Department of Health and Human Services

Delivering Efficient and Effective Health Care for All Americans

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The new president and his new secretary of the Department of Health and Human Services face a difficult but necessary health care challenge—expanding and improving health care for all of us while also working to reduce the cost of that care for individuals, businesses, and the government. Fortunately, these are not contradictory goals. Our health care system is the most expensive but least effective at promoting health in the industrialized world. Making health coverage affordable would expand it, and covering all Americans would, after an up-front investment, reduce system costs. The new president and his HHS secretary can begin to meet our nation's health care challenge quickly through a series of executive orders and HHS directives, then weigh in with key administrative and legislative reforms in the first year of the new administration, and then implement the long-term policy reforms necessary to deliver cost-effective, efficient, and affordable health care to all Americans.

One of the most critical challenges facing the next president—and by extension, the next secretary of the Department of Health and Human Services—is addressing problems of cost, coverage, and quality in the U.S. health care system. High and rapidly rising costs hurt families, employers, and the federal government, and represent a growing threat to the U.S. economy. Employer-based health insurance premiums nearly doubled between 2000 and 2007, rising at a rate four times higher than wage growth.[1] This growth in costs directly contributes to the rise in the number of uninsured Americans. In 2007, about 47 million Americans lacked health insurance—an increase of 7 million since 2000.[2] Over any two-year period, 82 million people, or about one-third of all non-elderly Americans, experience at least a one-month gap in coverage.[3] Lacking health insurance contributes to delayed care, more serious health complications, and an increased risk of death.[4]

Uninsurance, however, is not the only contributor to preventable disease, disability, and death. The lack of consistent, high-quality health care leads to higher rates of medical errors in the United States compared to peer nations.[5] Among 19 developed nations, we rank 19th in the rate of deaths amenable to health care before the age of 75.[6] Among Medicare beneficiaries alone, nearly a quarter-million deaths over three years may be attributable to low-quality care.[7]

These urgent problems overshadow persistent, neglected, and potentially deadly infrastructure gaps in the system. Our capacity to detect, track, and cure disease is seriously diminished due to chronic underfunding of public health. Case in point: the continuous collection of birth and death information almost halted in 2007 due to insufficient funding, making the United States the only industrialized nation at risk of lapsing in its vital statistics monitoring.[8] Our ability to react and respond to a natural or man-made health crisis is equally inadequate—as seen in the days following Hurricane Katrina and in the haphazard response to the recent national outbreak this past summer of foodborne illness due to salmonella. And preparation for clear, long-term health challenges is neglected. The inexorable aging of the U.S. population will strain what little long-term care safety net exists, while the obesity epidemic threatens to make children's life expectancy shorter than their parents' for the first time in a century.[9]

The Department of Health and Human Services has considerable, if not sole, authority to meet these challenges. The Veterans Administration, the Department of Defense, and Office of Personnel Management also operate health programs for their constituents. The departments of Labor, Treasury, Agriculture, and Energy, as well as the Environmental Protection Agency, have some jurisdiction over health policy. Yet even not counting these other agencies' spending, HHS's budget comprises nearly one-quarter of all federal outlays—second only to the Department of Defense.[10]

The HHS budget for fiscal year 2008 was $707.7 billion ($71.9 billion in discretionary funding), and the department fields 64,750 employees.[11] HHS contains 11 agencies, has 20 offices within the office of the HHS secretary, and runs over 300 programs. In addition to being a dominant force in the executive branch, HHS's programs fund a large share of national health spending. In 2009, for example, Medicare and Medicaid (including the state share of spending) are projected to finance about 35 percent of the $2.6 trillion health system.[12] While Congress sets the parameters for most of HHS's activities, the department itself boasts considerable ability to influence policy through its regulatory, guidance, and oversight authorities. The new secretary of HHS, working with the 44th president, can address the health system's most pressing challenges.

The First 100 Days

The policy actions taken by the new administration in the first 100 days will signal new policy priorities as well as a change in direction from the Bush administration. For the HHS secretary, such actions should fit with the goals of

improving health care access, efficiency, and quality. The policies should also involve changes that can occur quickly and with clarity rather than those that require complex policy or a long regulatory process.

An immediate step for the new president is to lift constraints on the expansion of state health insurance programs imposed by a set of administrative policies established by President Bush. Despite a growing uninsured population, the Bush administration implemented a number of executive-branch policies that limit states' ability to expand Medicaid and the State Children's Health Insurance Program. In August 2007, it issued a directive that set new, difficult-to-meet conditions for states' SCHIP expansions.[13] This directive also required states that already expanded coverage to higher-income children to limit eligibility to those who were uninsured for the previous 12 months. As of January 2008, 23 states either had proposed expansions that were blocked or had existing expansions that they may have to scale back.[14]

The department also issued several regulations that dampened Medicaid coverage. A 2007 regulation eliminated administrative funding for outreach and enrollment activities conducted by schools. Although Congress issued a moratorium on this regulation, it will become effective after the next administration takes office. Similarly, HHS's 2006 implementation of a 2005 law created onerous documentation requirements for all applicants to prove citizenship. Some states reported that enrollment in Medicaid declined because of the difficulty of finding and verifying the proof of citizenship as required by the new policy. Enrollment dropped by 14,880 children in Louisiana, between 18,000 and 20,000 in Kansas, and 13,279 children in Virginia.[15]

HHS also issued a number of regulations that constrain federal Medicaid matching payments for specific activities like targeted case management and hospital payments. The estimated total impact of all of these regulations could be nearly $20 billion over five years, according to the Congressional Budget Office.[16] Although some of these rules do not directly affect eligibility, their fiscal impact limits states' ability to invest in sustaining and expanding needed SCHIP and Medicaid coverage for their at-risk citizens.

The new HHS secretary should immediately roll back or amend these policies. Specifically, the new director of the Centers for Medicaid and State Operations should rescind the August 2007, directive. It has no strong policy rationale, has been challenged legally, and runs counter to efforts to promote state flexibility and coverage for low-income children and families. The new administration should also replace the citizenship documentation with a less burdensome policy. It could give states simple options for how to verify citizenship, as were offered in the SCHIP reauthorization bills vetoed by Presi-

dent Bush in 2007, or accept self-declaration with subsequent verification and enforcement policies.[17] Lastly, the new HHS secretary should extend the existing congressional moratoria on other Medicaid regulations while developing reasonable policy to balance accountability with state flexibility. Together, these policies would enable states to strengthen their safety-net coverage for vulnerable children and families.

Strengthen Consumer Protection in Medicare's Private Plans

The administration also needs to swiftly rework one of the mistaken health policy priorities of the Bush administration—encouraging greater private plan participation in public programs, at the expense of consumer protection and the long-term solvency of those programs.[18] The Medicare Modernization Act of 2003 increased funding and flexibility for private plan options in Medicare. It also created a major new Medicare drug benefit run entirely through private plans. The law authorizing both changes left most of the policy regarding consumer protection in private plans to HHS. The regulation and agency guidance issued by the Bush administration, along with parts of the underlying law, are riddled with holes and weaknesses.

Studies have shown that the per-beneficiary payments to these private plans are significantly higher than traditional Medicare, perhaps by as much as 12 percent to 13 percent. Some of this extra funding has been used by private plans to add benefits as an enrollment enticement. But in other cases, plans have scaled back other Medicare benefits to discourage high-cost enrollees. One analyst, for example, looked at a hypothetical woman with a broken hip in California and found that she would pay less than in traditional Medicare in five Medicare Advantage plans, but more if she were enrolled in other local options. These plans typically charge higher hospital and nursing home co-payments than under the traditional program.[19]

Private plans argue that this flexibility allows them to move resources to benefits that enrollees may value more than current Medicare benefits. These changes, however, increase the risk borne by sick beneficiaries, discourage high-cost beneficiaries from enrolling in the first place, and raise program costs. In addition, aggressive tactics have been used to sign beneficiaries up for private plans. Insurance agents have been offered trips to Las Vegas and flat-screen TVs for signing up large numbers of seniors. Unlicensed agents have been used; some agents have claimed that they are "from Medicare."[20] Strong incentives have led to unscrupulous marketing practices, including providing inadequate information about the options, for example by not explaining limits on providers in the network or benefits, or through misleading branding,

such as claiming that they were just signing them up for "new Medicare benefits."[21]

The new HHS secretary should direct the new administrator of the Centers for Medicare and Medicaid Services to issue guidance to clarify permissible benefit variations. It could set standards for supplemental benefits like those that govern Medigap, the individual-market plans that sell supplemental Medicare coverage. The CMS administrator should eliminate the guidance implemented under the Bush administration that allows a plan to raise cost sharing above Medicare's levels on services that are not discretionary, such as chemotherapy and hospitalization. Allowing plans to offer substandard benefits in these areas undermines the basic protections that Medicare had guaranteed to its beneficiaries.

In addition, CMS should strengthen both the guidance on marketing as well as the enforcement of it.[22] It should increase its review, standardization, and limitations on marketing material, which today tend to confuse more than inform Medicare beneficiaries.[23] This is especially true when sellers "cross-market" other products. CMS should limit the use of agents to those who are state licensed and trained according to national standards, prohibit door-to-door marketing for all products (not just private fee-for-service), and increase state insurance regulators' role in enforcement. And CMS should develop methods to ensure that no senior or person with disabilities signs up for a plan without understanding its tradeoffs on benefits, cost sharing, and the scope of provider networks. Many of these proposed policies could and should apply to Medicare Advantage, prescription drug plans, and to private insurers regulated by HHS when possible.

Promote Access, Scientific Integrity, and Data-Driven Policy

Increasingly, U.S. global leadership is due less to our natural resources or manufacturing strength than to our ability to innovate and compete in an information-based economy. This extends into the health sector. Our academic medical centers, research institutes, think tanks, and government research agencies, among them the National Institutes of Health and the Agency for Healthcare Research and Quality, are world-renowned. Strong data systems and research help us meet the goal of a high-performing health system. Data allow us to track problems and devise solutions. Research enables us to understand the basic relationships between actions and outcomes. Systematic demonstrations and program evaluations provide insight on what works and why.

In numerous instances, however, the Bush administration proved to be hostile to medical and health services data and research. President Bush issued an

executive order limiting federal funding for embryonic stem cell research to stem cell lines derived before August 2001—over the objections of bipartisan majorities in a Republican-led Congress and conservatives such as Nancy Reagan. HHS also suppressed health information (by deleting references to condom use from the Centers for Disease Control and Prevention website), distorted results (by giving unmerited weight to discredited studies on the alleged link of breast cancer to abortion), and discouraged research (by ceasing funding for research on sexual behavior and increasing scrutiny of proposals that include the word "gay").[24]

HHS also edited out some of the negative implications of a report on racial disparities, in contradiction to the science.[25] Richard Carmona, surgeon general from 2002 to 2006, stated, "much of the debate was being driven by theology, ideology, preconceived beliefs that were scientifically incorrect," adding, "I was blocked at every turn."[26]

The incoming HHS secretary should take a number of steps in the first 100 days to reinvigorate HHS's scientific integrity and to reinforce the highest ethical standards in conducting scientific research. In addition to issuing a new stem-cell research executive order—discussed in the Office of Science and Technology Policy chapter of this book—the HHS secretary should assert that all programs will be held to the highest standards of medical accuracy and scientific integrity, free from political interference and in accordance with leading ethical guidelines.

To assist in this, the surgeon general should be granted greater independence and authority. This step would include having the surgeon general report exclusively to the HHS secretary rather than to other assistant secretaries or the White House, and would allow him or her to issue reports or calls to action that can only be blocked by the secretary. The surgeon general could also be charged with annually issuing a clearly written, publicly understandable report on the state of the nation's health.[27]

Similarly, the HHS secretary could issue new data access and support policies. Currently, certain government-collected data are kept from researchers' responsible use, such as Medicare data on physician and drug utilization. In addition, data use agreements limit how the data may be analyzed and published, with no clear grounds for denial of access.[28] The secretary could clarify data access and release policies to ensure necessary information sharing while protecting privacy. This could include the protected collection of racial and ethnic information to reduce health disparities.

Another option is to streamline research and data functions through reorganization. Options for creating a new center or agency for comparative effec-

tiveness research, which could assess the relative merits of therapies and research critical to improving affordability, have been proposed by experts, Congress, and presidential candidates. This could be quickly adopted.[29] Additionally, the National Center for Health Statistics could be moved into the Agency for Healthcare Research and Quality to make it the single source for health services research. These changes would not only improve our understanding of health and the system; they also would increase accountability, transparency, and health system performance.

Prioritize Prevention

Preventable chronic diseases are this century's epidemic. About 70 percent of deaths and 78 percent of health care costs in the United States are attributable to chronic diseases, many of which are preventable.[30] By 2020, an estimated 50 percent of Americans will have some sort of chronic disease.[31] In addition, Americans still suffer needlessly from acute but preventable illnesses and injuries. More than one in five children fail to receive recommended immunizations, with higher rates in certain areas, such as Nevada, where the rate is 40 percent.[32] Only half of recommended clinical preventive services are provided to adults.[33] And injuries, many of which are preventable, account for more potential years of life lost before age 75 than cancer or heart disease.

All this carries economic as well as health implications. In 2000 alone, the 50 million injuries that required medical treatment will ultimately cost society more than $400 billion in direct and indirect costs.[34] One study estimates that if all elderly Americans received influenza vaccines, health costs could be reduced by nearly $1 billion per year.[35] Over 25 years, Medicare could save an estimated $890 billion from effective control of hypertension, and $1 trillion from returning to 1980s levels of obesity.[36] Effective prevention could, in some cases such as helping people stop smoking, increase direct medical costs as people live longer. Yet there is an intrinsic value to improved quality of life for these individuals, and their indirect contributions to the economy are generally high.[37]

The Bush administration did little to promote wellness and prevention, despite worsening trends. Its promotion of high-deductible health plans with health savings accounts arguably moved policy in the wrong direction.[38] Inadequate information plus the need to pay for prevention out-of-pocket (or out-of-accounts) also may contribute to less, rather than more, use of proven preventive services. In addition, funding for public health and community-based prevention remained low and inadequate. This was especially true for family planning services, education to limit sexually transmitted diseases,

HIV/AIDS prevention, and other interventions that raise concerns among some conservatives.

The new secretary of HHS should make prevention a priority. A new council, center, or agency could be created to signal its importance and concentrate policymaking authority.[39] The Centers for Disease Control and Prevention, for example, could maintain its traditional public health functions but relinquish its focus on clinical and selected community-based disease prevention efforts. The new organization would be in charge of setting prevention priorities, promoting healthy lifestyles, and developing policy for all HHS programs, including Medicare and Medicaid. It would become the main source of information on prevention, create a list of top concerns and goals, develop a cross-department budget, and issue a blueprint for administrative and legislative actions to advance the priorities.

This prevention blueprint would include policies for expanding the health care prevention workforce, creating incentives to promote prevention, and developing tracking systems for lifelong prevention. Over time, this agency, center, or council could, with congressional authorization, oversee a trust fund to pay for prevention. After all, insurers have little incentive to pay for prevention now that will benefit some other insurer or Medicare later. A Wellness Trust Fund that pools funding and directly pays for high-priority preventive and certain public health services could make disease prevention like other disaster preparedness: a public good.[40]

The First Year

The incoming HHS secretary should lay the groundwork through executive actions, regulations, and recommended legislation for a more accessible, affordable, and high-quality health care system. While most significant changes to the system will require comprehensive reform legislation, progress also could be realized in other areas.

At the top of this first year "to-do" list is to encourage proven, simplified eligibility rules, and regulations for public health insurance programs. The United States does not have a health coverage safety net for all low-income people. A patchwork of federal eligibility options combined with significant state flexibility yields a complicated and gap-ridden web of rules as to who is eligible for Medicaid and SCHIP. While this allows policymakers to target resources to subsets of low-income people, it also adds to confusion and increased administrative costs for both consumers and the government.

One study estimates that the cost of enrolling a child in Medicaid or SCHIP was $280—an amount that could be reduced by 40 percent by implementing simpler application requirements.[41] This complexity also affects participation by discouraging both enrollment and retention in Medicaid and SCHIP. Numerous studies have shown that simplifying the rules and applications for these federal and state programs can increase program participation among eligible individuals.[42]

The secretary could change Medicaid regulation to promote eligibility simplification. Specifically, the regulation that blocks states from receiving 90 percent matching funds for changing their eligibility systems could be modified.[43] This would allow states to access such funds to link eligibility systems in health to other state programs.[44] One of the most efficient ways to find and enroll eligible individuals into Medicaid or SCHIP is to use income information from non-health programs with comparable eligibility rules like the school lunch or food stamps program.[45] To ensure the greatest impact of these funds, their use could be conditioned on states adopting proven simplification practices, such as assets tests or continuous eligibility.

Promote Health Information Technology

Policymakers across the political spectrum agree that health information technology is essential to improving efficiency and performance. President Bush launched efforts to develop standards, and set a goal of equipping the majority of Americans with electronic health records by 2014. This is viewed as a good start, but it is not enough. Disagreement persists over how to accelerate adoption.[46] Some conservatives support letting the market pace the process. Others, including former Republican congressional leader Newt Gingrich, suggest greater government involvement.

As the country's major purchaser of health care, HHS could do what the Veterans Administration did—require its hospitals and providers to adopt basic technology standards as a condition of program participation.[47] Numerous other "carrots" (like loan funds) and "sticks" (like phased-in requirements for use) could also accelerate the adoption of health information technology.[48] The new administration should also appoint a new, high-profile national health information technology coordinator. The post has been empty for two years. This coordinator would be asked to prioritize resolving issues such as the legitimate concerns about medical privacy and whether the federal government should use only open-source software.

In addition, both Medicare and Medicaid could provide financial support for adoption of electronic medical records under certain circumstances. Medicare

could use its pilot and demonstration authority to test different models for implementing health information technology in ways that are cost effective. Medicaid could also use its 1115 demonstration authority for this purpose, as it has done in the past.[49]

In addition, the new director of the Centers for Medicaid and State Operations could issue a regulation that ensures that the implementation of electronic medical records for Medicaid beneficiaries qualifies for 90 percent federal matching payments, and that its ongoing operation qualifies for 75 percent federal matching payments, comparable to other information technology in Medicaid. Conditioned on using common technology that builds on the Medicaid Information Technology Architecture, this approach could jumpstart federal and state efforts for over 40 million beneficiaries. Lastly, the secretary could collaborate to allow safety-net providers, like community health centers or public hospitals, to use the Veterans Administration's successful VistA information technology system.

React Quickly to Health Emergencies

The United States remains ill-prepared to address health emergencies or crises, whether they are natural or man-made. Our emergency response system is swamped caring for millions of uninsured who have no other portal to the health care system. Between 1994 and 2004, emergency department visits rose by 26 percent while the number of emergency departments dropped by 9 percent.[50] Funding has been dedicated to protect against bioterrorism: nearly $50 billion since 2001 according to one estimate.[51] But this funding has primarily gone to the biotechnology and homeland security industries, with less invested in public health and hospital capacity, and with little attention paid to performance and accountability. The public health system remains plagued by fragmentation, inconsistency of response, and lack of integration with the medical system.[52] This was seen vividly in the haphazard response to Hurricane Katrina.[53]

In addition to working with Congress to increase funding, the HHS secretary could take several steps to increase the nation's readiness to deal with health emergencies.[54] It could continue to streamline and centralize the cross-agency communication and planning authorities in the HHS Office of the Assistant Secretary for Preparedness and Response. Currently, the ASPR both advises the secretary and coordinates federal, state, and local preparedness activities and response.

The HHS secretary could direct ASPR to increase its oversight of states' use of federal funding to achieve preparedness goals. Twelve states, for example,

now lack integrated disease surveillance systems, and 10 do not have plans for distributing emergency vaccines, drugs, or supplies.[55] ASPR could link these states' receipt of related federal funding to developing compliance plans, working in collaboration with other federal agencies. ASPR could also ensure that its nascent Emergency Care Coordination Center, created in 2008, has the authority to lead efforts in HHS to address the national crisis in emergency care.

The secretary could also keep reserve funding in the Public Health and Social Services Emergency Fund. This fund usually receives direct appropriations from Congress for time-limited activities, such as the Y2K scare or the very real threat of avian flu. The secretary also has the ability to reallocate (called "reprogram") discretionary funding from other programs to this emergency fund for public health emergencies. The secretary could annually reprogram funding to keep a reserve in this account as well as seek an annual appropriation for it. This would lessen the need to seek emergency supplemental funding or congressional approval for the reprogramming of funds in the case of an emergency.

Longer-Term Agenda

A number of health system challenges are slow burning: their onset, duration, and implications take place over years rather than days. Their solutions tend to be more complicated, often cutting across sectors and traditional policy silos. The political system is also biased against them because reelection to Congress and the White House is often based on what policymakers have delivered for constituents lately; changing a long-run trend line may have little currency in this context. The HHS secretary should both use the bully pulpit to develop cross-agency initiatives as well as employ existing authorities to lay the groundwork for long-term health care system improvements.

Arguably, the most troubling statistics about our health system are those that show systematically worse health access, quality, and outcomes for racial and ethnic minorities. The infant mortality rate for African Americans is 2.3 times higher than for whites.[56] Life expectancy is lower for Hispanics than whites. Native American and Alaskan natives are twice as likely to lack prenatal care as white women.[57] These differences are not just the result of unequal income, lack of insurance coverage, or illnesses. Even controlling for these factors, racial minorities receive less and worse quality of care.[58] Former Surgeon General David Satcher estimates that elimination of such disparities could have prevented 85,000 deaths among African Americans in 2000.[59]

The incoming secretary could make racial disparities the focal point of an HHS-wide quality initiative. A new assistant secretary for quality and value could have the mission of reducing variations in quality along racial as well as socioeconomic and geographic lines. The new assistant secretary could promote training in cultural competency, access to quality patient translation services, lifelong learning to accelerate the adoption of best practices, feedback on practice pattern variation, and financing incentives aligned with disparity reduction.

This type of work could also be achieved by restructuring the existing Office of Minority Health. The HHS secretary might also consider working with the secretaries of education and labor as well as the private sector, including the media and entertainment industries, to identify ways of reducing the discrimination that plays a role in lower quality of care for minorities. Given the broad social determinants of health, the HHS secretary could also urge a cross-department effort to develop a long-run agenda to reduce income inequality—a contributor to racial health disparities.

Advance Integrated Long-Term Care

Even though the United States has the most expensive health system in the world, it underspends on long-term care relative to peer nations.[60] The historic reliance on expensive nursing home care has diminished but has not been replaced with a quality-oriented, soundly financed, community-based alternative. Medicaid, through legislation, litigation, and administrative action, is now beginning to tailor care systems to community care and individuals' needs. Medicaid eligibility, however, is limited. Medicare covers some home health and skilled nursing facility care, but does not pay for the full range of long-term care needs. The private long-term care insurance market finances even less care. This already-inadequate system will be strained as the Baby Boom generation retires, doubling the number of seniors in the next 30 years.

The HHS secretary could use existing tools to expand demonstrations and state options for community-based long-term care services. For instance, demonstrations could assess integrated programs across service areas, such as Medicare-Medicaid dual eligible demonstrations linking health and income support or housing programs. The secretary could also encourage a reconsideration of federalism and long-term care. States have the primary responsibility for community-based long-term care, yet their ability to invest in such programs is constrained by the requirement that they fill in Medicare's gaps for low-income beneficiaries. Fully 40 percent of Medicaid costs are associated

with Medicare-Medicaid dual-eligible enrollees.[61] The secretary could explore ideas, such as making Medicare primarily responsible for filling in its acute-care cost sharing (as it does now for the drug benefit's cost sharing) while making states primarily responsible for certain types of long-term care.

Promoting private savings and long-term care insurance should also be examined since the strain on public financing, given changing demographics, will be enormous.[62] In addition, the HHS secretary should explore and expand complementary public program financing and expand capacity to provide care in homes and communities through assisted living, technology to allow home monitoring, and more community health workers and home health aides. Lastly, options for improving palliative care should be developed as a growing number of Americans die from chronic disease.

Support 21st-Century Health Care Workforce

While technology has increased the productivity of workers in most industries, the same is not true in the health sector.[63] Medical advances, along with disease and demographic shifts, have increased the need for health care workers as the content of care has intensified. Technology has also increased the number of jobs: in 2005, for the first time, health care exceeded manufacturing as a percent of all jobs.[64]

But the overall number of health care jobs masks distributional problems. Not all areas of the country have an adequate supply of providers. Moreover, the distribution of providers by specialty does not reflect the distribution of need. For example, the growing burden of chronic and preventable diseases is best met by primary care, yet between 1997 and 2005 the number of medical school graduates entering family practice residencies dropped by 50 percent.[65] Medical fields such as dermatology and radiology have gained in popularity, drawing off physicians.[66] Misaligned financing is partly responsible, with relatively low payment for primary care and long-term care providers. Undertraining and difficult working conditions are also to blame. And, as globalization takes hold, we may attract health care workers from other nations, but this may diminish their own capacity to deal with health crises like HIV/AIDS.

The HHS secretary could take a number of steps to steer the health care workforce toward new and emerging needs. The department's Health Resources and Services Administration operates a number of programs to fill these gaps; they could be reviewed for their efficacy and could probably be expanded. In addition, Medicare is the primary direct and indirect payer for medical education. Although Congress dictates this spending, the HHS secretary

could develop recommendations on how to spend it better, possibly by creating an all-payer trust fund for medical education.[67]

Beyond affecting the aggregate supply of health care providers, the secretary could shape the content of the training. Promoting prevention, reducing racial disparities in the quality of care, and adopting health information technology all could be advanced through the education and recertification processes. More radically, the secretary might examine scope-of-practice laws, such as reviewing what health services nurses, physician's assistants, and others are authorized to provide, to see if they need revision to adapt to current and changing demographics and health needs. The United States may need to enlist a new set of health care workers, such as pharmacists and community health workers, to achieve the full use of high-value preventive services.[68]

The need for different as well as more health care providers could rise if the next president succeeds in insuring all Americans. Massachusetts, which recently implemented its universal coverage system, has experienced a surge of unmet needs that revealed gaps in the state's ability to meet them.[69] This could be the most important long-term policy effort of the new HHS secretary should comprehensive health coverage become law during the new administration.

Food and Drug Administration

Protecting Public Health Through Science

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American consumers today are understandably skeptical about the safety of their food and medical products, yet the Food and Drug Administration is struggling to keep pace with breakthroughs in science, an expanding global market, and years of underfunding. The new administration can begin restoring FDA's place as a world regulatory leader by providing the resources it needs to do its job, guaranteeing there is a focus on science rather than ideology, ensuring the quality of imported products by increasing inspections abroad, and implementing several specific food and drug safety measures. Once the agency is able to effectively respond to these current challenges, it can begin to focus on