YANKEE DOODLING **Douglas Kamerow**

The rise and likely fall of Don Berwick

Failure to reappoint the Medicare chief will be a disappointment. What can be learnt?

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

The Centers for Medicare and Medicaid Services (officially abbreviated, incorrectly, as CMS) is the proverbial 800 pound gorilla of US healthcare. Its Medicare programme pays for care for Americans aged 65 or older, and its state based Medicaid programme covers uninsured poor people. More than 100 million US citizens have CMS administered insurance. The administration asked Congress for just under $850bn (£530bn; €615bn) to fund CMS next year, and its programmes are growing as the United States ages and more poor people are covered under the health reform's Affordable Care Act.

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

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

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

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

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

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

"Berwick and the Medicare and Medicaid recipients he could have helped deserved better than this"

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Recess appointments expire with the end of a two year congressional session, in this case December 2011. Presumably the administration hoped that Berwick could mend fences with enough Republicans to allow him to be renominated and (this time) properly confirmed by the Senate before then. It hasn't happened. On 1 March, 42 Republican senators wrote to Obama to urge him to withdraw Berwick's renomination because of the way in which he was appointed the first time, the now expanded role of CMS under health reform, and his "lack of experience" and prior "controversial statements."

How could this have happened? A visionary nominee, thought by many to be one of Obama's best appointments, who was endorsed by medical organisations, public health leaders, hospitals, and virtually everyone else in organised healthcare, is going to be scuttled after 18 months in office.

Perhaps it couldn't have been avoided, as the poisonous atmosphere between Republicans and Democrats seems to intrude at every level, especially where healthcare reform is concerned and given the many new Tea Party members of Congress. But maybe the president should not have waited until reform had passed to name his CMS leader, and maybe he should not have used the recess appointment to install him without hearings. It may have taken longer to get him into office, but perhaps Berwick would have ended up with more time—more than the 18 months he will likely have—to make the changes he needs and wants to make in the US healthcare system. As the *Washington Post* pundit Ezra Klein said, Berwick and the Medicare and Medicaid recipients he could have helped deserved better than this.

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Cite this as: *BMJ* 2011;342:d1640

LOBBY WATCH **Jane Cassidy**

The Cabinet Office Behavioural Insights Team

What is it?

Being rewarded for giving up smoking and being forced to choose whether or not to become an organ donor—these are among the first ideas to be rolled out by the UK Cabinet Office team popularly known as the "nudge unit."

Set up six months ago, the team is looking to use psychology to influence the choices we make, and health issues are high on its agenda.

The high street pharmacy chain Boots has signed up to pilot the smoking cessation project. People who make a commitment to quit, possibly in a written contract, will get rewards when they pass regular tests proving that they haven't been smoking.

Meanwhile people renewing or applying for a driving licence online will have to tick a box asking whether they want to become an organ donor. This "prompted choice" system is said to have significantly increased the number of US donors.

Other initiatives set out in a health discussion paper by the unit (www.cabinetoffice.gov.uk/sites/default/files/resources/403936_BehaviouralInsight_acc.pdf) include:

- Trialling a "teens and toddlers" charity project aimed at cutting pregnancy rates by getting teenagers at high risk of pregnancy to mentor a toddler at nursery
- Getting nurseries to team up with the Icelandic children's television show *LazyTown*, shown on BBC television, which motivates children to lead active and healthy lives. Iceland's prevalence of child obesity fell after the creation of the programme and its spin-off community activities
- The Welsh Assembly government and the charity Drinkaware working together on an advertising campaign to correct the false perception of how much alcohol students drink. This project is based on work by the University of Arizona, where a significant drop in heavy drinking was said to have been achieved after accurate drinking levels were communicated to students.

The Behavioural Insights Team's ethos goes further than simply trying to tackle pressing health issues. Last month it was due to start working with HM Revenue and Customs to look at ways of trying to encourage us to pay our tax bills on time.

The nudge philosophy was popularised in a book by Thaler and Sunstein

What agenda does it have?

The government calculates that lifestyle and behaviour factors are major contributors in around a half of all deaths. These factors include smoking, unhealthy diet, excess drinking, and sedentary lifestyles.

Legislation to try to put an end to such habits is not thought to be the way forward. The alternative is to use incentives instead of regulation as a cost effective way to persuade us to make healthy choices and behave in a more socially integrated way. To do this the government is turning to theories that are based on behavioural economics and that have been popularised by the book *Nudge: Improving Decisions about Health, Wealth and Happiness*.

One of its US authors, Richard Thaler, an economist at the University of Chicago Booth School of Business, is acting as an unpaid adviser to the unit, working with civil servants. The team is led by David Halpern, director of research at the Institute for Government and a former adviser to Tony Blair. Professor Thaler's coauthor, the Chicago Law School professor Cass Sunstein, is an adviser to the Obama administration. Critics of the nudge theory say that evidence of its effectiveness is scant (*BMJ* 2011;342:d228; *BMJ* 2011;342:d401).

Where does it get its money from?

The unit's work will be reviewed after 12 months and is funded for two years.

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Cite this as: *BMJ* 2011;342:d1648

doc2doc

The "Arab spring" revolution

BEN CURTIS/PA

On doc2doc, BMJ Group's global online clinical community, two Egyptian doctors recently blogged about the events in Cairo earlier this year.

Hatem: Tahrir Square demonstrations

In London on 27 January 2011 I watched the chaos in Egypt: large demonstrations; intolerable brutality. This chance might never come back—there was no stopping unless the president and his party fell. I had to be there. We demonstrated every day. I offered my help, but they had more doctors than were needed. People forgot their differences, their egos; they forgot "I" and became "we." By 10 pm our vocal cords stopped working, but there was overwhelming relief at supporting millions who had suffered over 30 years.

M B Ibrahim: The clean up of Liberation Square (Tahrir Square)

When I go onto the streets of Alexandria, I see children clustered along the roads wearing white coats, gloves, and masks.
"What are you doing?" someone asks.
"We're cleaning our country."
Some paint walls; some paint pavements; some collect garbage; some organise traffic; some even organise people using the underground. It is not the end of the story, neither the start.

Read these blogs in full at http://bit.ly/gLE1VP and http://bit.ly/ecCDY7

FROM BMJ BLOGS **Richard Smith**

Managing hypertension in a South African township

South Africa suffers from a "quadruple burden" of disease—infectious disease, particularly AIDS and tuberculosis; trauma from road traffic injuries and violence; perinatal and maternal health problems; and non-communicable disease. I thought of this burden as we visited the community clinic in Khayelitsha, the largest "township" in Cape Town.

The community clinic is familiar with HIV and tuberculosis, and large numbers of patients attend and are methodically treated with free drugs. The clinic staff have long recognised, however, that non-communicable disease is also a problem. We walked into the clinic where patients with hypertension were being treated. The first thing that strikes you is the huge numbers. People queue to enter the room where we stood, and perhaps 50 people were packed into the room—waiting to see the two nurses with their two assistants who were gathering information and measuring blood pressure. People wait until it's their turn, and then if they need to see the doctor they wait some more. People set a whole day aside to attend the clinic, and some arrive before dawn.

RS was visiting Cape Town to see the Centre of Excellence for Chronic Diseases in SubSaharan Africa, which is funded by the UnitedHealth Group, for which RS works.

Read this blog in full and other blogs at bmj.com/blogs