It is a great honor for me to be invited to speak at this first annual lecture devoted to Public Health Policy, and of course a greater honor to have this event named in recognition of my now long career in health policy development and public health administration. As the title of my presentation suggests, I did not aspire to be involved in these activities, but set out to emulate my father and older brother who were competent and committed primary care physicians and highly regarded in the communities where they practiced medicine. Circumstances, which I will explain, brought opportunities for participation in health policy development, and subsequently public health administration and academics. [NOTE: my wife used to say that given the stressful nature of some of my positions which required I deal with seriously competitive people with sharp elbows and big egos, she made the analogy that it was like sending me off in the morning “to swim with sharks”, but there were also many kind and good people I had the opportunity to work with who might be compared with dolphins].

At the outset, I must seek your indulgence for me to review my personal experiences, not for self-aggrandizement, but to illustrate how “policy” is made and changed, based on my having had the opportunity to work in positions at high levels of policy development in the federal government, in both Legislative and Executive branches, and in the state of Utah. While perhaps not unique, I think it fair to say few physicians have had the opportunity to participate in health policy development that I have experienced during my professional career. I apologize at the outset for those who may have expected me to discourse on the contentious politics related to the Affordable Care Act (“Obamacare”), and the ongoing efforts by the Republicans to repeal, replace, or at least “repair” this controversial legislation, but instead I am going to take you on a journey through the past, my past, in health policy.

The following remarks will be organized as follows”

I. How did I get from here to there?
II. Five years as professional staff in the U.S. Senate – principles learned in how to get things done (and not.)
III. Three years (almost) in the U.S. Public Health Service as Administrator of the Health Resources Administration (a big federal agency that few have ever heard of).
IV. Government service while in the private sector: Chair – the Council on Graduate Medical Education [COGME], and Chair - Clinical Laboratory Improvement Advisory Committee (CLIAC) for the Centers of Disease Control and Prevention [CDC].
V. Six years as the Commissioner of Health for the state of Utah and Executive Director of the Utah Department of Health [UDOH].
VI. Five years as Vice Chair of the federal Medicaid and CHIP Payment and Access Commission [MACPAC].
VII. Six years as a Professor of Public Health (primarily as a teacher of our future public health workforce).

As you can imagine, it will be impossible to include many of the experiences and specific policies I worked on during these eras, but I will highlight in my remarks some of the key issues I dealt with and attempt to identify principles that might apply in general to policy development.

Before I start, let me define “health policy”. There is no universal agreement as to what precisely constitutes the field of health policy but in overlaps with the disciplines on public health, health economics, health services research, and “includes all those factors that affect the health of the public”. [Donald A. Barr – Introduction to Health Policy, 2016]. My simplified view is that it is the legal framework that constitutes our “collective conscience”, our will and commitment to promote and ensure the health and well-being of our fellow citizens. Now, let me take you on a journey through the various phases of my participation in establishing health policies for our nation and our state.

I. How did I get from here to there, i.e. from a practicing family physician to working in health policy?

A. Concerns Primary Care: I have long had a specific interest in health workforce policy, having been a beneficiary of federal programs to promote and support the training of primary care physicians, i.e. financial incentives (grants) to balance what has long been perceived as an imbalance in our health workforce between “specialists” and “generalists”, those on the front lines of care. Just to let you know how long this has been an issue, let me quote from the recommendations of a report published in 1932 by the national Committee on the Cost of Medical Care - one recommendation was that “…united attempts be made to restore the general practitioner to the central place in medical practice”, and that “specialties be restricted to those specially qualified”. When I went to medical school in 1965 here at the University of Utah SOM there was a clear emphasis on specialty medicine, and little exposure of students to primary care nor encouragement for them to pursue a career as a generalist. In fact, I was directly discouraged from such by the Chair of the Department of Internal Medicine, Dr. George Cartwright, who told me when I said that I hoped to specialize in Family Practice (which was then a newly established medical specialty) that “you are much too good for that”.

NOTE: to put this in a policy context, at that time the federal government had invested in the analysis of our health workforce and concluded (again) there was a significant shortage of primary care doctors, but eschewed any specific policies that would regulate the specialty mix or geographic misdistribution of physicians. However, the Congress provided incentives to address the problem through categorical training grants to support establishment of family medicine residencies (and later in primary care internal medicine and pediatrics).

Based on Dr. Cartwright’s advice I matched with an internal medicine residency at the New England Deaconess Hospital in Boston, a Harvard teaching hospital, and during my internship year I learned that Harvard had recently established a four year “Family Medicine Residency Program” (thanks to a federal grant) which enabled participants to become board-eligible in Family Medicine, and Internal Medicine or Pediatrics, depending on which track the resident
chose. I chose the adult track and eventually became board certified in Family Medicine and Internal Medicine.

After my residency I returned to Utah to work with my father in his clinic in Murray, but after two years in private practice I was recruited by Dr. C. Hilmon Castle, Chair of the newly established Department of Family and Community Medicine at the University of Utah SOM, to become the director of the Family Medicine Residency program, which was also supported by a federal grant. During this time I was tapped by the Bureau of Health Professions in HRSA, to be a grant reviewer for a variety of federal grants designed to address the imbalance between primary care and specialists, that included not only financial support for residency programs, (like the ones I had benefited from at Harvard and at the U. of U.), but also to support the establishment of Departments of Family Medicine in medical schools, and the development of undergraduate curricula in family medicine. So, I was well aware of federal efforts to address perceived shortages of family doctors and the geographic misdistribution of health care providers, in that my post-graduate training and fledgling academic career was directly supported by such government grants. This was the issue that piqued my interest, which got me hooked, on “health policy”, and set me up to take advantage of an opportunity to become involved.

B. **Dr. Sundwall goes to Washington:** In late 1980 I was asked if I would be interested in working as a professional staff member for Senator Orrin G. Hatch, advising him on health issues. This came as a complete surprise in that I did not know Senator Hatch, had not voted for him, and did not share some of his political views, as I understood them. He had essentially just been catapulted from a low ranking first-term Senator, to become Chair of an “umbrella committee”, the Labor and Human Resources Committee (now the Health Education Labor and Pensions Committee [HELP]) in the U. S. Senate, when the Republicans became the majority party for the first time in twenty years. Senator Hatch wanted a “Utah doctor” on his staff, I think based on his having worked with Senator Ted Kennedy on the Health Subcommittee when the Democrats were in charge, and noticing that he always had capable physicians on his staff advising him on the complex and often science-based policies that came before them. This was intriguing to me in that Ronald Reagan had just been elected, and announced that his health policies would be based on the “Mandate for Leadership”, a sweeping document published by the Heritage Foundation, a conservative think-tank in Washington, which called for the elimination of Title VII of the Public Health Service Act, the “Health Professions Training Assistance” provision that authorized the programs that I had benefited from, and that I thought were so important to addressing health workforce problems in our country. So I responded to that I would indeed be interested, depending on my wife’s approval that we move, pack up our belongings and three children and move to the east coast (again). I first met with Senator Hatch in his office here in Salt Lake City, and had a final interview with him in his Senate office in DC. I felt it important that he understand that while I appreciated this opportunity, I had not supported him during his election campaign, anticipating that he may have some political litmus test for his staff. To my surprise and pleasure he told me that he had done his due diligence on me, that I came highly recommended by the University of Utah and the Utah Medical Association (he had checked with both, understanding that potential problems could arise with a “town/gown schism”), and that
his expectations were that I advise him on sound health policy and that I could leave the politics to him. This was just what I was hoping for, and I can say that was the way we worked together over the next five years. Thus, a family doctor from Utah went to Washington DC, thanks to Senator Hatch extending me the opportunity, and my family’s willingness to move across the country (and for me to make considerably less money), for what we expected would be a 2-3 year stint in the nation’s capital.

II. Five years as professional staff in the U.S. Senate – principles learned in how to get things done (and not.)

To understand the nature of my work in the Senate it is necessary to understand the purview of the Labor and Human Resources Committee [LHRC], where I worked as professional staff, and soon became the Health Staff Director. This umbrella committee had responsibility for oversight of many government programs, but the health aspect was limited to “public health” [the following web-site has a description of the jurisdiction of the current Health Education Labor and d Pensions [HELP] committee which replaced the LHRC: https://www.help.senate.gov/about ]. The significance of this is that this committee is not responsible for Medicare and Medicaid, which are under the purview of the Senate Finance Committee (and the Ways and Means and Commerce Committees in the House of Representatives). While these public health insurance programs are the “big ticket items” and the focus of recent efforts related to health reform, i.e. the Affordable Care Act [ACA], we had responsibility for “public health” and therefore had a lot on our plate - oversight of the National Institutes of Health [NIH], the Centers of Disease Control and Prevention [CDC], the Food and Drug Administration [FDA], the Health Resources and Services Administration [HRSA], the Substances and Mental Health Services Administration [SAMHSA], the Agency for Health Care Research and Quality [AHRQ] (it was then the National Center for Health Services Research), and the Indian Health Service [HIS] (which was then a Bureau in HRSA). We were required to do periodic reauthorizations of the laws governing them, and oversight of their performance. We were also to address new challenges and emerging science and technologies related to public health. In order to provide an overview of the work of this committee I am going to report on select issues I was involved with during my five year tenure, preceded by a “principle” which I think relates to the topic discussed, and which may have general application to health policy in general.

NOTE: The first “principle” that should be adhered to and which applies to all advocacy is the importance of being honest, being informed, being “evidence-based” in efforts to change policy. While politics and personal views are important and can’t be discounted as factors, unless a legislative proposal is backed up by valid information it is not likely to get very far.

A. The Importance of not “Judging a Book by its Cover” – the confirmation process for U.S. Surgeon General, C. Everett Koop.

Dr. Koop was nominated by President Reagan to be the 13th Surgeon General of U.S. Public Health Service. He had a long and distinguished career in this post, from 1982 – 1989, and according to the Associated Press, “Koop was the only surgeon general to become a household name”. However, his position required confirmation by the Senate, and I had responsibility for his confirmation hearings in our committee. Although he was an eminently distinguished physician, having been a world renowned pediatric surgeon at the University of Pennsylvania, he faced a barrage of opposition
requiring a series of hearings over almost a year. Many liberal politicians, women's groups, and gay 
rights organizations opposed his nomination because of Koop's conservative political and religious 
views, including strong anti-abortion beliefs. However, he proved over time that the policies he 
supported and promoted were based on the best scientific evidence available, not politics nor 
popularity. He became a champion of those with HIV/AIDS, was a vigorous anti-tobacco crusader, 
and though “pro-life” himself, he got into hot water with President Regan’s Administration, by 
refusing to support their contention that abortion was always psychologically damaging to a woman, 
stating “there was insufficient evidence to substantiate issuing the finding desired by the 
administration”. Dr. Koop is arguably the most successful and influential Surgeon General in our 
country’s history, and thanks to Senator Hatch’s strong support and persistence we overcame the 
opposition to having him confirmed for this post. [I did not anticipate at that time that five years 
later I would be appointed as an Assistant Surgeon General to Dr. Koop, in my capacity to serve as 
the Administrator of the Health Resources and Services Administration].

B. The Importance of Building Bridges – unlikely allies in working together for reauthorization of 
the Maternal and Child Health Care Block Grant

One of the most significant changes in health policy enacted during President Regan’s first term was the 
creation of three “block grants” from a myriad of categorical health-related health programs that had 
been created since passage of Medicare and Medicaid in 1965. In retrospect it seems that when federal 
government got into the business of “health” on a much larger scale than they previously had been with 
enactment of these public health insurance programs, the Congress appropriated responsibility to 
address many specific health concerns by authorizing many targeted federal programs, each of which 
required application for grants by states or not-for-profit organizations. In an effort to achieve more 
efficiency and economy, the Heritage Foundation’s “Mandate for Leadership” report, that served as a 
blueprint for the Reagan Administration’s policies, recommended enacting 4 public health “block grants” 
that would combine many of these categorical programs together and award states their share of the 
sum of the costs of these programs (minus anticipated savings from lower administrative costs), based 
on a formula that would take into consideration population, percentage of those in poverty, and illness 
burden. The Democrats were strongly opposed to this, fearing that states might not use the funds as 
intended; however, we succeeded in passing legislation creating 3 (not 4) of the proposed block grants: 
Preventive Health Services, Maternal and Child Health, and Mental Health and Substance Abuse [we 
were not successful in establishing a “Primary Care Block Grant”, and funding for Community Health 
Centers remained a federal categorical grant program]. However, as a condition of gaining Democrats 
support we agreed to have the General Accounting Office (GAO) evaluate how states were managing 
these block grants at two and four years after enactment. Fortunately for the Republicans the 
evaluations were overall favorable, and they have been sustained.

When the time came for reauthorization of these block grants we ran into a brick wall regarding the 
Maternal and Child Health Block Grant, with influential advocates for women and children disagreeing 
on the certain policies and funding levels. However, this impasse was overcome when an unlikely 
coalition of interest groups came together and testified at a Senate hearing - the Children’s Defense 
Fund (a liberal group based in Washington DC that had long advocated for specific federal programs for 
vulnerable children), and a group from South Carolina, affiliated with the Southern Christian Coalition. 
These organizations had widely differing views on many issues, each seeming to represent the poles of
the political spectrum, but they shared deeply held views on children’s health and with them coming together the reauthorization of the MCH Block Grant passed with bipartisan support. This served as a great example of what can be accomplished with you work to find common ground with diverse groups with a history of being on opposite sides.

C. The Importance of Science Driven Policy – the “National Organ Transplant Act” of 1984

Medical science and surgical technology had made great strides in organ transplantation during the 1970’s, but the promise of saving and extending lives by surgical organ transplantation was seriously hampered by “rejection” of the transplanted organs by the recipient. This was due to a massive immune response by the “host” of the new organ, which often perceived the transplant as a foreign object. However, with development of new immunosuppressive drugs, e.g. cyclosporine, this problem was largely overcome and most patients receiving organ transplants were able to accept the new organ, and often gain a new lease on life. Thus, with advances in science there were new opportunities and obligations for our committee to enact national polices to incorporate such advancements. Advocates for organ transplantation, patients and providers, made the case for federal legislation to facilitate the public benefiting from these new technologies, which resulted in our holding a series of hearings, and drafting legislation which was eventually enacted on to law. This legislation included establishing: a Task Force on Organ Transplantation to “conduct comprehensive examinations of the medical, legal, ethical, economic, and social issues presented by human organ procurement and transplantation”; providing grants to regional “organ procurement organizations”, establishing a national scientific registry, and perhaps most important was to establish the “Organ Procurement and Transplant Network”, (which became the United Network for Organ Sharing [UNOS]). This provision of the law was essential to facilitate timely matching of patients most in need of an organ transplant with organs that became available, and to ensure they would be immunologically compatible. Prior to this effort to rationalize and prioritize the degree of medical need of patients, it seemed to have been a “free for all”, with opportunities for some patients to obtain organ transplantation based on their location, influence, on factors other than just how sick they were. There is now a thriving enterprise in organ procurement and transplantation through the country, with more fairness and timely access to needed organs. NOTE: one of the most successful organ procurement organizations in the U.S. is Intermountain Donor Services located here in Salt Lake City, which has been remarkably successful in getting citizens registered to be organ donors, and in facilitating life-saving matches of patients with organs.

D. The Importance of Personal Pain in Driving Policy

Senator Jennings Randolph (D-WV), championed legislation that required more rigorous training and credentialing of radiology technologists, which I understood was due to the death of someone in the Senator’s family having received dangerously high doses of ionizing radiation. Senator Ted Kennedy and his family had a hand in enacting several laws related to providing services for patients with mental health and disability, based on their experiences with their sister, Rosemary, who suffered from significant limitations in intellectual capacity (perhaps due to birth trauma). These are just a few examples of health-related legislation based on personal experience with illness, disability, and death. I had a personal example, a tragic event that occurred in my family that motivated me to help enact legislation to improving emergency care of children. When my daughter was a two and a half years old I
ran over her in our driveway – both wheels of a 4 wheel drive vehicle. Miraculously she survived, but this event changed our lives, causing some life-long pain and physical problems for my daughter, and to some extent “PTSD” (post-traumatic stress disorder) for me. I still to this day, when going over a rut in the road, can flash back to this event, re-experiencing the emotional trauma. When this awful accident happened, we were beneficiaries of prompt and excellent medical care at the Cottonwood Hospital in Murray, when specialists arrived promptly at the ICU to evaluate and attend to our daughter, and where excellent nurses cared for her round the clock. To our great relief, she recovered enough to come home in four days, but the damage done to her musculoskeletal system persisted, causing some chronic pain and limited mobility. [In spite of these limitations she has a graduate degree in microbiology and is the mother of two adorable girls].

A friend and staff colleague, Pat Deleon, Chief of Staff for Senator Daniel Inouye [D-HI], approached me about asking Senator Hatch to co-sponsor legislation he was working on. It was to be a federally funded “demonstration project” to improve care provided for children in emergency situations. The basis for his interest in this was that Pat’s daughter had been hospitalized in Connecticut with meningitis. However, his experience was different than we experienced with our daughter - his girl's treatment demonstrated the shortcomings of an average emergency department when treating a critically ill child. I was immediately taken with the importance of this proposal, was supportive of the intent, and recommended the Senator sign on. Senators Orrin Hatch and Lowell Weicker (R-CT) did co-sponsor this bill, and with their support in 1984, Congress enacted legislation (Public Law 98-555) authorizing the use of federal funds to improve emergency medical services for children (EMSC). By this law, the EMSC program obtained funds to improve the pediatric capabilities of existing emergency medical services systems. By the way, this “demonstration” is ongoing – has provided grants to all 50 states an U.S. territories, with over $101 million having been awarded.

E. The Importance of Fear in Driving Policy – the emergence of a new and deadly epidemic, “GRID”, HIV/AIDS.

While sitting at my desk in my Senate office I got a phone call I will never forget. The caller identified himself as Bruce Decker, and that he was Governor Deukmejian’s (R-CA) “resident fairy”. When I asked what that meant he went on to tell me he was an openly gay man, a high level advisor to California’s governor, and a successful businessman in his own right. He said he knew of my position with the Senator’s health staff and that “you guys need to know what is going on out here”, that many gay men were getting sick and dying from an unknown cause. At his urging, and after confirming his report of mysterious deaths in San Francisco (and also Los Angeles, New York and Miami), with the CDC in the spring of 1982 I convened a meeting of key health staff in the Senate and the House of Representatives in the Russell Senate Office Building,. Mr. Decker came from California to speak, along with representatives from the Administration and the CDC, and he gave a most alarming report on the scope of the problem and the urgent need for enhanced surveillance and research as to what was causing this deadly illness. This prompted us to convene the first Senate hearing on this new emerging disease - then called “Gay Related Immune Deficiency” [GRID], then "the 4H disease", as it seemed to single out homosexuals, heroin users, hemophiliacs, and Haitians. In September of 1982 the CDC officially referred to it as AIDS (acquired immune deficiency syndrome). At that time there was a lot of genuine fear of this illness spreading throughout the population, and I am sorry to say significant discrimination of those who had it, so we were fortunate to find a perfect witness to inform the Senators about this illness. Mr. Smith (his real name) told us of his experience as a hemophiliac who seemed to have acquired it through
the administration of cryoprecipitate of Factor VIII (derived from human blood products) to control his episodes of bleeding. [NOTE: we did not know what “it” was until the next year when scientists at the NIH, and in France, independently identified the causative agent as novel retrovirus, which was eventually named as the Human Immunodeficiency Virus (HIV)]. I say he was the “perfect witness” because he was a white, heterosexual, an engineer from Dallas, Texas, whose illness could not be related to a homosexual sex, or intravenous drug use. Unfortunately at that time there was a tendency to “blame the victim” of this disease for their behaviors and personal choices. While unsafe sexual practices among gay men, and drug users exchanging needles certainly put them at risk of acquiring the HIV virus, it was no respecter or persons and infected many who received contaminated blood transfusions, blood products, female partners of infected men, and some health care workers from exposure to infected blood. Mr. Smith described with great clarity the shunning and prejudice that he and his family were experiencing – his children were not allowed to go to school and he suffered discrimination at work. He was a compelling witness, and again, there was not a dry eye in the hearing room. After the hearing I took Mr. Smith to Senator Hatch’s office for a photo opportunity (although I had to do some convincing to the Senator that this would not put him at risk), and the photo of him with his arm around Mr. Smith went around the world in 24 hours via the various press outlets, and sent a powerful message of compassion with the conservative Senator Hatch embracing a man with AIDS. He did in fact have full-blown AIDS, and died within six months of our hearing.

This first hearing started the ball rolling and we quickly enacted legislation authorizing “Education and Training Centers” [ETC's], to be established in the cities with the highest prevalence... This was followed up by a series of hearings focusing on the need for research and significant funds were authorized to address this new epidemic – for the NIH, FDA, and the CDC. I think it fair to say that never in history has there been so much spent on a single health problem than there has been for HIV/AIDS. However, I periodically got the question, “Why are you paying so much attention to and spending public funds on “those people”. My answer was that we are all the beneficiaries of this investment in research – it was not going to study illness in categories of people, but for infectious disease, immunology, cancer, etc. And our investment paid off, albeit too late for many, and too late for many advocates. It took almost a decade but anti-retroviral drugs against the HIV virus were identified, that there use in combination was effective, which essentially changed AIDS from an inevitably fatal disease to a chronic illness that can be managed over time. The story of how the HIV infection emerged, and was responded to by governments and the public has been captured in the book, “And the Band Played On”, by Randy Stilts, who was a journalist with the San Francisco Chronical (and who eventually died of AIDS himself). While doing comprehensive research for this book he interviewed me several time to get my perspective on how we dealt with this in the Senate, and when the book was published I was shocked to find that much of the content of our conversations were included in the book but were attributed to Senator Hatch, although to my knowledge the Senator never met with Mr. Stilts personally. So, I quickly highlighted all of the “Hatch” statements in the book, took it to his office and told him, “Now Senator, this is what you said, right”? Of course I wanted him to be aware of these “quotes” in case he was asked in public about certain policies as described in Mr. Stilts work. Fortunately for me he accepted my version of what he said, would own up to them if asked, and appreciated my giving him a heads up.

F. **The Requirement that Sometime You Need to Swim with Sharks** – working with (actually against) the “Tobacco Institute” to enact rotating warning labels on cigarette packages.
The fiction book, “Runaway Jury” by John Grisham, describes in detail the various nefarious tactics used by the tobacco industry to defeat legislation sought to award patients’ claims for compensation for their having suffered health effects and death from smoking. I can attest that all of these tactics were used by “The Tobacco Institute” (the somewhat lofty name used by the tobacco industry’s lobbying arm in Washington, D.C.) to defeat legislation Senator Hatch introduced (at the request of Surgeon General Koop) to require four explicit warning labels on tobacco products. The U.S. was the first country to require a health warning label on cigarette packages, but it was simply a general warning, the “The Surgeon General has determined smoking is dangerous to your health”. The new labels we proposed be required on all tobacco products were to be much more explicit, including that smoking causes cancer, lung disease, emphysema, heart disease, damage to unborn fetuses, and premature death. The Tobacco Institutes’ “expert witnesses” were shameless in hearings when they denied the well-documented health consequences of smoking (they were simply “relational”, not the result of smoking), and emphasized the importance of allowing choice, and strongly opposed government regulation.

They had different messages for members of both parties: for Republicans, they asked that they help get Senator Hatch out of this tough spot he had been put into when he introduced this bill at the request of his “liberal doctor”, that he did not personally favor it and was against most federal regulation. To our amazement they told Democrats that the Senator had been asked to introduce this bill at the request of the Mormon Church which was seeking to legislate their “health code”, to impose a prohibition on tobacco on everyone, and that it was essential he do this to get the Church’s support for his re-election. In other words, if you want to defeat Senator Hatch in the next election do not support this new and tougher anti-smoking labeling bill. When it came up for a vote in the Senate I was asked to go on the floor and count votes, i.e. to go around and get a head count on who would vote with him. One of the highlights of my Senate career was when I heard Senator Jesse Helms (R-NC), who had staunchly and effectively represented tobacco interests in his state for many years shout out in the Senate chambers, “It’s that damn doctor who works for Hatch”. The bill passed, and whatever my role was, I am proud to have been a part of this effort.

G. The Importance of Making Friends with People if High Places (or not) and influencing policy.

It should be obvious that personal relationships are key to influencing policy, but this is not always appreciated. During the second year I worked in the Senate, I had the responsibility for putting together the hearings to reauthorize the the National Institutes of Health (NIH), at that time 13 separate institutes devoted to basic biomedical research. Due to their achievements and international regard, the NIH was sometimes referred to as the “Crown Jewel” in our nation’s public health enterprise. The relatively new Director of the NIH at that time was Dr. James Weingarten, who before his appointment was the Chair of the Department of Medicine at Duke University, and enjoyed high esteem in the world of academic medicine. He invited me to attend a New Year’s Day “Open House” at his residence on the NIH campus in Bethesda, and I took advantage of this personal time with him to recommend that in advance of the Senate hearings on the NIH reauthorizing legislation that he get an appointment with Senator Hatch – to introduce himself, explain recent research achievements on the NIH, and mention some projects currently funded in Utah. [NOTE: approximately 80% of the federal funding for the NIH is awarded through grants and contracts to academic health centers and other private not-for-profit research organization throughout the country, and the remaining 20% spent on research conducted at the various research institutes housed on the NIH campus in Bethesda, MD]. Dr. Weingarten took my suggestion and on the appointed day I was called to the Senator’s office to attend this meeting. Well, it
did not go as I had hoped – when we went into see the Senator, Dr. W. said something to the effect, “David said that you wanted to see me – what do you want?” The Senator was nonplussed, and while not rude said that Dr. W. should meet with me, not him, to discuss the pending hearings (however, he was clear he not impressed with the new NIH Director). A startling contrast to this meeting was when I was invited a few weeks later to attend a courtesy call on the Senator by Dr. Vincent DeVita, Director of the largest institute at the NIH, the National Cancer Institute (NCI). Dr. DeVita was not new to his position and had taken the initiative to meet with Senator Hatch. Prior to our discussion on the importance of cancer research (nationally and in Utah), he presented the Senator with a gift. He said if his office was on the top floor of Building 31 on the NIH campus (the tallest), and that it has a great view of the Mormon Temple to the northeast. He said he had a photographer come in at dawn one morning to take a photo that captured the sun gleaming on the gold spires of the iconic building. We then discussed the current focus of cancer research including some promising initiatives in Utah. As we left this meeting, I thanked for Dr. DeVita for coming to meet with the Senator, and quipped, “I think you just got a blank check” for yours research budget”.

H. The Importance of Humor – Reauthorization of the National Institutes of Health (NIH), the Health Professions Training Act, and raising the ceiling on funding for the National Cancer Institute (NCI).

1. When we put together Senate hearings, we tried to get prestigious and respected experts to help us make a case for passage of the legislation we were considering. Unfortunately, sometimes the most “expert” persons, including Nobel laureates, do not prove to be the best witnesses – are dry, boring, and could seem patronizing to those who of us who are not as smart as they are (including Senators). This was evident when we had hearings related to the reauthorization of agencies with complex science-based programs, when witnesses felt compelled to lecture on the importance of their research, and bolstered their case with lots of scientific data. While impressive in many respects it was not always compelling. Fortunately, when we were considering legislation reauthorizing the NIH, I asked Dr. John Dixon, an eminently qualified surgeon and researcher from Utah to be our lead witness. Dr. Dixon was a remarkable man who had served as Dean of the U. or U. School of Medicine, as President of the Utah Medical Association, and as President of the American College of Surgeons (an unusual breadth of experience), and who had spent part of his youth in Washington D.C. when his father was serving in the House of Representatives. He began with the following statement, “Senators, I am here today to tell you that a good set of bowels is worth all the brains in the world”. Well, that immediately got everyone’s attention, including two elderly Senators, Howard Metzenbaum (D-OH), and Clairborne Pell (D-RI), who seemed to abruptly wake up, one of them asking “What did he say?”, implying they indeed were interested in this topic. Dr. Dixon went on to describe his NIH funded research, the breakthroughs in surgery for gastrointestinal problems, and of course how essential it is to authorize adequate funding for the NIH.

2. The following is what can happen when one does not have a sense of humor. When we convened a hearing on reauthorization of Title VII of the Public Health Services Act, the “Health Professions Training Act”, (the legislation that got me “hooked” on the importance of health
policy in the first place), we invited the American Association of Medical Schools (AAMC) to send a witness to testify as to the importance of these federal grant programs. Their representative was a Dean of one of our well known and highly regarded schools of medicine. However, as the hearing began, the bells rang signaling a mandatory vote on the Senate floor, requiring the attendance of all Senators. Senator Hatch asked for the hearing to continue, and turned the gavel over to me to “chair” the Committee. This was unusual, but legal, and he stated that all the witness’ testimony would be entered into the record and considered in their deliberations. Unfortunately, the AAMC representative was very offended by this, and gathered up his materials and left the hearing. He said he had not gone to all the trouble preparing testimony to present it to “just staff”. He obviously did not know how things work in Congress – that staff are responsible for putting hearings together, gathering testimony, drafting legislation, preparing for conference with the House on their version of the same bill, and writing the Committee reports that convey the “sense of Congress” (i.e. their intent with a particular bill). In short, getting things done. The AAMC witness embarrassed himself, he embarrassed me, and as you might expect his peculiar behavior was considered quite amusing by most who attended the hearing.

3. As we proceeded to draft the NIH reauthorizing legislation with legal counsel, Senator Hatch directed me to raise the level of authorization for spending for each of the several separate institutes at the NIH by a specified percentage, conveying support for all research (but at a more modest level than sought be the Democrats). As we applied his formula for increases in the authorization level in the current law to each institute, I noticed that the level for the National Cancer Institute would be approximately $970 million. We were laboring to draft the bill in the Legal Council’s office, it was almost midnight, we were tired, and in a moment of flippancy I said, “Why don’t we just round up the NCI authorization ceiling up to a billion dollars”. The legislative counsel said why not, and we did. Well, to my surprise, the press took this and ran with it – the story being “NCI becomes the first agency at the NIH” to be authorized for a one billion dollars annual budget!” This proved to be a popular topic, and while likely not well received by budget hawks it was very well received by the research community and Senator Hatch got a lot of credit for his strong support for cancer research. [I don’t recall him scolding me for this particular action, but I was advised to not “round up” any more].

I. The Power of a Single Person in Policy – speaking up at the right time and place can make a difference.

After we had passed the NIH reauthorization bill, and gone to conference with the House committees to iron out differences in our bills, I was given responsibility to write the “Conference Report”, the document that accompanies legislation sent to the White House for the President’s signature, this conveys to the Executive Branch the “intent of Congress” i.e. issues that were deemed important for the responsible agencies to focus on, based on our hearings and the particular interest of Members, to help them set priorities for funding. While I was in the process of writing this report I received a call in my office from a man who said he represented patients and advocates for funding research related to Fanconi Anemia, (FA). I immediately said I knew what that is, a rare genetic disease, and that the majority those affected go on to develop some form of cancer. [I knew about this rare disorder because
medical students at the University of Utah SOM had the benefit of excellent training in hematology, thanks to our having been taught by Dr. Maxwell Wintobe, who was then the world’s most renowned hematologist. I told him that as we spoke I was in the process of writing our Committee Report on the NIH reauthorization bill, and was actually in the section providing direction to the National Health Lung and Blood Institute [NHLBI], which had responsibility for hematological research. The man on the phone seemed stunned that I even knew what FA was, and then he stared to weep. He said that his family was affected by this disease, and furthermore that he was a committed Christian, and felt that somehow God had directed him to call me when he did. I am a person of faith, and I had to wonder if he was right – after all, what are the chances that this man would randomly call the U.S. Senate to “lobby” for funding for a specific rare disease, and find himself talking to someone familiar with this disease and who was in the process of providing direction for funding priorities for the NHLBI. If just a coincidence, the timing was perfect. I included language directing this institute to include research on FA, and spoke with staff at the NHLBI when they contacted me to discuss this particular directive. The result was that research grants were in fact developed specifically for FA, I believe for the first time. As Margret Mead, the cultural anthropologist said, “Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has”. In this case it could be paraphrased to read, “Never doubt that a thoughtful, committed, informed person can change the world”.

III. Three years (almost) in the U.S. Public Health Service as Administrator of the Health Resources Administration [HRSA] (a big federal agency that few have ever heard of).

In 1986 I was appointed by President Ronald Reagan, a “political appointee”, in his second term to be the Administrator of HRSA

The official description is: “The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services (HHS), provides health care to people who are geographically isolated, and/or economically or medically vulnerable. This includes people living with HIV/AIDS, pregnant women, mothers and their families, and those otherwise unable to access high quality health care. HRSA also supports the training of health professionals, the distribution of providers to areas where they are needed most, and improvements in health care delivery. In addition, HRSA oversees organ, bone marrow, and cord blood donation. It compensates individuals harmed by vaccination, and maintains databases that flag providers with a record of health care malpractice, waste, fraud, and abuse for Federal, state and local use”.

This is a huge agency, and at that time I was appointed it was even bigger in that the Indian Health Service [IHS], was a Bureau within HRSA, so I was the “boss” of >16,000 federal employees. During my tenure the IHS was “elevated” to become a separate agency in the public health service (an administrative move that was long overdue and enthusiastically received by Native Americans). Even without the IHS this agency has responsibility for > 90 programs, and it now has a budget of over $10.0 billion, nearly 90 percent of which is awarded through grants and cooperative agreements to approximately 3,000 awardees, including community-based organizations, colleges and universities, hospitals, private entities, and state, local, and tribal governments.
As a political appointee, I had the option of joining the Commissioned Corp of the U.S. Public Health Service (a uniformed service established in 1889), or as a civilian in the Senior Executive Service (SES). The pay grade would be similar, but the benefits of the Commissioned Corp were the same as the military, I would have the rank of “Rear Admiral”, and I would also be appointed as “Assistant Surgeon General”, to Dr. C. Everett Koop, whom I knew and admired since his series of confirmation hearing in 1981. It was not a hard choice for me, but I am not sure I did the uniform justice (my daughter said I looked like the “Good Humor” ice cream man in my summer whites, and another colleague in the Corp was even less kind, saying I looked like the Pillsbury Dough Boy).

I very much enjoyed my almost three year tenure as Administrator of HRSA, in large part because at that time the Public Health Service enjoyed a higher profile than it has since – the agency heads met together every other week with the Assistant Secretary for Health which meant I was well aware of challenges faced by the NIH, CDC, FDA, and SAMHSA (the Substance Abuse and Mental Health Services Administration), and worked together to the extent we could. I also had the perk of a car and driver for government business, which was not just a luxury in that the headquarters of HRSA were in the Parklawn Building in Rockville, MD, but I also had an office in the Hubert Humphry building which houses HHS (Health and Human Services) on the Mall, close to the Capital Building, and I had meetings there frequently. [I have spoken with others who have had the privilege of having such a benefit, whether in the public or private sector, and all agree that life is not the same without it. Can you imagine never having to look for parking and to have your car waiting for you curbside when you exit a building?]

I also got to go on some memorable “junkets” on government business, including but not limited to:

Accompanying Surgeon General Koop, and Dr. Jerold Michaels, the Dean of the University Of Hawaii School Of Public Health, to Bangkok Thailand, to present a Public Health Service Award to the King of Thailand in his palace.

Accompanying Secretary James Baker, Secretary of State, to participate in the Bi-Annual U.S./Saudi Arabia Economic Summit, in Riyadh, Saudi Arabia – to review progress on a HRSA grant to train Emergency Medical Services personnel.

Accompany Dr. Terry Rogers, Dean of the University of Hawaii on a site visit to Kolonia, Pohnpei, in the Trust Territories of Micronesia to determine the feasibility of establishing a “Medical Officers Training Program” to help provide basic health care to residents of the Federated States of Micronesia.

J. The Importance of Personal Relationships in Health Policy – how it helps in Government oversight and the budget process.

There was an almost year-long gap in my being appointed the Administrator of HRSA, and the previous administrator, so the year before the agency was led by the Deputy Administrator, John Kelso. He as a remarkable man – smart, capable, and committed to public service. The most important role of an administrator of a public health agency
(this applies to federal, state of local health departments) is to prepare an annual budget for your agency, and to identify what funds will be necessary to meet your legal responsibilities, and to address what are perceived as current challenges under your prevue. This is an arduous process, and when the budget is prepared it is submitted to your superiors (in my case at that time the Assistant Secretary for Health), who after review and approval submits to the Secretary of HHS, and who must consider the budget requests for all other agencies and develop the total budget request for HHS. This must then go to the Office of Management at the White House, where all agencies budget requests are reviewed and considered to prepare the “President’s Annual Budget”. This is then submitted in formal hearings to the Congress, an important exercise but is usually considered “dead on arrival”. [Note: the press made a lot out of President Trump’s budget earlier this year being “dead on arrival”, implying that he was an ineffective leader, but the Congressional response to the “Trump budget” was hardly unusual]. The reason for this cynical view of the budget process is because the different branches of government have different responsibilities – the Executive “proposes” a budget, but the Legislative branch “disposes” of public funds. While the President’s policies are priorities are reflected in the budget he develops and submits to Congress, it is the legislative branch that authorizes and appropriates funding.

When I assumed my position as head of HRSA they were already well into the process of preparing the agency’s budget, and Mr. Kelso took great pains to prepare me for the grueling process of going “to the Hill” and presenting testimony that would explain why and what amount of funding we were asking for our agency. He was most anxious about this because the previous year he had represented HRSA at these hearings and had been given a very tough time by Senator’s and staff during the Senate Labor and Human Resources Committee. He felt so abused and humiliated that he said he had considered retiring. So I went to my first reauthorization hearing prepared for the worst, but after I presented my formal testimony it went something like this: Senator Weicker (R-CT), thanked me for my testimony and then said, “Dave, do you think you have enough money for Title VII (the Health Professions Act, that I personally cared so much about)? I don’t see that you have a line item in your budget for geriatric training – could you use funds for this”? Well, I was not expecting to get beat up as Mr. Kelso had been the precious year, but I was not expecting such mild mannered treatment. I thanked for Senator for his support for HRSA, and told him that I was there as a representative of the Administration and therefore was seeking only the funding they has approved. Senator Weicker then said, but if we authorize more can you use if for geriatric funding, and I said that whatever funds were authorized by the Senate that I would see to it they were used “wisely and well”. The friendly exchange between me and member and staff at this committee got me off to a good start at HRSA, some of my senior colleagues expressing amazement at how different that year’s hearing had gone compared to Mr. Kelso’s experience the year before. My having worked together with these same Senators and their staff for five years, having a personal relationship with them, certainly helped.

IV. Government Service While in the Private Sector – working both side of the revolving door?
I left my position just prior to the Presidential elections I 1988, which surprised some because there was no indication that I would be required to do so by a new President. Nonetheless, I had become a “believer” in political appointments – I had been personally asked by Secretary Otis Bowen to join his team at HHS as head of HRSA, I knew many of the folks working with him as HHS, a few folks at the White House, and those at the OMB responsible for budgets and regulations. In short, I was comfortable working with this team, and not sure what the future would bring with a new Administration. So I accepted a position as Vice President and Medial Director of the American Healthcare Systems (AmHS), and large purchasing group for not-for-profit integrated healthcare systems. NOTE: I do not want anyone to suppose I got “Potomac Fever”, that I simply could not leave the excitement of living in the Washington DC area. My wife pointed out that we had 3 children in school and that then was not the time to uproot them, again, and move across the country. I worked for this organization for about 6 years, and learned a lot about the trend to integrate healthcare delivery systems and the importance of including physicians in the process. In 1965 I accepted a position as President of the American Clinical Laboratory Association (ACLA), a not-for-profit organization representing the nation’s leading commercial laboratories, e.g. ARUP Laboratories, and Myriad Genetics, Utah companies who were members.

1. COGME
While I found these positions rewarding intellectually and financially, I missed the satisfaction of public service so was surprised and pleased when I was appointed to serve on, and to Chair, the Council of Graduate Medical Education (COGME). Nothing in my day job posed any conflict of interest in this position, and I could enjoy wrestling again with the ongoing challenges related to health workforce policies and preparing reports to advise the Congress and Administration about how to better address perceived shortages of providers, financing of GME, foreign medical graduates, etc. It was during this time I learned some other “principles” of advocacy.

K. When Proposing Important Policy, and nobody cares? – Passions are not always shared to the degree your advocacy makes a difference.

My predecessor as Chair of the COGME was Dr. David Kindig, a highly regarded public health academic who had previously been Director of the National Health Service Corp program at HRSA. This program addresses the very real problems of access to care in medically underserved areas by offering partial payment of student loans to health professional graduates who are willing to serve for two years in such regions. David had led the COGME through the developing and publication of a COGME report on International Medical Graduates (“Foreign” Medical Graduates). At that time they constituted approximately 25% of our medical residents (a significant proportion training in New York State). This report recommended that their training should not be paid with GME funds through the Medicare Program, which is the life blood for funding post-doctoral residency training, citing the Congress never intended these funds be used to train IMG’s. Instead it recommended these doctors’ training should be funded by the U.S. State Dept., targeting them strategically, to help countries determined to have the most
need for doctors, anticipating they would return to their country of origin after their residencies. Or, that the country where these doctors came from would pay for their residency training. Dr. Kindig was so sure this would be of great interest to all with vested interests in GME, and concerns about excessive federal spending, that he scheduled a press conference at the National Press Club in Washington to announce the release of this report. I attended this with him and to our surprise, and his great disappointment, almost no one came – no national news outlets, and only a handful of the local health trade press. While this report was progressive and specific in its recommendations, few seemed interested. Whether or not spending GME funds for foreign doctors was an appropriate use of Medicare dollars, these residents provides a lot of relatively inexpensive labor in hospitals based in medically underserved areas, urban and rural. As you might expect the recommendations were not acted upon by the Congress. It should be acknowledged that while the COGME’s effort to monitor and recommend policies to address our nation’s workforce are important, the Congress rarely acted on the COGME’s recommendations. I think this is due to entrenched dependence of Medicare (and some Medicaid) funding for GME, and reluctance to regulate numbers of providers, specialty choice, practice location, etc., preferring to rely on “incentives”, even though they had not proven very effective in addressing these concerns.

2. CLIAC

My appointment to serve Chair of the CDC’s Clinical Laboratory Improvement Advisory Committee (CLIAC) came as much bigger surprise than my appointment to serve on the COGME. After all, I was then the President of the ACLA, the organization representing the country’s major commercial laboratories – LabCorp, Quest Diagnostics, and about 20 more independent labs – and could be assumed to have conflict of interest in chairing the federal committee that had oversight of these companies compliance with federal regulations. The Clinical Laboratory Improvement Act had been passed in the late 1980’s in response to poor quality of some PAP smear tests that were thought to have contributed to the deaths of some woman from cervical cancer. It was amended over the years to include much more sweeping regulations of clinical labs, which are now subject to random “proficiency testing” to determine if they have the capacity to get correct results on samples given them by regulators. Furthermore, some ACLA member labs had been fined for alleged fraudulent billing practices and much of my work was related to making sure they were all aware of government requirement to be accredited and to be in compliance with CMS payment policies. In this position I learned a lot about issues I was previously not familiar with, e.g. how to get a CPT code from the American Medical Association [AMA], how to navigate the complexities of CMS to set a level of payment for a specific test, and how to get the FDA to “waive” a test from regulation under the medical devise laws. While this was new territory for me, I could testify in Congress, and before regulatory bodies, that as a primary care physician I felt that clinical lab test results were “the most reliable, available, and affordable information” I could have in caring for my patients. This seemed to be more credible coming from a user of lab tests in caring for patients than from a provider of such services, i.e. a pathologist. I still feel this way.

L. The Importance of Regulations and Rules (not just “laws”) in addressing policy issues.
Sometimes the opportunity to achieve policy objectives through modifying exiting rules and regulations of public health laws is overlooked. The Clinical Laboratory Improvement Act is a good example a common situation where Congress gives a framework and leaves it up to the regulatory agency to fill in the details of how the law is to be implemented. This led to very complex regulations and which posed costly requirements on clinical laboratories and even labs in doctor’s offices. Simplification of such regulations can be achieved by seeking a change in the rules, and if the responsible agency is persuaded that there is merit to such changes, they can publish a “Notice for Proposed Rule Making” (NPRM), inviting public comment, and if consensus on changes within the scope of the law is achieved they can adopt the proposed changes. This is usually a much more streamlined process that trying to amend the law. In fact, modifying regulations certainly applied to management of the Medicaid program in Utah when I was the Executive Director of the UDOH – most of the changes in this program were achieved by amending our “rules”, not be seeking legislative changes.

V. Six years as the Commissioner of Health for the state of Utah and Executive Director of the Utah Department of Health [UDOH].

I have a vivid recollection of receiving a call in June, 2004 (while buying an ice cream cone at the Iceberg on 9th east and 39th south) from Dr. James O. Mason, informing me that Jon Huntsman Jr. was running for Governor and that if he were successful he would like me to consider joining his team as head of the Utah Department of Health [UDOH]. Dr. Mason was (and is) one of our most accomplished Utah physicians, having served as Executive Director of the UDOH, the Director of the Centers for Disease Control and Prevention in Atlanta, and as the Assistant Secretary for Health in Washington D.C., the highest level health position in the federal government (the Surgeon General reports to the Assistant Secretary for Health). I have long admired Dr. Mason, so I told him yes, I would be interested in this position and that I was honored to be asked. I interviewed with Jon Huntsman at his home that fall, and shortly thereafter he won the election, becoming Utah’s 16th Governor. And after a Utah Senate confirmation hearing early in the 2005 legislative session, I became the 14th Executive Director of the UDOH. This is a large agency with a budget of over $2.0 billion (most of it to pay for the state’s match to participate in the Medicaid Program), and approximately 1100 employees). The Executive Director serves on the Governor’s cabinet, which is important to ensure health issues are considered at the highest level of government, and as an integral part of our economy. Some policy lessons learned when I was in this position included:

K. The Importance of Understanding and Respecting “Who’s in Charge” – cultivating relationships with key elected officials.

During my first month on the job I gained support from Governor Huntsman to seek from the legislature approval for the Medicaid Program in establish a “Preferred Drug List” [PDL] program, a widely used policy that authorized Medicaid to cover payment for drugs deemed appropriate and “medically necessary”. I testified vigorously at legislative hearings in support of this, promising that if approved it would save our state millions of dollars annually in drug costs for Medicaid beneficiaries. I also informed the legislature that we were one of only eleven states that had not adopted a PDL. Notwithstanding my efforts and the Governor’s support, this was not approved in 2005, when I first presented this cost-savings policy to the legislature. After the legislative session I
was interviewed by the Salt Lake Tribune and in an article published soon after the session I expressed my disappointment and how I felt the legislature may have been unduly influenced by the pharmaceutical companies who vigorously opposed this proposal. Soon thereafter I was summoned to a meeting in the Capital with House Speaker Greg Curtis, and several of his senior colleagues. At the outset he said something to the effect that he was aware of my opinion on the PDL and my criticism of the legislature in the Tribune, and told me in front of the group of legislators that I was “Nothing more than an arrogant doctor from Washington D.C. who had come out here (to Utah) to tell them how to do their business”. Of course I was stunned, and the only think I could think of to say that I was from Murray. He conceded that perhaps I had been a long time ago, but that I had apparently forgotten my roots, and did not know my place in the legislative process. This was a humiliating experience for me but I was also genuinely humbled, recognizing that I had not met with key leaders in the legislature prior to hearings to explain the potential benefits of the PDL. I had also embarrassed some of the legislators for their having received campaign funds from the pharmaceutical companies, implying that it had influenced their vote. I apologized, to these legislators and to the Governor, and subsequently invested more time in educating our elected officials about the benefits of any proposed policy or budget requests. [NOTE: the PDL was approved in 2007 (Senate Bill 42), and has saved tens of millions of dollars to Utah’s Medicaid Program.

M. **Budget Driven Policy** – You can only do what you can afford to pay for (particularly when living in a state which required a balanced budget).

The first three years of my tenure as Executive Director of the UDOH Utah’s economy was good and I had the good fortune of the legislature funding not only our agency’s base budget, but some special initiatives I has proposed, e.g. building a new public health laboratory facility, public outreach to enroll children in the Children’s Health Insurance Program [CHIP], development of opioid prescribing guidelines, a public education program about the deadly consequences of not taking controlled substances as prescribed, and a public education about obesity epidemic, etc. Each of these initiatives were documented as having a positive impact on our states health measures. However, then in 2008 the economy tanked, worldwide, and there was no longer discretionary funds to address new or emerging public health problems. It felt as though we had hit a brick wall, and we had to accommodate cuts in our agency’s budget. However, the legal responsibilities of the UDOH (codified in Title 26) and of the Local Health Departments (Title 26 A), of the Utah Code remained on the books. So, much of what we were expected to do simply could not be done due to lack of resources, and we were therefore out of compliance with the law. The same applies to the federal government, but on a much grander scale – many laws authorizing health-related programs are “broken” when there is insufficient funding to implement them. This situation exposes governments to suits for non-compliance, and when such suits are filed and successful we have to reorient our priorities to meet the terms of the suit. Fortunately, most unfunded programs or legal responsibilities are not challenges in court, and we wait for better economic times to re-instate them.

VI. **Five years as Vice Chair of the federal Medicaid and CHIP Payment and Access Commission [MACPAC].**

The MACPAC was authorized as part of the CHIP reauthorizing legislation in 2008, and became functional in 2010. There are 17 commissioners appointed from across the country with diverse
expertise on Medicaid and CHIP, and who are charged to analyze and report on: payment; eligibility; enrollment and retention; coverage; access to care; quality of care; and the programs’ interaction with Medicare and the health care system generally. The Commission was intentionally designed to parallel the Medicare Payment Advisory Commission, which had been established in 1997, and both are required to prepare two reports for Congress and HHS each year, due March 15, and June 15. I feel as though I learned more than I contributed to this Commission, and can highly recommend its reports which are available online to anyone wanting detailed information on these complex federal/state health insurance programs (www.macpac.gov). I think my primary role on the Commission was to repeatedly remind my fellow commissioners to “stick to their knitting”, meaning that we needed to report on Medicaid and CHIP as directed in the statute, and not to be perceived as advocating for Medicaid and CHIP, e.g. expansion opportunities available to state’s under the Affordable Care Act (ACA). This was difficult for several of the commissioners who had long histories as advocates for Medicaid and CHIP in their professional careers, but seemed a bit tone deaf to the chorus of detractors on the political right. While some in Congress questioned the objectivity of the Commission, we weathered some political storms and became respected as a source of valid and useful information about Medicaid and CHIP. While I appreciate the importance of these programs to many of our most vulnerable citizens, I came to believe that due to the complexities and the great variations related to eligibility, access, and costs across the country, that we should replace Medicaid as we know it. I have some ideas on how this could be done but will save this discussion for another time and place.

VII. Six years as a Professor of Public Health (primarily as a teacher of our future public health workforce).

I feel very fortunate that I have had the opportunity to return to my alma mater as a clinical Professor of Public Health, and to teach young people at the outset of their careers. They are a remarkably diverse group – in age, ethnicity, county of origin, and their range of educational and work experiences prior to becoming graduate students. I sometimes jokingly say that I am “right back where I stared so many years ago – can this be progress?” Yet, this chapter of my life has been stimulating and rewarding on many levels and given me an opportunity to be taught and nurtured by the students. And I feel especially blessed to have had the responsibility to teach “health policy” at this time in our history when access to affordable health care has risen to become our number one domestic policy concern. In classes I have taught since 2011 we have witnessed the role out of the Affordable Care Act (“Obamacare”), the intense politics surrounding this legislation including the challenges to its legality, and to consider the complexities of its policies. I customarily ask students in courses I teach to present a “current event”, to report on an article in the popular press related to the topic at hand for our class discussion. There is never a shortage of such articles, and the students often site something that was in the news that day. And this brings me to my final “principle” or lesson learned:

N. The Importance of Nonpartisan Advocacy in Public Health – how to steer clear of partisan politics during an era of political polarization in our country.

The “ politicization” of the ACA has been astonishing to most of us, with the legislation having been misrepresented by both parties – the Democrats characterizing it as the “most important social reform since the enactment of Medicare and Medicaid in 1965”, and the Republicans characterizing as
“socialized medicine”, a great overreach of the federal government. In my opinion, neither view is correct. The ACA was intended to expand health insurance coverage to many more Americans, and it has achieved this, but by working within the framework of our very complex and costly system – not exactly “reforming it”. And while Republicans railed against the personal mandate for individuals to purchase health insurance, this requirement was upheld by the Supreme Court. It is important to note that not one Republican voted for the ACA, and it has been “repealed” over 50 times by the House of Representatives, and multiple attempts in the Senate failed for just a few votes. So in this climate of extreme partisanship in our nation, it is essential for those aspiring to achieve public health goals through legal or regulatory reform, we keep our message nonpartisan – appeal to the economic and personal health benefits of public health programs and initiatives. Regardless of who is in the White House or which party controls Congress, public health is essential for the health and well-being of all of our citizens, and needs to be supported, sustained, and strengthened.

In closing, we are in the process of an intense national debate related to health care in the United States – what should be provided, for whom, and how to pay for it. The outcome will redefine the roles of governments (federal and states) and the private sector in our health care enterprise. This is likely to continue for some time, so as Better Davis said in the movie, All About Eve, “Fasten your seatbelts – it’s going to be a bumpy night [ride]”. For those who care about the outcome of this debate I encourage you to be involved.

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