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**Health Policy and Women's Health: Current Status and Future
Priorities**
**George Washington University School of Public Health and
Health Services**
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JOSEF REUM, PH.D.: -Today's presentation is along those lines. In fact, you'll not only hear from an exceptional leader, Dr. Karen Davis, but you'll have the chance to honor an exemplar of changing the public health dialogue, Dr. Edward Brant, Jr. who's often considered by his peers to be the father of women's health. More information will follow on Dr. Brant.

Today's session though is a special partnership between the [inaudible] Family with us today, the University of Oklahoma College of Public Health, and the George Washington University School of Public Health and Health Services. Please join me in welcoming Patrick Brant, Rex, and Beth Brant as well as Deans Gary Raskob and Vivian Glore [applause].

Today's a special event as well because Dr. Peter Budetti is back in the building and we'd like to acknowledge Peter for his great leadership in helping establish the Center for Health Services Research and Policy and we're delighted to have him here today. So Peter [applause]. We also want to thank Pfizer who sponsor our grand rounds each year and the Kaiser Family Foundation who are bringing you this web cast.

Today's program, it's my honor to introduce to you Dr. Susan Wood who will introduce Dean Raskob. Susan is a research professor in our Department of Health Policy where here work on public advocacy focuses on the use of scientific knowledge to

inform public policy. She's also our interim executive director of the Jacobs Institute for Women's Health and an adjunct associate professor at American University.

She earned her Ph.D. in biology from the Boston University, their marine program. She's recognized internationally for her work particularly in women's health, family planning, and health care reform.

She's been featured on 60 Minutes and Nightline and this week alone, I've read three or four pieces, two praising her, two condemning her, and everyone saying she's going somewhere not too far from here. I hope she'll stay with us and I hope that she'll continue to lead the Jacobs Institute with vision and integrity.

In her career, she's served the U.S. Department of Health and Human Services, the United Kingdom's Department of Health, and the FDA. Her leadership policy, her policy breadth, and her experience have made her not only a productive researcher but a leader in women's health. So ladies and gentlemen, please join me in welcoming Dr. Susan Wood [applause].

SUSAN WOOD: Only two that condemn me, okay. That's good. Thank you Dean Reum and I also want to thank the Brant family and thank Professor Rosenbaum for putting together this wonderful inaugural lecture in memory of Ed Brant. I want to

talk a little bit about the Jacobs Institute because, of women's health here at GW, it joined GW's School of Public Health and Health Services two years ago and has a long history of pulling together the research community, the health policy community, and the women's health community to help translate what we know into what we can do to promote women's health across the lifespan.

So I'm very pleased that Jacobs Institute is not only here at GW but that I have the opportunity to work with it and to help move it forward. As my visual aid, I have a copy of the journal Women's Health Issues, which is published by the Jacobs Institute and is a leading resource for research and information on women's health policy across the nation and internationally.

I also want to talk just a little bit about Dr. Brant and his relationship with women's health particularly at the federal level over many, many years. Dean Reum said he's known as the father of women's health.

I think he's been referred to as the godfather of women's health and that transformational leader who helped really identified the need for more women's health research and more women's health services and prevention across the Department of Health and Human Services ahead of the curve before it became a topic that people talked about and knew

about and worked on in the multiple agencies of Department of Health and Human Services.

Dr. Brant realized in the early 1980s that there was a lack of research on women's health. There was a lack of focus on women's health and he convened and directed the first taskforce on women's health that, the Public Health Service Taskforce on women's health that put out a really groundbreaking report in 1985 calling for more work and more research to be done in women's health.

That really launched a whole wave of activities that continues to this day, a focus on women's health policy in federal health agencies. So I'm really delighted that both Jacobs, the University of Oklahoma, and George Washington University can pull together to not only honor his memory but to carry forth the work in women's health policy.

I have the pleasure of introducing Dean Gary Raskob from the College of Public Health at the University of Oklahoma where he also serves as Associate Vice President for Clinical research at Health Sciences Center in Oklahoma City. He has academic appointments in the Departments of Biostatistics and Epidemiology as well as in the Department of Medicine in the College of Medicine.

He's received his Ph.D. in pharmaceutical sciences from the University of Oklahoma, his Masters in Clinical

Epidemiology in Health Research from McMaster University in Canada and his Bachelor's in Pharmacology from the University of Toronto.

He's been a leading researcher and academic and clinician over a number of years and has been involved in things ranging from development of practice guidelines for a range of different medical and scientific societies but also to testify before the Senate on the issue of protection of human subjects in research.

He is recently elected to his second term on the Board of Directors for the Association of Schools of Public Health. Most importantly for today, he's joined us in creating this lectureship and coming from Oklahoma to help us launch it here at GW. Dr. Raskob [applause].

GARY RASKOB: Thank you very much Dr. Wood for that kind introduction. Good afternoon. Let me say it's a true pleasure and honor to be here at GW Hospital and to partner with the George Washington University School of Public Health and Health Services on this effort to honor our mutual friend and colleague, Dr. Ed Brant.

I'd like to thank and say how much we appreciate the efforts of Dr. Wood, Professor Rosenbaum, Dean Reum. Thank you. It's been a wonderful collaboration in launching this initial

inaugural lecture we hope will be an annual event that will go forward in perpetual memory and honor of Dr. Brant.

Thank you also for reminding me about Dr. Budetti and I just have to say I think my proudest accomplishment as Dean has been getting Peter Budetti, who's a diehard Notre Dame alum to wear the tie he's wearing today in honor of the OU Sooners.

So everybody has to see Peter Budetti after this round and look at his tie because if you know the history of Oklahoma football, you know that that's a major, major accomplishment [laughter]. So we will ask, Peter can fill you in on the background of that later on.

Rex Brant, Beth, Patrick, thank you for being here as well to participate in honor of your father and to again, perhaps even learn more about many of his wonderful contributions. Those of us who knew and loved Ed Brant knew that he was a man who really, in addition to being a very devoted Oklahoma Sooners fan, to the extent to that devotion it was actually directed by him that at his memorial service, we exit to the music of Boomer Sooner.

In his career Ed was, before we started hearing and reading literature about work-life balance, I think Ed was the absolute quintessential example of how to do that properly. He was a loving and dedicated father and it was wonderful to share

the stories with you Patrick and Rex about the experiences you had with your father.

He was a completely devoted public health professional dedicating his work in the public health service and to the betterment of public health in the United States. I didn't learn until after his death that he was a very accomplished minister for his church.

Ed was able to keep these activities as very distinct and clear missions in his life but knew how they should or should not influence each other and I think that that was just something that I learned about him that was very, very moving.

As we said, we are here to honor Ed's particular leadership with respect to women's health and we could think of no better individual to give this inaugural lecture than Karen Davis. Karen Davis is a native of Oklahoma. She was born in the town of Black Ball, Oklahoma, which is close to the big city of Ponca City, Oklahoma and if you don't know where that is, that's a couple of hours drive north of Oklahoma City closer to the Kansas border.

We really wanted someone who had known Ed, who had, being an accomplished individual with respect to women's health and health policy and I think that Karen Davis meets all of those goals. As you know prior to her current role as President of the Commonwealth Fund, she served as Chairman of the

Department of Health Policy and Management at the Johns Hopkins School of Public Health. She also served as Deputy Assistant Secretary for Health Policy in the Department of Health and Human Services from 1977 to 1980 and was the first woman to head a U.S. public health service agency.

Dr. Davis received her Ph.D. in Economics from Rice University. She's had many, many honors and awards over the years, too numerous to mention, but I do want to just highlight a couple of those. She's the recipient of the 2000 Baxter Allegiance Foundation Prize for Health Services Research.

She, in 2006, was selected for the Academy Health Distinguished Investigator Award and in addition, she is the recipient of the Picker Award for Excellence in the Advancement of Patient-Centered Care amongst many, many others.

She has authored many, many seminal publications related to health policy issues and as you know, her leadership at Commonwealth Fund has been extraordinary. All of us were commenting earlier on what a fantastic resource that is and so we thank you for that leadership and know that you'll be there continuing that in this very exciting time. So with no further delay, please join me in welcoming Dr. Karen Davis [applause].

KAREN DAVIS, PH.D.: Thank you Dean Raskob for that very lovely introduction and Dean Reum for making this possible. Dr. Brant and I spent more years of our life in two places, D.C.

and Oklahoma than any other places. So it's nice to have the co-sponsorship of the University of Oklahoma Health Sciences Center and George Washington University and it's particularly an honor to be here with Dr. Brant's family, Rex and Beth as well as Patrick Brant. So thank you for being here.

We all know him in various ways. Many of us knew, got to know him when he came to Washington as the Assistant Secretary for Health. I also had the pleasure of serving with him since 1991 on the Kaiser Commission on Medicaid and the Uninsured but obviously the things we treasure most are our own personal associations with him.

He served at the Commonwealth Fund as our Senior Program Advisor in the late 1990s and early 2000s and that was a period of time when we had a commission on women's health. We were aided by excellent research, by the Jacobs Institute. So it's nice to see Dr. Wood bring that activity here to GW.

Dr. Brant gave the Margaret E. Mahoney Award to Dr. Vivian Pinn, the Director of the Office of Women's Health at NIH, which he helped to establish. She used that phrase, the godfather of women's health because that is the way he's known at NIH.

Those of us who care passionately about this issue of ensuring that women have the best health possible, that they

have equitable access to health care, that they are included in clinical trials, and that their needs are addressed.

Mostly I think about Dr. Brant as a caring person. Last night, we had an opportunity to share some stories including the way he looked after my mother who still lives in Northern Oklahoma, alerting her on one occasion to the fact that a tornado was approaching and she needed to watch that on her television.

He was also a fantastic mentor. I'm sure that was true for many of you in this room. He really cared about health professional students. He also cared about staff at the Commonwealth Fund and every time he would come to our board meetings, he would check in to see how they were doing.

So I know he would be delighted that this lecture is focusing on women's health and particularly at a time when there is a unique window of opportunity for moving forward as a nation to advance health access and quality of care for all people in the United States.

Obviously, health insurance is important to everyone but it's particularly important to women. Women have greater need for health care but they also play an important role in their families, often as health care givers for frail parents or for children or simply getting their husbands in to see a

doctor but they also are important decision makers about health care for their families.

Okay so to begin, and to back up some of those statements that I made first of all with regard to health insurance coverage, perhaps it's surprising to some of you that women are less likely to be uninsured than are men.

That's partly because they are more likely to be covered under the Medicaid program of mothers of dependent children than are men. They do have employer health insurance coverage but typically they are more likely to be covered under employer health insurance as a dependent under a husband's policy.

The trend, over time, has been for that dependent coverage to be less secure. There have been steep drops in health insurance coverage in general under employer coverage but particularly under dependents. While there's been a growth in Medicaid coverage to offset some of the decline in employer coverage, that hasn't been adequate to keep the numbers of uninsured from rising.

So as women entered the labor force in greater numbers in the 1970s and 1980s, they were more likely to get their own employer coverage but they were also more likely to be part of the, particularly a part of the trend toward eroding coverage as dependent.

As a result, a proportion of women who are uninsured went up from 12-percent in 1980 to 18-percent in the most recent figures.

Why is health care particularly an issue for women if they are more likely to be insured than men? First of all, it's not just a function of coverage at a given point in time but the coverage over longer periods of time and the adequacy of coverage and the stability at that coverage given that women are more likely to depend on their spouses for coverage. They're also more at risk for instability in coverage.

The real issue is that health insurance matters especially for women because they are more likely to have low incomes. They are more likely to need health care services and to use services and they are more likely to have high out-of-pocket costs as they seek that care particularly when viewed as a percent of their much lower incomes.

Because they have more difficulty affording needed care, they are more likely to avoid or delay getting needed care because of costs and when they do get care, they are more likely to have medical bills and accumulated debt problems.

So just to look at that, young women are particularly at risk of being uninsured. In fact, 41-percent of women between the ages of 19 and 23 are uninsured at some point during the year. They are less likely to be working full-time

than are men, so less likely to be working at all and more likely, when they do work, to work part-time.

They are more likely, as I said, to have coverage through a spouse rather than through their own job but they are also greater users of health care services and just to use one illustration, they are more likely than men to be taking prescription medications on a regular basis.

So the comprehensiveness of coverage, the quality of benefits matters to women particularly as well as simply having coverage. That differential narrows for women and men over age 65 but it's particularly marked among young adults where women are much more likely to be taking prescription medicines on a regular basis than are men, not surprisingly, given the fact that they are greater users of health care services.

The total dollars spent on health care per person are higher for women than for men. You don't see differences among children. There the rates of utilization, the total cost of care is fairly similar. It's really when they hit that young adult stage at ages 18 to 24, ages 25 to 44 that you see the strong differential by gender.

Obviously a large part of that is pregnancy-related but not all of it. Even taking out prenatal care, delivery, postnatal care costs, women have greater use of health care services and greater expenditures.

Those differentials continue up into the Medicare age range of age 65 and over but are much narrower differences between women and men once they are on Medicare.

The most important way to think about these patterns of use of services and out-of-pocket expenses is how they relate to income. Fifty-percent of women spend more than five-percent of their income on out-of-pocket health care expenses. That's a third of women spending more than ten-percent of their income contrasted in that case by about 19-percent of men.

Given the out-of-pocket costs that women face, they are also more likely to say they simply don't get the care they need. That's obviously particularly true for women who are uninsured at some point during the year where two-thirds of women report that they experienced one of four different access barriers to care.

They did not fill a prescription, did not see a specialist when needed, skipped recommended test treatment or follow-up, or simply didn't visit the doctor at all when they needed care, so again, greater problems for women overall. Those problems are particularly pronounced when women are uninsured.

They have these problems over time. You see the specific kinds of barriers, again, I would stress the importance of medications but simply getting the kind of care

that is recommended by their doctor, whether that's a mammogram or other type of specialist care, or procedure, they're simply more likely to go without that care than are men.

Turning to the financial burdens in more ways, the Commonwealth Fund's recent survey on health insurance coverage found that about 116 million adults, under the age of 65, report that they're either uninsured at some point during the year, underinsured, have accumulated medical debt, or have problems paying medical bills. It's just devastating the effect of this inadequate coverage has on men as well as on women. You see that 31-percent of all women, ages 19 to 64, are talking about having accumulated debt that they're paying off over time.

Often these people have used credit card debt to charge prescription drugs. That's part of their debt problem. Some report that they have taken out home equity loans or used home equity loans to help pay their debt and they report that in many cases, they have used up all of their savings, savings that they need for their own security during this period but also need in retirement, to meet the expenses when more women are likely to be on their own, living alone in older age.

Alright, let's talk about more specifically how well the health insurance market works for women. In general, health insurance works best for everyone when they get it through a

stable source particularly good benefits through employer coverage. When women try to buy health insurance in the individual market, they experience many difficulties.

I think one of the most shocking recent findings contained in the National Women Law Centers report nowhere to turn, how the individual health insurance market fails women is the fact that premiums are often explicitly higher for women than they are for men. Thirty-eight states do not prohibit setting different rates for men and women in individual health insurance coverage.

On issues like maternity coverage, it is typically missing in the individual health insurance market or available on a very costly rider if available at all. The New York Times had a story by Robert Pear in October, documented the differences in premiums that women pay under specific health carriers in specific geographic locations. Women paying, in many times, 20 to 30-percent higher premiums than are assessed to men for coverage.

We have found, in our studies, that many people, who seek coverage in the individual market, do not buy that coverage. One of the reasons they give is that it does not meet their needs. One of the first major issues there is that maternity coverage is often not part of health insurance coverage and only rarely, in 12-percent of the cases, does it

cover comprehensive maternity care. More typically when it is offered, it's offered through a separate rider with high premiums for that coverage.

The benefits are often limited. It may pay a maximum of \$2,000, require women, for example, to pay 20-percent of the bills up to the limit of the policy but then obviously, everything over that benefit. For \$2,000 worth of benefit would typically charge a premium of about \$1,300.

So even for an uncomplicated delivery in 2006, the woman would be paying almost \$7,000 for that delivery even with coverage. If she were to have a Caesarean section with complications, she would be facing bills of \$16,000.

The whole purpose of health insurance is to spread risk and since you don't know for the most part whether you will have complications during pregnancy to be able to charge a uniform premium, uniform cost across those who might need more expensive care in the form, in this case of Caesarean section with complications, that's simply not happening in these kinds of policies.

Well I think that's enough of all of the dreary statistics. To turn to a note of optimism about the future and the hope that, I think, everyone in this room shares about what we might do to replace this current system of coverage, it is, I think for all of us, extremely exciting that President-Elect

Obama made health care a major feature of his campaign and promised change, promised a new direction including high priority to health reform.

Our commission on a high performance health system at the Commonwealth Fund is there's really five things that you need to do to get to a high performance health system.

The first and foremost is that we extend health insurance to everyone, and certainly health insurance that insures affordable access to care, continuity of care, has low administrative costs.

In addition we need a health system that is rewarding, rewarded for providing high quality care, getting good outcomes and we need a health care system that makes it easy to be a patient rather than so many times, being on your own to find the care you need or calling Dr. Brant and to getting advice about how to get the care that you need.

To have a high performing health system, we need to invest in the infrastructure that it requires to have data on that performance, to improve that performance, to have guidelines of what constitutes high quality evidence-based medicine, and health information and health information technology that pulls all of the information together and is accessible both to patients and to those caring for them.

Finally, we need leadership and a coherent set of policies that are all pulling in the same direction. Well what do we have to choose from? Well there are lots of different strategies for health insurance coverage, expanding the employer-sponsored market, expanding the individual market, expanding public programs, making coverage universal. All of those have advocates but they all have strengths and weaknesses as they affect women.

So colleagues at the Commonwealth Fund, Kathy Shanes, Sarah Collins, and I published an article in Health Affairs in May of this year setting forth what we called a Building Blocks Framework for automatic and affordable health insurance coverage for all.

The basic strategy is to offer choices to women and men that let them select health insurance coverage that best meets their needs. For those that have employer coverage, employer coverage would be kept in place, in fact it would be improved.

All employers would be required, except very small employers, would be required to provide health insurance to their workers or make a financial contribution toward that coverage. They would be required to cover young adults up to age 26 under their parents' health insurance policy. So you remember those very high rates of gaps in health insurance coverage, gaps in adequate health insurance coverage. It would

permit them to stay on parents' health insurance policies up to age 26.

It would also establish a national health insurance connector, a national health insurance exchange, and provide an array of private plans. So unlike where women go into the individual insurance market now, there would be a comprehensive set of benefits that would be included in those policies. So there would be standards on what constitutes an adequate plan.

The other feature of this proposal, I just came from a meeting of our commission on a high performance health system where they're voting as I speak, on this feature, but it would provide a public plan option modeled on the Medicare program but with the benefits more similar to what is in the federal employees' Blue Cross/Blue Shield standard option benefits package but administered by the Medicare program, make that available.

One of the issues the commission was debating this morning is whether it's just small employers or everyone but at a minimum. In our Building Blocks proposal, we said it would be available to all employers with employees of 100 or fewer and to individuals could buy into that.

In addition, the Medicaid and state children's health insurance programs would be expanded in the Building Blocks

proposal, we set a floor of 150-percent of the of the federal poverty level of the coverage of low-income adults.

It expands Medicare in two ways, eliminating the two-year waiting period for coverage of the disabled under Medicare as well as letting older adults, in the case of our proposal, those age 60 and over buy into Medicare.

For those of you who have followed President-Elect Obama's health plan, he has nearly all of these provisions in his health reform proposal. We don't get involved in politics. We didn't help him develop it but a lot of the ideas are ideas certainly have been tried in Massachusetts with their 2006 health reforms.

There are a few provisions we have here. First of all, we have what's called individual mandate. We require everybody to have health insurance and we specify the generosity of that income-related premium assistance, which assures that nobody below 200-percent of poverty ever has to pay more than five-percent of their income for premiums or even above that, never has to pay more than ten-percent of their income.

So we also have these Medicare improvement strategies that bring a few more people into Medicare but also improve benefits for current beneficiaries. This is an issue nobody's talking about is if you're going to have these financial

protections for people under aged 65 and adequate benefits, it means also improving the Medicare benefit package.

So anyway, in other respects very similar to what President-Elect Obama has put forward, he's advocating having employers have responsibility for providing or contributing to health insurance coverage. He has a national health insurance exchange where he provides private plans and a public plan option, would expand Medicaid and the state children's health insurance program.

Again, what I'm missing at the commission meeting, Senator Max Baucus, who chairs the Senate Finance Committee's aide, Liz Fowler is speaking to our commission in 15 minutes about his recent plan, which again has all of these elements.

He has the employer pay or play. He has the national health insurance exchange. He has a public plan model on Medicare available through that exchange. He would cover adults up to 100-percent of the federal poverty level, children up to 250-percent of the federal poverty level. So he's made quite explicit what the income ranges would be for expanded Medicaid and SCHIP program.

He also includes eliminating the two-year waiting period for the disabled under Medicare and a buy-in for people ages 55 to 64. So when I read those last two pieces, I was so

excited just to see those provisions because I think we have been neglecting the importance of also improving Medicare.

So what else needs to happen besides coverage? For one thing, care needs to be much better coordinated. I'd say our health care system works like building a house where you are the general contractor. You have to find the best specialists for this, the best specialists for that.

You have to arrange for those services, get on the phone, call, complain if things aren't done right. You're kind of on your own in the health care system in a very fragmented system where you get care in lots of different places.

By contrast, there are a few organizations in our health care system that provide integrated care and really serve that. We took our commission to San Francisco to see Kaiser Permanente, George Halverson, the President of Kaiser Permanente's on the commission.

We were in the Chinese module where not only are all the providers and staff bilingual but before a patient left, they had gone on the computer, found a specialist, a GI specialist that that patient needed to see, made sure that their language was spoken there or translation services were available and had the appointment and printed it out before the patient ever left. So I don't know if that's typical of your experience getting health care [laughter].

My experience is, at best, the doctor says at the front desk, they'll give you a card with a name of somebody that you might call. So trying to move what we call, move up the Hill from our very fragmented health care system to a more integrated delivery system and to do that, we're going to have to change the way we pay, moving to what's called bundled payment.

So a flat fee for the total care of the patient over a period of time and getting explicit bonuses, pay-for-performance that rewards care coordination achieving good outcomes for patients.

We released a report last December called Bending a Curve that said this is not so far-fetched. There actually is a way to cover everybody if you're willing to combine it with these kinds of payment reforms, these kinds of changes in the health care delivery system, invest in health information technology, set up a center on comparative effectiveness. I see Dr. Brian Isle in the audience.

It also means eliminating some of the overpayments from Medicare Advantage plans, research that he's done here at GW for the Commonwealth Fund; negotiating prescription drug prices, increasing taxes on tobacco and sugar soft drinks, and giving that money to states and local governments that really pursue a set of policies similar to some of the things that

have been done in New York City like banning smoking in bars and public spaces, banning trans fats in restaurants so that \$1.6 trillion could be saved at the same time that we cover everyone if we're willing to take this kind of a comprehensive integrated strategy toward health reform.

It still will require federal budget dollars but those budget dollars decline over time as those kinds of reforms, investments in information technology and provider payment reform take hold.

So it is important to women that we pursue a health reform agenda. It is important to all of us that, that strategy be comprehensive, that it address not only health insurance coverage but giving us the kind of health care system that's rewarded for excellent results on health outcomes and that really makes care patient-centered for men and for women.

So many thanks for this opportunity to speak, for your attention, and to all of my colleagues at the Commonwealth Fund for their assistance. Thank you [applause].

JOSEF REUM, PH.D.: Thank you. Would you be willing to take one or two questions? Questions? Questions?

MALE SPEAKER: I have a question, somewhat two wildcards in terms of [inaudible] the workman's comp system and also the Department of Veterans Affairs, do you think that there are any reforms in terms of what you're talking about that would be

necessary, either work comp or the level of services from the VA?

KAREN DAVIS, PH.D.: So the question has to do with what changes are needed in workman's compensation and in the Veterans Administration. Wouldn't you know that the first question at GW would be a tough question. So I think the honest answer is I don't know.

What I like about President-Elect Obama's reforms is that they would apply to all public programs. So they would apply to Medicare, Medicaid, Tri-Care, for defense. They would apply through places like the Veterans administration.

I haven't heard explicitly on workman's compensation, they would apply to Medicaid. Obviously, the more that these reforms are built into all sources of payment, the easier it is for patients and the more leverage it has over health care costs.

I didn't present the population estimates from Building Blocks but roughly 60-percent of the population would be covered under Medicare, reformed Medicaid or this connector that offers plans that would follow in President Obama's scheme. these kinds of reformed payment systems.

He doesn't go so far as to saying what private plans, what policies whether they would require information technology, whether they would use comparative effectiveness,

information in designing benefits but what our commission on a high performance health system is talking about is at least having the public sector, Medicare, or a Medicare health board convene private payers and talk about how their policies of coverage and payment might be harmonized to get greater simplicity and greater impact.

So I basically finessing your question more directly on workers' comp and VA but at least the notion of trying to create more uniform policies within anything that is publicly funded and then try to encourage, on a voluntary basis, participation by private payers in those policies.

FEMALE SPEAKER: The Commonwealth Fund does such wonderful work for different subpopulations and one of the other subpopulations that you focus on is young children and I wonder whether any of your research sheds light on the particular effects that poorer health in women have on the rest of the family members, whether there are any differentials between a father who's in fair to poor health in terms of how it may affect income or family well being versus a mother in fair to poor health, whether they play out the same or it's somewhat differently, both on the family's wellbeing and on the children.

KAREN DAVIS, PH.D.: That's a good question. The question having to be what the interrelationship between family

health and children's health. I'm sure there are people in the audience who know the answer to that better than I do. What I'm more familiar with is that if parents have health insurance coverage, they are more likely to take their children for health care.

So if you provide health insurance just to the children, they're not as likely to have developed relationships with the health care system as if the parents are covered but I'm sure your point about the health status being interactive is also true. I do think that the state children's health insurance program is likely to be one of the early initiatives for the simple reason that it expires at the end of March.

Those of you and Dr. Rosenbaum, is absolutely the nation's leading expert on that, know that it passed Congress twice but was vetoed by President Bush. So I think everybody thinks it will definitely get passed very quickly in the 111th Congress and signed into law by President-Elect Obama.

There's a lot of questions about whether it will be unfinished business, be passed separately or whether it be folded into an economic stimulus package, whether it be folded into an omnibus budget reconciliation act, whether it would be folded into an even bigger budget act that included health reform.

So I don't think we quite know what form it should take but as I talk about how it's important to go beyond coverage, I think the state children's health insurance program is a real opportunity to help children get into systems of care that really work for children.

So if it were up to me, I would definitely link coverage to encourage that children be enrolled in what are called patient-centered medical homes. The whole concept of a medical home started with the American Academy of Pediatrics and it's basically a physician practice or pediatric practice or a nurse planning that would be held accountable to certain standards of care.

Among them, 24/7 access to care, among them helping coordinate your care when you do need specialist care, among them really using the tools that are available to achieve excellent results on care.

So I would include an SCHIP, a requirement that all children be enrolled in a patient-centered medical home and that quality standards be established for those practices and that they be appropriately rewarded on my up the chart.

I really focused on the far end of that integration but at the bottom left, you see the blended fee-for-service medical home fees. Even relatively small physician practices could take that form of blended payment and get extra payments for every

child enrolled in the practice, every adult enrolled in the practice as well as getting bonuses on the extent to which that practice really provided the kinds of quality process and structural as well as outcome measures that one would want like getting children immunized for example.

So I do think this is an important issue, one that needs to be addressed early on in the Obama administration and that I'm quite, quite confident will be.

JOSEF REUM, PH.D.: That's about all the time we have. Would you join me in thanking, I don't know if Dr. Brant were the godfather of women's health, I want to introduce you to the Thomas Jefferson of health care reform [laughter] [applause].

[END RECORDING]