CRISIS, LEADERSHIP, CONSENSUS: THE PAST AND FUTURE FEDERAL ROLE IN HEALTH

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ABSTRACT This paper touches on patterns of federal government involvement in the health sector since the late 18th century to the present and speculates on its role in the early decades of the 21st century. Throughout the history of the US, government involvement in the health sector came only in the face of crisis, only when there was widespread consensus, and only through sustained leadership. One of the first health-related acts of Congress came about as a matter of interstate commerce regarding the dilemma as to what to do about treating merchant seamen who had no affiliation with any state. Further federal actions were implemented to address epidemics, such as from yellow fever, that traveled from state to state through commercial ships. Each federal action was met with concern and resistance from states' rights advocates, who asserted that the health of the public was best left to the states and localities. It was not until the early part of the 20th century that a concern for social well-being, not merely commerce, drove the agenda for public health action. Two separate campaigns for national health insurance, as well as a rapid expansion of programs to serve the specific health needs of specific populations, led finally to the introduction of Medicaid and Medicare in the 1960s, the most dramatic example of government intervention in shaping the personal health care delivery system in the latter half of the 20th century. As health costs continued to rise and more and more Americans lacked adequate health insurance, a perceived crisis led President Clinton to launch his 1993 campaign to insure every American—the third attempt in this century to provide universal coverage. While the crisis was perceived by many, there was no consensus on action, and leadership outside government was missing. Today, the health care crisis still looms. Despite an economic boom, 1 million Americans lose their health insurance each year, with 41 million Americans, or 15% of the population, lacking coverage. Private premiums are going up again as federal programs are capped and the lack of a federal framework for quality assurance leads to growing problems of access and quality that will need to be addressed as we enter the 21st century. What role will government play?

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INTRODUCTION

The topic I agreed to take on for this symposium is that of the government and health. If I try to relate it to what I know of Martin Cherkasky's attitude toward government, at least in the field of health care delivery, he made clear his feeling that private sector institutions should bring to their work a social commitment to community well-being in the broadest sense. Government would be needed to ensure that institutions were playing their proper role and to address inequities in financial coverage for health care, economic opportunity, and other public services such as education and security.

I do not know if this approach represents the notion of "the third way" contemplated by those now reinventing government, but it does raise the question: If government's role is to change, what are the obligations of other sectors to work in partnership with it for important public purposes like promoting health? When does government (for my purposes, the federal government) intervene, and how can it be most effective in the health sector as we move into the 21st century? A look at the historical role of the federal government in health care may be instructive.

It is an old saying that those who cannot learn from the past are condemned to repeat it. In the health sector, each step lays the groundwork for future progress. As we enter the 21st century, one major lesson from the reading of history is that politics and health are inseparable; there is always unpredictability about the window of opportunity and when it may open for change. One thing is clear, however: significant federal government action in the health sector in this country—the population-oriented public health arena and the personal health care arena—has been largely reactive, occurring when there was a widely shared perception of crisis, the availability of leadership (not always from the top), and a reasonable consensus on a way forward. As Philip Lee said often during the national health reform efforts of 1993, consensus on the "way forward" is the trickiest, and without it, the window of opportunity can close on one's fingers.

BACKGROUND

Unlike interstate commerce and national defense, the notion of federal government involvement in health was not considered by our founding fathers. Almost from the very beginning, federal action in health has been reactive, a response to pressure from states and localities, especially large cities, reacting to a crisis—large in scale or high in visibility—and the final federal action has been tempered greatly both by resistance from states asserting their rights and from differences of opinion among professional groups within the health sector.

The first federal action in health concerned “a bill for the relief of sick and disabled seamen,”^{1(p10)} to be financed by deductions from their wages, with federal money used to arrange for hospitalization in existing facilities and to build hospitals to serve them where none existed. In a sense, seamen were the migrant workers of their time—not citizens of or the responsibility of any single state. During debate over the bill in the Fifth Congress in 1798, supporters asserted that, without federal action, the burden would fall to the states, even though merchant seamen were not citizens of any state. Indeed, Massachusetts already levied a surcharge on its citizens for care of the sick and disabled, many of whom were seamen. Opponents contended that this particular group was no different from other sick and disabled individuals who could not provide for themselves and thus should be provided for through charity, not the federal government.

In telling this story, Mustard² recounts an interpretation by some contemporary medical historians that the ultimate passage of the bill set certain precedents for federal action in health: compulsory support for a group of nondependent persons (seamen), financing by payroll deductions and general tax revenues, and federal funding of treatment by private hospitals and private physicians. Mustard disagrees with such an interpretation when the action is considered in the context of the times, and draws a different set of lessons, which seem more likely.

First, the bill was referred to the Commerce and Manufacture Committee; consideration of the health or medical care element came about only because it was a problem of commerce—thus setting a precedent of approaching health issues indirectly, a pattern that, 150 years later, has resulted in health programs and functions located in over 40 different government departments, ranging from agriculture to treasury to labor to commerce. Alexander Hamilton’s argument for the bill did advocate care for a needy group, but there was greater emphasis that the availability of care would “attract men into service to the country” and therefore would be in the national commercial interest. The financing structure supported self-reliance and kept care in the private sector. One year after the passage of this bill, another pattern was established—incremental expansion of coverage—as naval personnel were added to the list of beneficiaries.

The progress under this act over the next 75 years was very mixed. There were corruption and influence peddling to get new facilities; broad expansions of groups using the facilities beyond those designated as eligible; and poor quality of service, with increasing complaints and increased costs—a crisis, at least of embarrassment, to the federal government.

In 1869, the secretary of the treasury appointed a supervising surgeon (the

precursor to the surgeon general) to reorganize the Marine Hospital Service. He increased utilization, raised costs, improved quality, established laboratory and research services, and generally expanded the role of the service, which eventually became the US Public Health Service.

While states and large cities began to develop health boards and authorities and take on most of the responsibility for both public health and—through charity care provisions—health care for the poor and disabled, the first major populationwide public health issue taken on by the federal government did not occur until almost 100 years later. In 1877, a national quarantine law was passed in response to a yellow fever epidemic that killed 20,000 in the Mississippi basin area and cost between \$100 million and \$200 million. An attempt 75 years earlier to create a federal quarantine authority had been gutted in Congress due to concerns over states' rights. The President responded to pressure from states for federal action in the light of the failure of certain states to deal with this health threat, which put neighboring states at risk and cost them money. A National Health Board was created, acted for a short time, became too confrontational with states, and faded away, officially dropped from the books by 1893.³

Over the next 20 years, especially with impetus from the Progressive movement, a series of national actions was taken: the establishment of the first national Hygienic Laboratory, authority to what now is the Public Health Service to conduct health screening of immigrants, and authority for the federal government to convene state health officers and to collect health data.¹ All these activities were underfunded, not totally by accident.

As England and Germany established social insurance programs in the early part of the 20th century, the Progressives in the US established a Social Insurance Commission that in 1917 proposed a model compulsory health insurance bill for workers earning less than \$100 per month and their families. The premiums would be divided among employer, worker, and state. Bills were introduced in state legislatures around the country, and the American Medical Association (AMA) leaders supported the bill. AMA members did not, and state medical societies, together with insurance companies, scuttled it. US involvement in World War I killed any remaining momentum the legislation had.^{3(pp145-146)}

After World War I, there was a shift in focus from contentious broad health coverage issues toward federal investments in research and, again, attention to additional subpopulations—especially the mentally ill and substance abusers. Federal funding to states for demonstrations such as rural sanitation projects began in 1916. This kind of swing from a highly contentious political period

toward a quieter one with a focus on investments in research, more categorical programs, and state funding has also become a pattern in subsequent federal health action.

The Social Security Act (SSA) of 1935 codified large, more discretionary grants to states for special populations—maternal and child health—and special health problems, with matching fund requirements and allocation formulas based on population, financial need, and mortality rates from the disease related to total mortality in the US. There was considerable debate over the advisability of further expanding this fragmented approach to singling out populations and issues, but it appeared politically the only way forward.^{2(pp28–33)} What the SSA did not do was establish a national program of health insurance; it was left out after significant opposition by the AMA led President Roosevelt to determine it was not worth the political fight.^{1(p104)} The Wagner-Murray-Dingell Bill, introduced following passage of the SSA, attempted to set up a “general medical care program supported by taxes, insurance or both,” but the states’ rights activists were strongly opposed, and the bill was gutted of federal authority. Even though 100 million Americans were uninsured, the political constituency for national health insurance could not be organized, and organized labor, while supportive, was distracted by other activities. AMA members (100,000 physicians), most of whom were enjoying new postwar prosperity, were effective in stirring public sentiment against the measure.⁴ Meanwhile, significant advances continued in federal support for public health infrastructure, biomedical research at the National Institutes of Health (NIH), the creation of the legislative framework for the modern Food and Drug Administration in 1938, and eventual consolidation of the majority of the diverse health programs in over 40 agencies and 5 cabinet departments in the 1930s into what later became the Department of Health, Education, and Welfare.^{1(p89–90)}

Continuing efforts under President Truman for universal health insurance coverage did keep the debate alive and undoubtedly laid the groundwork for Medicare and Medicaid in the 1960s, though these were programs constructed quite differently and, again consistent with past history, targeted to vulnerable subpopulations—the elderly and disabled and categories of the poor. Additional direct federal roles in supporting health insurance coverage are played by the Veteran’s Health Administration, the Department of Defense, and the Federal Employees Benefits Program, which altogether provide over half of all the health insurance coverage in the US. This potential leverage may become a focus for federal action in the future. Smaller-scale categorical programs proliferated in the mid-1960s in the Great Society era—programs for migrant workers, community

health centers, Head Start, vaccine assistance—continuing the pattern of programs targeted at particular institutions, populations, or diseases.^{1(pp150-151)}

While federal assistance concerning environmental health began in the 1950s with water safety support to states, President Nixon's tenure saw the systematic entry of the federal government into the area of environmental health with the creation of the Environmental Protection Agency and entry into the workplace with the National Institute of Occupational Safety and Health and the Occupational Safety and Health Administration. There was also continued support for providers and facilities for the underserved through the National Health Service Corps and Community Health Centers, programs further expanded under President Carter. To address a cost crisis, President Nixon developed a cost-containment strategy linked to professional peer review, a federal health planning law, and support for federally qualified HMOs to launch managed care.^{1(pp174,179,187)}

The Reagan period marked a strong retreat from federal action to more historical states' rights strategies in health through consolidation of many categorical programs into block grants to states with few conditions, lessening federal control and oversight and reducing the budgets for these programs by 25%. National health planning legislation was also repealed.

Beginning in the late 1950s and continuing to the current time, another strategy for federal action in health was established by a series of activist surgeons general, starting with Luther Terry, who began to translate evolving scientific knowledge about health risks from research at NIH and the Centers for Disease Control and Prevention into highly visible national public health education campaigns (about smoking, HIV/AIDS, and, recently, poor nutrition and lack of exercise) aimed at reducing risky behavior. Thus, the bully pulpit role of the federal government in health became established both within the Department of Health and Human Services and, more recently, with the tools of social marketing, extending public health leadership to the President and Vice President. These have proved to be win-win political actions for the politicians, although their effectiveness has depended on the less visible, but equally important, strategy of developing extensive networks of non-governmental organization, academic, professional, and advocacy group partnerships to share and sustain the education program and the political pressure to move the issue. This has been apparent especially in President Clinton's tobacco initiative.

In 1993, an effort again was made to move an agenda to ensure health insurance coverage for all Americans. There was a perceived crisis of health security for middle-class Americans that appeared to demand a populationwide solution; there was leadership at the presidential level to gain a broad public understanding

of the issues, but the complexity of stakeholder interests precluded any consensus for action.

PRESENT STATUS OF FEDERAL INTERVENTIONS

At present, federal efforts to intervene in the personal health services area of the health sector have placed some issues on the agenda for continuing public debate. This is important because the debate instigated by the Clinton proposals was the first national debate on health care in this country in over 30 years. As we shall see, one of the challenges health professionals have not taken up effectively is sustaining this public involvement and interest in broad health care concerns, especially the importance of financing. The debate left this legacy:

- First, the need for health security, universal health insurance, was put on the agenda, including a public willingness to pay more to get it.
- Second, prevention was put on the agenda as a serious concern of the public, and with managed-care financial incentives, the combination shows promise in some states of forging partnerships among plans, providers, and the public health community to promote health through personal and population-oriented prevention programs.
- Third, a public appreciation of the importance of primary care in the system replaced a previous focus largely on the need for the specialties and tertiary care institutions.
- Fourth, and very dramatic, public advocacy for parity in health benefits for mental health services gained ground, although follow-up legislation was flawed.
- Fifth, long-term care was noticed as eventually requiring federal action.
- Finally, the quality issue was raised—although we are not yet clear who will make the decisions on quality for whom, and which criteria will be used.

Another lesson learned was a reinforcement of the deep public concern about federally led action in the health sector. This is exacerbated by more recent loss of trust in government, but as we have seen, it is not a new phenomenon in American health politics. Since 1994, there has been a sustained, if fragmented, level of public activity and advocacy for continuing federal action on specific health concerns (breast cancer, HIV/AIDS, diabetes); increased institutional support for community health centers and academic health centers (if indirectly through graduate medical education waivers and research dollars); and the traditional swing back to investment in biomedical and, to some extent, health services

research, with dramatic increases in the NIH budget, repeating a familiar pattern.

Finally, once again we were reminded of what the difficulty in getting consensus to promote effective federal action in a system as complex as the one we have allowed to develop in America means, and that difficulty has led, as before, to a strategy of making incremental change. The Kennedy/Kassebaum bill, Senator Domenici's mental health parity bill, and the State Children's Health Insurance Program (SCHIP), the latter particularly, follow the historically successful pattern of incremental change or state-led reform within a federal financial framework and with new federal support to cover a politically popular constituency—children. A little over 1 year into the SCHIP program, some implementation concerns are appearing as states are slow to take advantage of the program. There is concern in some quarters that failure of the SCHIP program with significant underexpenditure could scuttle future efforts at incremental coverage. This is made more likely as Medicaid disenrollments associated with welfare reform among the target group exceed enrollments under the new program in some states, and the problems of effective federal monitoring and technical assistance are becoming apparent. This relative inability to finance effective monitoring schemes has also been a problem for the Health Care Financing Act's oversight of the other ongoing incremental health care change instrument, the 1115 waivers.

LOOKING FORWARD

As we reflect on lessons from the past and look to the future, I should like to identify a few areas in which I think federal action holds considerable promise for improving health in the 21st century and two areas that, I think, are going to be tougher. These opportunities assume a continued commitment to funding of biomedical research at increased levels, although, even now, we are beginning to see that this funding in future years could well be at the expense of other important federal health programs, as well as public funds for education and labor. If this pattern is set, it may require a harder look at our relative priorities for investments that promote health.

First, there must be continued emphasis on population-oriented public health assessment and action. Some of this effort will be continuing the use of the bully pulpit and partnership strategies to sustain high-visibility public education efforts aimed at reducing key risk behaviors like smoking, alcohol and drug abuse, unsafe sex, poor diet, and lack of exercise. Other efforts are less visible outside the health community, but no less important. First, developing an effective argument for support of the public health infrastructure at national, state, and local levels is critical to ensure clean water, effective waste disposal, safe food supply,

safe drugs and medical devices, effective disease surveillance systems, and data systems to generate the information that permits timely and effective intervention by public health authorities against disease threats, as well as programs to promote preventive strategies at the population level. We have the technology and expertise; we lack the resources, which will need to be supplied largely by the federal government.

The federal government must also sustain and grow broad-based support for the Healthy People 2010 effort, which has proved to be a model for national performance measurement and monitoring in health and has been adapted for use by 46 states. New targets within the framework call for eliminating disparities in health status for communities of color; attention and financial support must be sustained for this effort.⁵

The second great federal opportunity is in the area of quality of care. This is a legacy of the Clinton reforms that is being driven politically from a wide-ranging concern among the public and the professions about both the perceived excesses of managed care and the sense that there are severe quality problems in the health care system. Patients' rights legislation did not pass in the last Congress, but will be on the agenda as we move into the next century. While this aspect of the quality agenda might be likened to a consumers' bill of rights in the marketplace, there are other important elements of a quality agenda. These are being advanced through voluntary private sector efforts and through a federally created body, the Forum for Health Quality Measurement and Reporting, led by James Tallon. This group is charged to develop a framework for systematic measurements of and improvements in quality—moving beyond the "bad apple" approach to the quality improvement approach. A more direct role for the federal government is in its potential leverage on setting quality standards as a potential purchaser of care through Medicare, the Veterans Administration, the Department of Defense, and for federal employees. The President already has directed the federal government to implement the Patients' Bill of Rights recommended by his earlier Quality Commission.⁶ There is an opportunity for the federal government to advance the quality agenda significantly through concerted efforts as a prudent purchaser; the action could be administrative, and a strategy is needed.

A third opportunity is in the area of implementation—a sorely overlooked issue in sustaining any political commitment to change in the health sector. If the nation cannot implement the policies that seek to achieve an effective and increasingly equitable health sector effectively, we will lose the political support needed to take on the tough issues of health care coverage, education of health

professionals, and the timely translation of our significant research investment into programs that tackle significant health issues faced by the population. The government also must be able to evaluate the results of significant policy changes, such as the ones we will face in health in the coming decades, so that it can exercise its responsibility to protect and promote the public health.

This implementation gap is one of the most serious problems in health sector change; it gets very little attention and support. Efforts to “reinvent government” have forced agencies to define the appropriate role of government and to develop the capacity to create effective contractual and/or partnership arrangements needed to ensure the provision of public services by other sectors.⁷ The Government Performance and Results Act demanded performance measures for each line-item program in the federal budget starting in 1999. It also requires an effort to involve the public in planning, implementation, and evaluation of programs affecting them. Progress in all of these areas has been hampered by federal employment-reduction targets applied across the board, regardless of the increased roles of agencies like the Department of Health and Human Services, and Congressional earmarks for administrative cost reductions that preclude adequate infrastructure for sound management and human resources development.

While the federal role may vary, it is critical to accept that any future health sector reform effort, regardless of extent, will involve the states as key implementers; this was true in the Clinton reform effort, which was seen as a federally led, centralized reform, and it is certainly true in the explicitly devolved programs like welfare reform, SCHIP, and the like. The Milbank Memorial Fund’s Reforming States Group, comprised of health and political leaders from over 40 states, has conducted a self-study on state readiness for its oversight functions in managed care.⁸ Many are well ahead in providing models for broader adaptation; others have severe limitations in their ability to implement programs. The federal government has a critical role to play in helping to address this uneven capability and, to the degree possible, ensuring that the timing of any program implementation is consistent with the capacity of the receiving entity to assume the new responsibilities effectively. Since most legislative programs do not provide for such time, it is critical that administrative actions be taken to develop effective and sustainable federal-state partnerships and mechanisms for mutual learning that can be the basis for future action.

DiIulio and colleagues wrote about this issue in their Brookings series on the new federalism. They identified the federal role as defining the entitlement, creating the financing framework and responsibilities, monitoring the results,

and guaranteeing the integrity of the process for deciding and implementing the first three.⁹ These are good starting points.

The time frame is less clear for action on two other issues in which the federal government has a clear role: education for the health professions and securing universal health insurance. Both are critical for achieving our vision for better health, but if we apply the test of crisis, leadership, and consensus for action, the alignment of the three seems far away. Until that alignment is achieved, the federal government is unlikely to act on the issues.

Briefly, there has been a long-standing realization that federal funding for education for the health professions, especially graduate medical education through the Medicare program, has little relation to explicit health manpower policy goals of reducing the number of physicians and achieving a better balance of generalists and specialists with incentives that support practice in the right geographic areas. Federal discretionary programs supporting smaller-scale efforts have been successful, but not widely institutionalized, and our unwillingness to engage in any national health professions monitoring and reporting—much less planning activity—has exacerbated the problems of oversupply and maldistribution. A number of foundations have funded studies to try to develop solutions; the federal government's Council on Graduate Medical Education has issued reports for years with recommended action steps. While some consensus is developing in certain areas, there is a distinct lack of leadership from the profession, some believing—perhaps correctly—that any change will be worse than the current rearguard action to fight annual efforts at funding reductions of Indirect Medical Education (IME) and Direct Medical Education (DME). This strategy may not be sustainable in the face of the Wilensky Commission's upcoming report and the concerns about the future of Medicare. While there have been widespread predictions of crisis (due to managed care) for the academic health centers that train many of these residents, it has not happened yet, and the "public goods" argument that has been proposed to defend current federal investment levels still is not connected to any sense of public accountability for those resources. Further penetration of managed care and decisions about Medicare may precipitate the crisis needed to promote action by the federal government. In the absence of alternatives from the profession, the outcomes may not be the best.

The final area of federal opportunity is universal health insurance—again showing the effects of our triad of crisis, leadership, and consensus. First, as to crisis, the facts indicate that we have increasing numbers of uninsured. The main source of the increase is workers previously insured through their jobs who are

losing coverage either due to the cost to employers, who choose to forgo benefits for dollars in the paychecks, or because of the increasing use of part-time and other models of contract labor that do not include health benefits. Even when benefits are offered, choices are limited. If the fundamental policy framework for the American health insurance system—voluntary insurance through employers—is failing, an alternative is needed.

Shortly before the failure of the Clinton reform, Jones talked about four options: regulating insurers and encouraging employers/individuals, regulating insurers and mandating employers/individuals, chartering insurers (eliminating plans that do not demonstrate a capability to manage care well), and replacing employers (with purchasing cooperatives).¹⁰ Each stage implies progressively more government intervention. One of the interesting questions is, Which level of government? Most would say state governments, as they have historically regulated health services within their borders. However, given the changes in the health sector (national systems of plans and providers, national employers, and national insurance companies), is it time to re-examine the origins of the first federal action in health—the issues of commerce and “interstate” commerce at that? Is there a different role for the federal government in the health arena that comes in “indirectly” throughout our historical concern for commerce? This may be an idea worth developing, using national utilities regulation for its potential in shaping action in the health sector.

So far, the insurance industry has been the most effective in resisting any change. Employers seem too preoccupied with managing costs for their own workers to look at the potential impact of their cutbacks in coverage on destabilizing the entire framework of private coverage. If market failures continue, stabilizing market rules is a legitimate role for federal government. Government might also choose to extend access to its federal employee insurance plan to other public employees on the state level.^{8(p6)} Some states, like California, have done this with their county employees, with positive effects on cost and quality.

Other pressures come from welfare reform, which has led to significant reductions in the Medicaid roles, often exceeding efforts to enroll new beneficiaries under the SCHIP program. Congress continues its focus on reducing Medicaid costs, and state rate setting is already driving for-profit plans out of the market. Medicare choice has not caught on, again due to low rates of provider participation and anxiety among seniors. Drug costs are going up, and most out-of-pocket and private premiums are edging up after 2 to 3 years of stable rates. Safety-net providers are particularly at risk due to reductions in disproportionate share funding, the need to adapt to price-based reimbursement, lack of capital to

prepare the management systems needed for effective competition, and lack of size to compete in the market.

All of the above sounds like a crisis, but what does the public think? If we ignore broad-based sentiment, we do so at our peril. In the March 1998 issue of the *American Journal of Public Health*, Blendon presented some striking poll results.¹¹ In February 1994, 54% of American adults said that health care was one of the two most important issues for government to address; in October 1997, only 12% named health care (excluding Medicare) as one of the two most important issues for government. Education is now at the top of the list for government action, and Social Security is at the top for additional domestic investment.

We clearly have a public education job on our hands to present the facts of the impending crisis to the public, but we also have a responsibility, once again, to develop sustainable leadership to keep attention on the issue. Leadership, the second piece of the triad, may come from states addressing their own population needs and circumstances and many are doing so. If resources become a problem and the public outcry increases, they may turn to the federal government for that financial framework. The implications of a state-by-state strategy for equity and quality, given resource constraints and the variable capacity for implementation, again raise the question of clarifying the federal role. The profession of medicine has been supportive of achieving universal coverage conceptually, but politically it has been relatively inactive in developing alternative ways to move forward on the issue. Most providers still are arguing that they need more money to do more.

What about consensus? We may agree on a vision—of universal financial access—but merely naming the goal does not make the definition of strategy and tactics easier due to the high numbers of conflicting stakeholders. We cannot be satisfied with a demand for the ideal unless we are willing, again, to work through the difficult issues required for consensus development and implementation. This area does not appear to be promising for significant federal action soon, although there is room and a critical need for creating the environment that guarantees at least continuing incremental progress.

In New York, there has been enormous effort put into creating the analytic underpinnings for action: renewal of the Health Care Reform Act is a year away and the increase in the number of uninsured is higher than in the US as a whole, but there is little consistent leadership to search for broader systemic solutions short of adding new dollars to the program.

Perhaps this brings us full circle. Since federal-level action began in health over 200 years ago, significant progress has been made in developing a distinct

and meaningful, if targeted, “proactive” role for the federal government to play in health. Many of these steps are bipartisan in nature—“win-win” situations for specific beneficiaries, programs, and institutions. Increasingly, most such actions, to be effective, must be in partnership with state and local governments (especially those in large cities), the private sector, and the community. Managers in government are making huge efforts to effect the kinds of radical changes in government operations demanded to act on this opportunity. Increased involvement of those who must implement and receive services in federal program design may decrease the obvious fragmentation that results from such targeted efforts.

Nevertheless, we must learn from history that sweeping action by the federal government on highly political issues in health—most of the big ones are political—has tended to be “reactive” to pressures developing from the profession, other governmental health leadership, and, most importantly, from the public. Leadership from outside the government is also needed to work toward consensus and to achieve tough compromises, not just to advocate for more for all stakeholders as a solution.

The challenge of Martin Cherkasky’s legacy is that he would have participated in such partnerships for change in the spirit of enlightened self-interest. Further, I believe, he moved beyond self-interest to contribute to leadership for broader social good. While we may have a reasonable number of institutions and individuals willing to do the former, we have precious few, in this environment, willing to do the latter. That seems to me a challenge for all of us to consider over the next months and years if we are serious about improving health.

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