.

The pundits are having a field day with this one. Elizabeth and John Edwards were immediately called courageous and forthright by many, but others have criticized their decision to carry on with the campaign under such uncertain circumstances. Some thought it callous to focus on his career
instead of her health. Others say that they are short-changing their young children by not spending every possible minute with them. Katie Couric, the television network news anchor who famously lost her own husband to colon cancer, interviewed them and asked whether they were in denial and being unrealistic in their expectations. Many wondered how candidate (let alone President) Edwards could focus on the affairs of the world while his wife’s health is so precarious. Others saw this as a plea for a sympathy vote.

Mrs. Edwards responded by saying that all of us are dying; her only difference is that she now knows what she will die from. She wants to be seen as living with cancer rather than dying from it, and to her the only choice is whether to “push forward or start dying.” She and her husband have spoken about their young children and how they told them the news. John Edwards says that he wants no one to vote for him out of sympathy but that voters may learn something important about him from this. He feels that he has shown his ability to continue to function in his job during periods of family stress because he has done it twice before: when their elder son died and at the time of his wife’s first cancer diagnosis.

So why all the press furor over this news? I think there are three reasons. First, Americans are obsessed with the domestic affairs of our political leaders. Nothing that Hillary Rodham Clinton does as a candidate for president engenders greater interest and attention than her role as wronged wife during her husband’s presidency. Similarly, the Republican candidate Rudy Giuliani, former mayor of New York, gets more press for the ongoing saga of his wives and their previous husbands than for his policy statements. John Edwards only made it onto the daily network news shows when his wife’s cancer recurrence was revealed.

Second, this was a recurrence of cancer, not a primary diagnosis. As one of my friends, herself a cancer survivor, said, “Everyone’s got breast cancer—it’s no big deal.” It is commonplace to hear about a celebrity with breast cancer who undergoes treatment and announces that she is cured. Recurrence, however, is not part of the public drill. It is scarier, and terms such as “stage IV,” “metastases,” and “incurable” upset the press and the public. In a world full of media consultants and carefully scripted appearances, everyone understands that the future for this couple is not predictable. It is going to play out in real time in front of the entire country.
Finally, and related to that, there is clearly something very special about Elizabeth Edwards. Her direct, no-nonsense approach is genuine and appealing. Her intelligence, thoughtfulness, and toughness come through clearly. She is a woman who has been given much but has also been put through much. We all wonder how we would deal with such devastating news in private and in public. At least some of us, myself included, would hope for her strength and grace. It is as much about us as them.

As actor Tim Robbins’s character Andy Dufresne said in the film The Shawshank Redemption, “It usually comes down to a simple choice, really: get busy living or get busy dying.”
Conflicts in office

A former surgeon general’s testimony reveals battles between science and politics

In a July congressional hearing, the immediate past US surgeon general, Richard Carmona, testified about the problem of political meddling in what he saw as the proper functions and activities of his office.

Carmona spoke generally about repeated interference by the George W. Bush administration (which appointed him) in his attempts to speak out on controversial issues, such as stem cell research, abstinence-only sex education, and the emergency contraceptive pill. His speeches were scrubbed of any mention of these matters, even when his comments were based on science.

The former surgeon general also said that he was told by an unnamed senior Bush administration official that he didn’t “get it” when it came to the political basis for scientific reports, which had to agree with the administration's political agenda or they would not be approved. Two other former surgeons general—C. Everett Koop, from the Reagan years, and David Satcher, from the Clinton presidency—also testified and cited similar examples from their own tenures. They said, however, that the censorship seemed to be getting worse.

The testimony brought a swift response from the Bush administration and from Washington’s punditocracy. The administration dismissed Carmona’s charges, saying that it had given him all the support and opportunities he needed and that it was disappointing “if he failed to use his position to the fullest extent.” The pundits either praised him for coming forward with his story or questioned his courage for waiting until he had left office before speaking out.

Carmona’s general accusations became more specific at the end of July, when the Washington Post said in a front page story that one of the reports Carmona was complaining about was a 2006 global health study. It was never released, because Carmona would not make political changes demanded by a Bush official named William Steiger. A godson of the first
President Bush, Steiger had no medical or public health background when he was appointed director of the government’s Office of Global Health Affairs. (He still occupies this post while he awaits Senate confirmation as ambassador to Mozambique.) It is common practice for presidents to appoint well-connected but inexperienced allies to key policy posts. Although they can be depended on to follow the president’s political agenda, they often have little or no substantive knowledge about the agencies they administer.

Steiger maintained that the global health report should focus mainly on the steps that the Bush administration had taken to improve health worldwide. Carmona wanted to release a version drafted by international health experts that reviewed the links between poverty and ill health and advocated that disease prevention and treatment become a part of the US’s foreign policy. When Steiger wouldn’t approve this report, which he called “often inaccurate and out of date,” and Carmona refused to release the administration’s version, the report was cancelled.

The Bush administration seems more likely than most to suppress scientific information to further political ideology, with recent complaints surfacing from disgruntled employees at the National Institutes of Health, the Food and Drug Administration, and NASA. Such meddling happens in all administrations, though, and it raises two issues that transcend administration and subject matter: what happens when an official disagrees with an announced policy, and what to do when scientific expertise is disregarded and evidence is manipulated or ignored.

In the first of these, the traditional advice to political appointees has been to advocate for their opinions strongly in private discussions but support whatever policy eventually emerges. A well-known example of this was when President Clinton’s Health and Human Services Secretary, Donna Shalala, strongly disagreed with making a major change in welfare payment policy that would result in many people being thrown off the welfare lists. But when the president endorsed it she went along publicly, despite opposition from her liberal constituency. Most now agree that it was, on balance, an important and successful reform.

The second issue is trickier. Carmona complained that political ideology was trumping science when, for instance, he was not allowed to advocate any type of sex education for young people except abstinence, even though
Conflicts in office

scientific reviews showed clearly that abstinence-only sex education does not work well. It was reminiscent of an episode in the Reagan administration when then Surgeon General Koop was ordered to prepare a report on the adverse psychological effects of abortion. After reviewing the literature, Koop refused, saying that he had found none. As a conservative surgeon whose appointment was opposed by liberals, he had enough stature and support to weather that particular storm.

Clearly a presidential administration should be allowed to attempt to set its agenda, to focus on what it thinks are important issues, and to prioritize. It also, of course, has a right to tout its accomplishments and take credit for even the serendipitous achievements that have taken place during its tenure. When, however, administration officials knowingly cite inaccurate or misleading information or bend the rules of science or evidence in pursuit of a political agenda or policy, it is a different matter entirely. That is the time for honorable government employees—whether career status or political appointees—who are unable to convince the administration to desist from such distortions to call attention to them in the only way they can: resignation.
What the candidates fail to mention

Primary care is nowhere to be seen, either as a problem or a solution

Although the Iraq war and, more recently, the sad state of the economy have dominated the political campaign for US president, health care problems have continued to be cited by voters as a big concern. Each candidate has a retinue of health care advisers, and their websites are full of position papers and multi-point plans on this topic.

Everyone agrees about the nature of the problem. Health care now consumes 16 percent of the US gross domestic product, and costs continue to climb. We spent about $7,000 per person on health care in 2006, over $2 trillion in all. Around 45 million Americans have no health insurance for at least part of the year. The population is aging. We baby boomers, who expect and consume lots of health care, are now beginning to turn 65. We are going to be a big problem.

But despite all of the money we spend on high-tech medicine, the US is consistently near the bottom of rankings of health care outcomes in developed countries. There are continuing concerns about the quality of health care and medical errors. While most patients like their doctors, they are grossly dissatisfied with the US health care system.

The candidates also more or less agree on many changes that are needed to fix things: an increased focus on preventive medicine, wider use of computerized medical records to decrease errors and improve care, more information for patients, and improved care and coordination for people with chronic diseases.

The candidates differ, though, on the organizing principles behind their prescriptions for change. The Republicans tend to focus on cutting costs and increasing patient choice and control over their health care, usually through some type of market-based solution where people can choose their own privately sponsored insurance. Democrats are for cutting costs too, but they give more attention in their plans to providing insurance coverage for everyone (or almost everyone) as a way to improve health and health care.
Unless I am missing something, however, all of the major candidates omit a major issue from their discussions and proposals. My web search of the health care platforms of the candidates failed to find a single mention of the term “primary care.” Does no one realize that the current woeful state of primary care medicine in the US is both a likely cause of many of our problems as well a potential solution for them?

The advantages of a strong primary care infrastructure have been well documented in studies around the world. Where there is good primary care, patients have reduced mortality and better outcomes from cardiovascular and pulmonary diseases. They are hospitalized less frequently and use emergency services more appropriately. Strong primary care systems are associated with better delivery of preventive services and better detection of breast, cervical, and colorectal cancers. Patient satisfaction is better in primary care patients. Medical care delivered by primary care clinicians is less costly, with less testing and comparable outcomes. In areas of income inequality, increased primary care services are associated with reduced health disparities.

All of which argues that the US should have a vigorous primary care system. But in fact, primary care in the US is in crisis, and things are getting worse. Currently, primary care doctors, which in the US include general internists and general pediatricians as well as family physicians, comprise about 35 percent of the US medical workforce, compared to 50 percent or more in most industrialized countries. The number of US medical students choosing family medicine residencies decreased by half in the past 10 years, as did the proportion of internal medicine residents who planned careers in primary care instead of a subspecialty. So not only are there too few American primary care doctors, but their numbers are likely to decrease in the foreseeable future.

This is not surprising, given that the median income of primary care doctors in the US is only slightly more than half of that of subspecialists. Graduating internists who go into primary care can expect to earn at most half of what their medical subspecialty colleagues make. Primary care doctors see more patients than subspecialists, and yet their income, adjusted for inflation, declined by 10 percent from 1995 to 2002.

What will it take to reverse these trends? What can the presidential candidates propose that would make a difference? Much of the needed
reform is financial. Primary care doctors should be paid more. Care that is continuous and coordinated should be rewarded. Health-related counseling and other time-intensive but low-tech services should be reimbursed generously.

Subsidies could be used to increase student incentives to enter primary care training programs. Similar incentives could be provided to medical schools and hospitals to partially offset trainee salaries. Loan forgiveness programs for primary care doctors would make higher paying subspecialties less attractive and ease young doctors’ transition into primary care practice. Finally, the practice of primary care medicine should be improved by providing increased support for preventive care, better reimbursement for nontraditional service provision (such as group and e-mail care), and more incentives for health care delivery by primary care teams.

Primary care medicine is a crucial missing piece of the health care puzzle. It needs to be a part of the proposals of all the presidential candidates.
A cautionary tale for the presidential candidates

A look back at the Bush administration’s record on health

With the US economy in shambles, it is hard for the presidential candidates to talk about anything else. The small amount of newsprint and bandwidth available for other issues is devoted to Iraq, Afghanistan, and terrorism. Nobody is focusing much on health care and science policy any more. When health care is discussed, it is mainly about coverage and cost: how can we change our health care “system” to take care of more of our population and afford to pay for it? Pundits proclaim that health care reform will be unachievable in the next president’s first term because there is no money to do it and no energy for anything but the economy and the war. This is depressing.

One thing that doesn’t depend on funding, however, could be done immediately by the next president: reverse the unprecedented policies of George W. Bush’s administration that have subverted scientific integrity throughout the government.

The Union of Concerned Scientists has documented dozens of examples over the past eight years of direct interference with government scientists and their work in the service of the administration’s political beliefs and goals. The examples range across the scientific agencies of the government and cover topics from the environment to pollution and contamination to national security. Examples from public health include

- Insisting on and publicizing the effectiveness of abstinence-only sex education, despite a lack of evidence for it,
- Censoring testimony before Congress by the Centers for Disease Control and Prevention (CDC) on the health hazards of climate change,
- Posting erroneous data linking abortions and breast cancer on CDC’s website,
- Distorting evidence on the effectiveness of condoms in preventing HIV transmission and prevention,
- “Stacking” a federal advisory committee on prevention of lead poisoning to prevent more stringent standards, and
- Adding non-scientific proponents of positions favored by the administration to sessions at scientific meetings, in the guise of providing “balance.”

Every incoming president has a political agenda that he wants to promote throughout the government, the nation, and the world. For example, it was no secret that Bush was against abortion. When he took office in 2001, he immediately ended support for all foreign aid to family planning clinics that counseled patients on abortion as an option, even if the funds for abortions were not supplied by the US aid. One can argue (and I believe) that this was a harmful action that should not have been done, but it was at least presented honestly as a policy decision, not a scientific one. People who were against it could lobby for its reversal, and those who voted for Bush could see clearly that this was a direct result of their vote for his anti-abortion views.

Similarly, all administrations want to present their accomplishments in the best possible light. So it is not surprising that they would prefer that all their policy interventions work, that all health trends be positive, and that good news be the only kind of news that emerges. It is also expected that they will try to put the best possible “spin” on results that are not positive. Spin, however, is not the same as distorting science in the service of politics.

A case in point is the delay in approval by the Food and Drug Administration (FDA) of over-the-counter sales of the emergency contraceptive Plan B. Despite overwhelming evidence of the drug’s safety and effectiveness, the FDA delayed approval for more than 3 years from the time its own advisory committee recommended it by a vote of 23 to 4, officially citing concerns about skimpy data on 14- to 16-year-olds. In fact, the concern was the widely publicized but inaccurate “fact” that Plan B worked by preventing implantation and thus caused abortions.

The Bush administration’s attack on scientific truth has not been limited to contraception and abortion. It refused to publish scientific evidence of the extent of racial disparities in health outcomes and health care in the United States that were assembled by government scientists for a congressionally
mandated report. It repeatedly allowed bogus “science” to be presented by special interest groups to “balance” discussions and to delay and sometimes reverse environmental health decisions supported by valid evidence. It prevented its own surgeon general from speaking out on topics in the areas of mental health, global health, and secondhand smoking. It rigged testing and fudged results of formaldehyde level testing in government-supplied trailer homes for victims of Hurricane Katrina. And it fired or did not reappoint members of dozens of federal advisory committees who did not agree with Bush's views. Friends and former colleagues throughout the government have told me that the extent of falsification and suppression of scientific evidence by this administration is unprecedented.

So what should a President McCain or Obama do about all this? During his first week in office the new president could issue an executive order supporting unimpeded scientific research, the primacy of peer review, and the freedom of government scientists to submit their research results for publication. He could pledge not to interfere with the scientific processes and activities of government agencies. And he could encourage transparency and public scrutiny of appointment procedures of advisory and review committees. This is a low-cost policy change that has a good chance of improving the health of all Americans.
What should the surgeon general do?

Sanjay Gupta is a television star—but the problem lies elsewhere

As I write this, it is being widely reported that the neurosurgeon Sanjay Gupta, who is also a medical correspondent for CNN and CBS, is the leading candidate to be appointed surgeon general by the president-elect, Barack Obama. I have nothing against Gupta, who I am sure is a fine neurosurgeon, specializing (according to his biography) in “complicated spine, trauma and 3-D image-guided operations.” He is also a skilled television medical correspondent. His potential appointment, however, raises two important issues about the role of what everyone calls the “surgeon general of the United States.”

The first is that the surgeon general is actually statutorily only the surgeon general of the Commissioned Corps of the US Public Health Service. The corps comprises more than 6,000 uniformed officers who work in public health positions throughout the federal government and on assignment in public health agencies around the nation and the world. It is not clear what qualifies a neurosurgeon with no public health background to lead this uniformed service.

Second, and more importantly, I am concerned at reports that Gupta has been offered a major role in the White House Office of Health Reform, working with the Health and Human Services secretary-designate, Tom Daschle, to create and pass health care reform legislation. If this is true, it reflects a fundamental misunderstanding by the Obama administration of the role—and potential contributions—of the surgeon general.

We certainly need health care reform in the US, and it is good news that the Obama administration is going to make it a priority issue. It will be, however, a contentious, highly political struggle. If Gupta, with his background in the Clinton administration and his communication skills, wants to work on changing the US health care system, that’s great. The president should appoint him to the White House staff or make him the assistant secretary for health and let him go at it. But not surgeon general.
What should the surgeon general do?

The most important traditional role for the surgeon general, the one that the nation knows about, is not the statutory one. It is to provide impartial, independent, evidence-based advice to the president and the country about health and disease. This is the reason that everyone thinks of him or her as the “nation’s chief doctor.” If the surgeon general is seen as just another adviser to the president or as an administration spokesperson on health, the result is a huge loss of credibility and effectiveness.

There are many recent examples of surgeons general successfully taking on this role. The most notable was Luther Terry, who issued a landmark report in 1964 that unequivocally linked smoking and cancer. This came at a time when almost half of American adults smoked. Terry later recalled that he chose a Saturday for the press release of his report, to minimize the effect on the stock market and to maximize coverage in the Sunday papers. The report “hit the country like a bombshell” and was “front page news and a lead story on every radio and television station in the United States and many abroad.”

Another example was C. Everett Koop’s courageous insistence in 1986 on reporting the facts about how HIV infection is spread. Despite concerns from both conservatives in the Reagan administration and gay rights activists on the left, Koop graphically described what was known about risky sexual behavior to all Americans. He sent a mailing on AIDS to every household in the country.

And, in 1999, Surgeon General David Satcher issued an important report on mental illness in America that documented the disparities in health care and coverage for people with mental disorders. Only last year were these issues finally addressed, with congressional passage of the Mental Health Parity Act of 2008, mandating equal insurance coverage for treatment of mental disorders.

These and other crucial public health achievements could never have been accomplished if the surgeon general had been just another member of the president’s political team, trying to get his programs passed. This is why the surgeon general’s appointment is for a fixed term of 4 years, which does not necessarily coincide with the term of the president and his other appointees. The surgeon general must be independent and not identified with any of the president’s personal agenda. The easiest way to do this would be for Obama to appoint a current senior career officer in the Public Health
Service to be surgeon general, just as career officers are appointed to be the surgeons general of the US Army, Navy, and Air Force.

The argument for Gupta’s appointment is, of course, that he already has a national following that would allow him to stand up to political attempts to silence him. But if the Obama administration does wish to appoint Gupta, it should first decide whether it wants him to be their front man for health care reform—which I’m sure he could do very capably—or whether it wants him to do something else entirely: to be the surgeon general of the United States.
The taxing case of Tom Daschle

A lesson for the new president, perhaps with wide ranging consequences

The former US senator Tom Daschle seemed like the perfect candidate to lead President Obama’s effort for health care reform and to serve as his Health and Human Services secretary. As a former Senate majority leader, Daschle knew both the players and the processes necessary to get legislation through Congress. He coauthored a book on health care reform and was passionately interested in the topic. As one of Obama’s earliest supporters and advisers, he was likely to have the president’s confidence and attention. Daschle had led the Obama health transition team since the election; conducted numerous discussion sessions with citizens and experts on health care reform during the interregnum; and was awaiting Senate confirmation.

Yet, in a stunning reversal of fortune, this consummate insider felt it necessary to withdraw his name from consideration just days before he was likely to be confirmed by the Senate and sworn in. What happened and what does it mean for the president’s agenda in general and health care reform in particular?

After being defeated by the Republicans for re-election in 2004, Daschle left the Senate but not Washington. Though not a lawyer, he joined the law and lobbying firm Alston and Bird and provided advice to clients about how to deal with Congress. His advice and connections were apparently enough to earn him a seven-figure salary. He also traveled the country, giving speeches to dozens of organizations that were happy to pay him $10,000 or more to hear his opinions on policy matters. In addition, Daschle advised an investment fund, which also paid him well and provided him with a car and driver. A standard career after federal service for senior legislators who, like the missionaries in Hawaii, came to do good and did well.

It is a bit unfair to paint the former senator as a money hungry sell-out, though. He also served as an unpaid fellow at the Center for American Progress, a liberal think tank, where he collaborated with staff there on his health care reform book. He was a visiting fellow at Georgetown University’s
Public Policy Institute, where he conducted a popular series of policy seminars with visiting Washington luminaries. Plus, he was careful not to actually lobby his former Senate colleagues by going back to Capitol Hill and importuning them on behalf of his clients.

All was going swimmingly until it was announced that Daschle had not paid taxes on the value of the car and driver that had been supplied to him and thus owed over $100,000 in back taxes, penalties, and interest. He paid up just before he was to appear before various Senate committees for questioning. In the context of similar tax delinquencies uncovered in two other senior Obama appointees, this led to strong criticism from the press, Republicans, and some Democrats. It seemed contradictory both to the ethical positions that Obama had campaigned on and the restrictions against hiring former lobbyists he had imposed on himself. Indeed, many felt that the published list of health-related organizations that had paid hundreds of thousands of dollars to hear Daschle speak was more damaging to his candidacy than the unpaid taxes. In response to the criticism, and despite still being likely to be confirmed, Daschle withdrew his name from consideration, some say only a step ahead of a request from Obama to do so.

Then, in a truly remarkable reaction to this problem, Obama took the offensive and used five different previously scheduled prime-time television interviews to apologize and take responsibility for the mistake of appointing Daschle. “I screwed up,” he said, in a shocking admission for any president to make. You cannot imagine either of his two predecessors voluntarily owning up to an error of this sort.

Which leads to the most important question about all of this: What will be the fallout? Narrowly, most commentators feel that Daschle will be hard to replace as the leader of Obama’s health reform effort. His combination of policy knowledge and political skill was close to unique. It will likely delay the initiative by weeks if not months, and it may threaten it altogether.

There may also be broader implications, in two areas. First, the Daschle debacle may affect the selection process for future senior appointees, both assuring that they are not tax delinquents but more importantly by shining a light on their former financial dealings with the industries they will be regulating. It would be more than a small victory if in the future the Washington revolving door didn’t spin quite so quickly or effortlessly.
Second, it is interesting to speculate about the effect of this episode on the very young presidency of Barack Obama. To the extent it delays or prevents health care reform, its effect is negative. To the extent that admitting a mistake casts the president as inexperienced and incompetent, its effect is very negative. Another way to look at it, however, is that it is rather refreshing and even admirable to see a president struggling to act consistently with his professed ideals and admitting when he comes up short.
The papal position on condoms and HIV
It would be a blessing if Benedict XVI could stop advocating policies that endanger health

When I was 6 years old or so I used to go through my father’s top dresser drawer looking for pennies. One day I found a strange rubber balloon wrapped in foil. I didn’t know what it was and didn’t recognize the big word printed on the outside of the wrapper: “prophylactic” (this was the genteel 1950s). An inquisitive child, I looked it up in the dictionary and found out that the word meant “acting to defend or prevent something, especially a disease.” I idly wondered what disease my father was trying to prevent with this balloon but soon lost interest.

I thought of this memory when I read about Pope Benedict XVI’s recent comments about the use of condoms to prevent HIV transmission. As I write this, news accounts of his recent trip to Africa have been dominated by reactions to comments he made as he was flying there from Rome. He was quoted as saying that AIDS “can’t be resolved with the distribution of condoms.” “On the contrary,” he said, “it increases the problem.” Health officials and editorialists around the world have strongly objected to the pope’s statement, but I think that there is more to the story than just correcting his facts.

It is no surprise, of course, that the pope is against the use of condoms and supports sexual abstinence as the best way to prevent the spread of HIV. He rejects condom use as part of the Catholic Church’s position against what it terms “artificial contraception.” As many have already pointed out, however, the pope was just plain wrong when he said that condoms make the AIDS problem worse.

Many studies done around the world, including in Africa, have found that condom use can decrease the risk of HIV transmission by about 80 percent—not perfect, by any means, but an effective strategy. For instance, analyses have shown that the famous “ABC” (abstain, be faithful, condom use) program in Uganda, which was successful in decreasing the number of new cases of AIDS, probably owed most of its effectiveness to greater use of condoms.
A second concern is the pope's position that fidelity within and abstinence outside marriage obviates the need for condoms to prevent the spread of HIV. While such behavior—though difficult to attain—would certainly help, this position ignores the reality of family life in sub-Saharan Africa. There, much of the spread of HIV occurs within, not outside, marriages, from infected husbands having unprotected sex with their wives. If condoms are not available, these women are forced to make the impossible choice between refusing to have sex with their husbands (and risking abuse) or consenting to sex (and risking HIV infection).

Some argue that critics of the Catholic Church's position on condom use are wrong when they say that it will be likely to lead to a greater spread of HIV. They say that anyone observant enough to follow the church's teachings on condoms will also adhere to its policies on sexual abstinence before and fidelity within marriage. I'm not sure where the evidence for this position comes from; I can't imagine that many Catholics are any different from many Jews or Muslims in selective observance of commandments. Furthermore, this position completely ignores the pope's influence on non-Catholic Christians and others.

Others state that if Catholic rules about condom use were an independent risk factor, then African countries with a higher proportion of Catholics would have higher HIV infection rates, which they don't. We know, however, that correlations, or the lack of correlations, cannot be accepted as arguments for or against causality. In addition, this view certainly discounts the hugely important effect of the many wonderful Catholic missionaries who provide health care and social services throughout Africa and the developing world, regardless of the local religions, and who cannot advocate condom use.

One possible approach to the seemingly irresolvable conflict between condoms and religious dictums might be to separate the disease prevention attributes of condoms from their contraceptive effect. There is precedent for this, at least in the United States. Many Catholic hospitals and doctors here prescribe oral contraceptives to women not to prevent pregnancy but instead to prevent heavy, painful periods. Would it be too much of a stretch to imagine the Catholic Church tacitly condoning condom use as part of an overall disease prevention program to decrease the spread of HIV, even if only within marriages?
That is where my childhood memory kicks in. We could advocate using prophylactics in the dictionary sense of the word I learned when I was 6—preventing disease instead of babies.

The pope’s job is to be the spiritual leader of the world’s Catholics. It would be a true blessing if he could do that without advocating policies that endanger the health of some of the world’s neediest people.
The case of the sugar-sweetened beverage tax

A cautionary tale of political influence

We are fat, and we’re getting fatter. Nearly a third of American children are overweight or obese. In our inner cities a prevalence of obesity of more than 50 percent among both children and adults is not uncommon. Too many calories in, too little energy out.

Changing behavior is hard. Obesity has several causes, and it will take a multifaceted campaign to reverse the trend. The tobacco experience has taught us that education is not enough; regulation, litigation, and legislation are needed, too. Increasing taxes on cigarettes has been the single most effective strategy in reducing smoking.

Which brings us to the sad story of the tax on sugar sweetened beverages (SSBs).

An important part of the obesity story is clearly the huge increase in consumption of SSBs: carbonated sodas, sweet teas, energy drinks, flavored water, and sports drinks. Their use has more than doubled in recent years, and of all food types they are the single largest contributor to energy intake in the United States.

Especially perniciously, SSBs have essentially no effect on satiety, research shows, unlike candy or other junk food. Our bodies seem not to sense the empty calories we’re swallowing and to count them toward feeling full. Gobble some jelly beans and you feel like you’ve had something to eat. Drink a cola drink—no such feeling. Add in the fact that the price of SSBs has actually fallen after adjustment for inflation and you have the makings of a big problem.

Experts have been agitating for a “penny per ounce” tax on SSBs for about 2 years. An excise tax imposed at the wholesale level has several advantages over a percentage sales tax collected at the cash register after the purchases have been totaled. Because it is imposed at the wholesale level, an excise tax is easier to implement. It is then passed on to the consumer in higher retail prices, allowing price sensitivity to work its magic. Also, it produces the same tax on a discounted generic soda as on a brand name drink. Thus,
rather than driving people to purchase cheaper products or larger serving sizes to get a better price, as a sales tax does, excise taxes can actually reduce consumption. What amounts to about a 10 percent tax will likely lead to an 8–10 percent reduction in consumption.

Just as with tobacco products, we especially want to discourage young people from buying and consuming SSBs, and the young are notoriously price-sensitive. Poor people, who are disproportionately obese, are the most price sensitive of all in food shopping.

Simple sales taxes have been shown not to work. They don't change behavior or weight. The best chance for success is to impose a penny per ounce SSB tax, resulting in a rise of a dollar or two in the price of a six-pack of sodas or a 2 liter bottle. Pilot studies and some early research have found promising decreases in consumption and even positive health outcomes from such pricing strategies. Public opinion polls have found that most people are in favor of such taxes. It seems like a pretty good public health strategy.

Needless to say, SSB manufacturers and retailers did not think these taxes were a very good idea at all. This was a threat they would beat back at any cost.

The industry's response to proposed SSB taxes has been swift and massive. In cities and states where SSB taxes have been proposed, industry-financed “grassroots” organizations sprang up out of nowhere. They had names like “New Yorkers Against Unfair Taxes” and “NoDCBevTax.com.” Their websites listed dozens of ordinary citizens and small mom-and-pop stores as members, masking the source of their funding: the major soft drink companies and retailers.

In New York State, projections found that a penny per ounce tax on SSBs could prevent 145,000 cases of adult obesity and 37,000 cases of diabetes in a decade. It could save $2 billion in health care costs. To fight the tax, SSB manufacturers paid $90 million to the same public relations firm that created the famed “Harry and Louise” advertisements against US health reform in the 1990s. Their signature New York TV spot showed a housewife urging viewers to “tell Albany to trim their budget fat and leave our groceries alone.” The governor withdrew his tax proposal.

Washington, DC, was another battleground: a liberal, black-majority city with chronically underperforming schools and a large budget deficit.
A city council member proposed a penny per ounce SSB tax to decrease obesity and fund better school food and exercise programs. Immediately, we heard insulting but effective radio advertisements with stereotyped African American voices saying that “soda’s ’bout to git waaay more expensive” because of unfair taxes. It wasn’t even a close contest. The city council chairman never called for a vote on the proposal.

The story was the same around the US. In many cities and states, proposals were withdrawn in the face of “public” protest and petitions. In others, excise taxes were converted to ineffective sales taxes. Public health was outgunned and outspent. SSBs are still safe for all to buy and enjoy at record low prices.

As the mayor of Philadelphia said about the victory of the beverage lobby’s campaign, “They’re successful the old-fashioned way. They pay for it.”
Smoking or obesity: must we target only one?

Funds for anti-obesity campaigns increase while tobacco programs languish

In a landmark article published almost 20 years ago, McGinnis and Foege showed that the actual leading causes of death in the United States were not cardiovascular disease and cancer, which had long led the “leading causes” rankings calculated from death certificate analyses. Using data cobbled together from a number of sources, they estimated that smoking, with 400,000 deaths a year, and diseases related to diet and lack of physical activity, with 300,000 deaths, were in fact the leading killers of Americans. Together they caused about a third of all deaths in 1990.

The headlines then were all about how smoking was at the top of the list and that almost half of that year’s deaths were a result of it and other preventable, behavior-related causes. Many people were also surprised at the huge toll taken by poor diet and lack of physical activity, but it wasn’t a focus of discussion.

The intervening decades have been a terrific success story for anti-tobacco efforts. As a result of an effective, multi-tiered campaign, including higher taxes on tobacco, bans on smoking indoors, targeted counter-marketing, cessation help lines, drugs, and counseling, the prevalence of smoking in the has fallen to around 20 percent in American adults—less than half what it was in 1955.

The past few years have seen increasing attention on another public health problem: obesity. It has threatened to dethrone tobacco as the number one public health catastrophe in the making. Indeed, a redo of the McGinnis and Foege analysis 10 years later found that, while tobacco was still in the lead in 2000, with 435,000 attributed deaths, diet and activity (largely obesity-related) deaths had risen to 365,000 a year. The authors cautioned that “poor diet and physical inactivity may soon overtake tobacco as the leading cause of death.”

Obesity is a huge problem that is probably getting worse. The prevalence of childhood obesity has tripled among school-age children and adolescents
since 1980, and more than 70 million US adults are now obese. Obese adults and children have an increased risk of several chronic diseases and incur dramatically increased health care costs.

The anti-tobacco strategies were not lost on those trying to combat obesity. The same multi-focal approach that worked so well for smokers is being applied to obesity. Interventions currently under way range from regulatory to legislative to clinical. In fact, public health attention and funding have now tilted toward obesity. A recent iconic photo of the first lady, Michelle Obama, says it all. She was shown on the south lawn of the White House vigorously exercising with a group of kids at the kick-off of her anti-obesity “Let’s move!” campaign. Needless to say, no similar anti-tobacco campaign is being led by her reportedly still-smoking husband.

A recent article in the *New York Times* described how public health funding, from both government and private sources, has shifted from tobacco to obesity in the US. The country’s largest health charity, the Robert Wood Johnson Foundation, which funded many of the tobacco policy initiatives that have been so successful, has now decreased its anti-tobacco funding in favor of a $500 million anti-obesity campaign. Federal stimulus money earmarked for prevention has funded both tobacco and obesity efforts, but recently obesity programs have received more than tobacco. States have had to cut their budgets and have decreased spending on tobacco. All of this has preventionistas like me worried. How do we decide whether to fund anti-tobacco or anti-obesity campaigns?

On the one hand, while tobacco control programs have been a poster child for success, the war is not over. The downward trend in smoking seems to have stalled; prevalence has hovered around 20 percent since 2006. Some 450,000 Americans still die each year from tobacco-related illness, and more than 8 million are sick or disabled because of it. Further, smoking and smoking-related diseases are now more than ever a class phenomenon. More vulnerable people smoke, including poor people, many ethnic minority groups, and people with chronic mental illnesses. Don’t forget that the tobacco companies are still out there pitching, trying to recruit new smokers to replace those who die or quit.

On the other hand, at least trends in smoking have long been going in the right direction. The obesity problem seems to be getting worse. Also, anti-tobacco efforts have a new champion now that the Food and Drug
Administration has regulatory authority over tobacco and a new office and staff to make and enforce its rules.

One big test for federal funding will come as the new Affordable Care Act (health care reform) goes into effect. One provision of the law calls for increasingly large amounts of public funding for public health and prevention, starting with $500 million in 2010 and rising to $1 billion a year by 2012. How much of this investment, totaling $15 billion, will go to anti-obesity efforts and how much to tobacco?

The lobbyists are lining up, but in this case they are all lobbyists for the “good guys.” Maybe there will be enough money to go around for both worthy causes. Funding to combat the two leading causes of death in America—whatever their rank order—should not have to be a zero-sum game.
Guns don’t kill crowds, people with semiautomatics do

Why can’t we do a better job of protecting society from this type of attack?

Once again in the United States, a seriously mentally ill man is suspected of mowing down a crowd before he can be wrestled to the ground.

This time the victims included a congresswoman and a federal judge. A wave of shock spread across the country and around the world. Liberals blamed the mood of the country and violent rhetoric from conservative leaders. Conservatives howled with injustice and attacked the liberals for attacking them.

The handgun used for the attack was a Glock 19, a lightweight, compact, semiautomatic pistol that comes with a standard magazine holding 15 bullets of 9 mm caliber. Glock pistols have become the overwhelming choice of police departments around the world because of their light polymer construction and their ease of firing. They are called “semiautomatic” guns because, unlike revolvers that have one bullet per chamber, all the bullets can be fired by simply squeezing and re-squeezing the trigger. Jared Loughner, the alleged gunman, had legally purchased this weapon in November, along with an extended capacity magazine that allowed him to fire 33 times without stopping to reload.

Loughner, 22, was clearly mentally ill. Press reports after the event have documented a mind unraveling and descending into madness over the previous year. He lost his friends. He had repeated run-ins with school authorities. He disrupted his college classes, and classmates sat next to the door, fearing that he might get violent. He posted bizarre theories and claims on Internet sites, leading one regular poster to label him as having schizophrenia and to plead with him to get help or start taking his medications again. He had several encounters with the police, including one on the day of the shooting. But no one made a formal complaint, and Loughner never received a psychiatric evaluation.

Ever responsive, the US Congress immediately sprang into action to fix the problem. One congressman introduced legislation making it a crime
to carry a gun within 1,000 feet of a member of Congress. Laughably unenforceable, patently self-protectionist, and just plain silly, it seemed the perfect response to the tragedy. In fact, no legislation is likely to be passed in response to this event.

The second amendment to the US Constitution states that “the right of the people to keep and bear arms shall not be infringed.” Americans, with the exception of some pockets of opposition on the two coasts, believe that citizens have a right to own and carry guns. Apparently most of us like having guns around, and there is no chance that any laws will be passed to limit access to them significantly. No amount of handgun-related violence and no high-profile killings will change this.

Three years ago a similarly deranged young man, Seung-Hui Cho, killed 32 fellow students at a Virginia university. He used a Glock 19 as well. His rampage did lead to changes in state and national laws to make it more difficult for mentally ill people to buy guns. Unfortunately such restrictions work only if a person is in the mental health system, and Loughner never made it that far.

We are told that guns don't kill people, that people kill people, and that what we have here is a failure of the mental health treatment system, not the legal system. But in order to kill a lot of people fast before being stopped, even crazy people need access to guns that are easy to fire and have lots of bullets in them.

I don't think the problem is the mood of the country or who was placed in Sarah Palin's cross-hairs in her campaign literature. There will always be seriously disturbed individuals out there who, because of our country's history and experience, will have a chance to access guns. Given that we have no realistic chance of banning handguns, if we have any hope of preventing such future tragedies there are only two things we can do.

First, we need to prevent the sale of equipment that facilitates such easy carnage: high-capacity magazines for easily concealed guns. What is the purpose of a 33-shot magazine for a Glock? Who needs to fire 33 times without reloading? If Loughner had had a revolver instead of a 33-shot Glock he would have succeeded in shooting his target but probably not many more people. Cho would have had to stop to reload more often and likely could have been stopped short of killing 32 others.
Second, it must be made clear that it is everyone’s job to report obviously disturbed people and get them into treatment. Neither Loughner nor Cho was a close call. Many people sensed that they were dangers to themselves and others. If someone had stepped up and reported Loughner, he might have had a paper trail that would have prevented him from buying his gun.

Guns don’t kill crowds, but mentally disturbed people with high capacity semiautomatic pistols do.
The rise and likely fall of Don Berwick

What can be learned from this appointment disappointment at Medicare?

Democrats have given up hope of saving Donald Berwick, the current director of the influential and costly US Medicare and Medicaid health insurance programs. He will now likely lose his job at the end of the year. It is a disturbing and discouraging development, worth reviewing for possible lessons learned.

The Centers for Medicare & Medicaid Services (officially abbreviated, incorrectly, as CMS) is the proverbial 800 pound gorilla of US health care. Its Medicare program pays for care for most Americans aged 65 and older, and its state-based Medicaid program covers uninsured poor people. More than 100 million Americans have CMS-administered insurance. The administration asked Congress for just under $850 billion to fund CMS next year, and its programs are growing as Americans age and more of the poor are covered under health reform’s Affordable Care Act.

In addition to its direct role in paying hospitals and doctors for care, CMS has a huge influence on private-sector insurance as well. Because of its size, CMS sets standards for coverage policies and payment levels that are almost universally adopted (or at least adapted) by private health plans and insurance companies. So the head of CMS—in government-speak, the administrator—is a key position indeed.

Soon after his election in 2008, President Obama made many key health sector appointments, but he chose not to appoint a CMS administrator. Once health reform passed last March it became even more vital to have someone running CMS. Finally, a month later, Obama nominated Berwick to be CMS administrator.

It is hard to imagine a more inspiring, exciting, and forward-looking nominee than Don Berwick, a pediatrician who has spent much of his career focusing on improving the quality and safety of health care. His experience in improving quality and safety in hospitals and medical practices would seem to be exactly what the huge federal systems needed, not to mention
his charismatic leadership style. I first met and worked with Don in the early 1990s, when he was vice-chair of the US Preventive Services Task Force. It was clear then that he was a brilliant thinker and a dynamic, even inspirational, leader. He went on to found and lead the Institute for Healthcare Improvement, a private, not-for-profit organization that works with hospitals, health systems, and practices to find measurable ways to improve quality and safety and cut waste and needless expense. He also co-authored two hugely influential reports from the US Institute of Medicine, *To Err is Human* and *Crossing the Quality Chasm*.

Senate confirmation is required for appointments at this level, but the necessary hearings for Berwick were never scheduled. The administration blamed Congress, saying that they had delayed considering the appointment for political reasons. Not at all, responded Congress, blaming the administration and Berwick for dragging their feet in providing necessary background information. The nomination went nowhere.

In July, tired of waiting, the president bypassed the Senate’s confirmation powers by using a mechanism called a “recess appointment” to install Berwick as CMS administrator unilaterally. This loophole, roundly condemned and yet widely used by all presidents, was designed to keep the government running during long periods in which the Congress was not in session. Obama appointed Berwick during the week-long July 4th break, hardly meeting the intent of a recess appointment.

Republicans were incensed, and even many Democrats were disappointed that they did not have a chance to question Berwick before he took office. It is easy to find quotes from his long career that upset conservative free-market Republicans, including discussions of how the US already rations health care and praise for the many accomplishments of the United Kingdom’s National Health Service.

Recess appointments expire with the end of a 2-year congressional session, in this case December 2011. Presumably the administration hoped that Berwick could mend fences with enough Republicans to allow him to be renominated and (this time) properly confirmed by the Senate before then. It hasn’t happened. On March 1, 42 Republican Senators wrote Obama to urge him to withdraw Berwick’s renomination because of the way he was appointed the first time, the now-expanded role of CMS under health reform, and his “lack of experience” and prior “controversial statements.”
How could this have happened? A visionary nominee, thought by many to be one of Obama’s best appointments, who was endorsed by medical organizations, public health leaders, hospitals, and virtually everyone else in organized health care, is going to be scuttled after 18 months in office.

Perhaps it could not have been avoided, as the poisonous atmosphere between Republicans and Democrats seems to intrude at every level, especially where health care reform is concerned and given the many new “Tea Party” members of Congress. Maybe, however, the president should not have waited until reform had passed to name his CMS leader, and maybe he should not have used the recess appointment to install him without hearings. It might have taken longer to get him into office, but perhaps Berwick would have ended up with more time—more than the 18 months he will likely have—to make the changes he needs and wants to make in the US health care system.

As the Washington Post pundit Ezra Klein said, both Berwick and the Medicare and Medicaid recipients he could have helped deserved better than this.