The Richard and Hinda Rosenthal Lecture 2008: Prospects for Health Reform in 2009 and Beyond

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THE RICHARD AND HINDA ROSENTHAL LECTURE 2008

PROSPECTS FOR HEALTH REFORM IN 2009 AND BEYOND

20TH ANNIVERSARY LECTURE

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

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The serpent has been a symbol of long life, healing, and knowledge among almost all cultures and religions since the beginning of recorded history. The serpent adopted as a logotype by the Institute of Medicine is a relief carving from ancient Greece, now held by the Staatliche Museen in Berlin.

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"Knowing is not enough; we must apply.
Willing is not enough; we must do."
—Goethe

INSTITUTE OF MEDICINE
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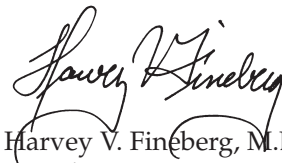
Foreword

The Institute of Medicine launched an innovative outreach program in 1988. Through the generosity of the Richard and Hinda Rosenthal Foundation, a lecture series was created to bring greater attention to some of the significant health policy issues facing our nation today. Each year a major health topic is addressed through a lecture presented by an expert in the field. The IOM later publishes this lecture for the benefit of a wider audience.

The Rosenthal Lectures have attracted an enthusiastic following among health policy researchers and decision makers in Washington, DC, and across the country. The lectures produce a dynamic and fruitful dialogue. In this volume, we are proud to present the remarks of the 2008 Rosenthal Lecturer, Julie Rovner, who spoke about "Prospects for Health Reform in 2009 and Beyond."

I would like to thank Clyde Behney, Jody Evans, Abbey Meltzer, Autumn Rose, Marty Perreault, Sara Sairitupa, Judy Salerno, Vilija Teel, Lauren Tobias, Jackie Turner, and Ellen Urbanski for skillfully handling the many details associated with the lecture program and the publication.

In their lifetimes, Richard and Hinda Rosenthal accomplished a great deal. The Rosenthal Lectures at the Institute of Medicine are among their enduring legacies, and we are privileged to be the steward of this important ongoing series.



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President
Institute of Medicine

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Welcome

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Harvey V. Fineberg, M.D., Ph.D.

Good evening everyone. I'm Harvey Fineberg and it is my great privilege to welcome all of you to the 2008 Rosenthal Lecture, here, at the Institute of Medicine. This lecture series dates back 20 years and it is only possible because of the generosity of the Richard and Hinda Rosenthal Foundation.

Hinda Rosenthal, until her death 2 years ago was a very active philanthropist, who was especially concerned in fulfilling the work that she and her husband started in such areas as medical care (clinical medicine was his passion), the social sciences, and scientific research.

Richard L. Rosenthal was a prominent member of the Presidents' Circle of the National Academies, a corporate executive and private investor, as well as a philanthropist with a wide range of interests, particularly in the intersection of the social sciences, medicine, and the humanities. After his death in 1998, in tribute to his memory and in recognition of his service, the Rosenthal family endowed this lecture series and named the President's Suite of the Institute of Medicine.

Tonight, we have a very special opportunity to continue the tradition of this lecture; to bring to our community a discussion of some of the most timely and significant issues in health policy of our day. I want to say at the outset that if you look at your program this evening, there is a typographic error on the times. It says welcome at 7:00, presentation at 7:25. I wanted to hasten to assure all of you here that it should read 7:05, lest you fear that I will continue indefinitely to sing the praises of those who do deserve 20 minutes of praise, the Rosenthals, but, my great privilege this evening is to welcome and introduce to you our speaker, Julie Rovner.

You all know her. She is a health policy correspondent for National Public Radio, specializing in the politics of health care. She also serves as a contributing editor for the National Journal's CongressDaily. In 2005, she was recognized with the Everett McKinley Dirksen Award for Distinguished Reporter of Congress for her coverage of the passage of the 2003 Medicare Prescription Drug Bill and its aftermath.

She's also a prolific author and, indeed, I want to remind everyone and I believe you'll find the announcements just outside, that the third edition of Julie Rovner's book *Health Care Politics and Policy A to Z*, or as they say in England, A to Zed, has just been introduced and is available now to edify all of us. It is a kind of encyclopedia of health policy.

Julie was actually born here, in the Washington, DC, metropolitan area. She graduated with honors from the University of Michigan, Ann Arbor. Her degree was in political science. She resides now in North Bethesda, Maryland.

Her topic for the evening, Prospects for Health Reform: 2009 and Beyond, has gained increased momentum since this was discussed with her during the campaign. I'm sure many of you have heard through the course of this day of President Elect Obama's announcement that Tom Daschle will be nominated to be his Secretary of Health and Human Services.

So with great anticipation and with a great sense of pleasure, it is indeed my privilege to welcome and introduce to you Julie Rovner.

Keynote Presentation

Julie Rovner

National Public Radio Correspondent and Health Policy Expert

Thank you. I actually hasten to add that the President Elect did not announce that former Senator Daschle would be his HHS Secretary but it got leaked.

Well thank you all very much for being here. I see some friendly faces in the audience, which is always nice. I have been asked to talk about the prospects for health reform and I am pleased to report that for the first time in many years there actually seem to be prospects for health reform. In fact, I'm going to go out on a limb and say that this seems to be a pretty good time to be a health policy reporter. It may even be a good time to be in health policy.

On the other hand, it's pretty risky out there. I was talking with one of my colleagues at National Public Radio last week and I mentioned one of the candidates for Health and Human Services Secretary—Tom Daschle, actually, and she said, gee, he's such a nice guy, why don't they give him something that achievable like Middle East peace?

Seriously, in 1993 I traveled around the country and I made a lot of money talking about why health reform in 1994 was inevitable. Now I'm not allowed to take money, and I've pretty much stopped making predictions. But I will predict that we will see another effort in health reform in the next year and I'm going to give you several reasons why.

First and foremost, President Elect Obama's voters are expecting it. You know if you spend 80 percent of your advertising money on one issue, as candidate Obama did late in the campaign, by God the people who vote for you expect you to deliver on that promise.

Now, health care was not the top issue in most of the exit polls—that

would have been the economy by a very wide margin. But of the voters that said that health was their top issue, they voted for Obama by very large margins and, more ominously, 60 percent of Obama's voters said in a Harvard School of Public Health poll in late October that they expected that if he was elected it would make, "a great deal of difference on health care." So economic woes notwithstanding, this is an issue that the new president can't afford to put on the political backburner for very long.

The second reason I think health care is likely to come up soon is Senator Ted Kennedy's last hoorah. Unless you've been living under a rock for the past 8 months, you certainly know that Senator Edward Kennedy, Chairman of the Senate Health, Education, Labor, and Pensions Committee, is undergoing treatment for a malignant brain tumor. Senator Kennedy actually returned to Capitol Hill this week looking pretty good, all things considered, but it seems pretty clear that this next Congress is likely his last best chance to realize his career-long goal of achieving universal health insurance. Kennedy has been quietly laying the groundwork for another major health reform push, his fifth or sixth by my count—there may be someone in this audience who knows better than I—since he helped broker the deal that produced Massachusetts's landmark health reform plan in 2006.

So Senator Kennedy has been pretty active on this the last couple of years. In fact, just yesterday he appointed Hillary Clinton to head a working group of his committee on insurance coverage. I guess that's assuming that she doesn't become Secretary of State or, knowing Hillary Clinton, she might try to do both.

Speaking of laying groundwork, the third reason I'm bullish on health reform is the proliferation of bipartisan and strange bedfellow alliances sprouting up around town. It seems just about everywhere you look people who don't usually agree on health issues are working together. That strange little donkey-phant creature in the Divided We Fail ads representing AARP, the SEIU, the Business Round Table, and the National Federation of Independent Business—wow, who would have thought those groups would find common ground. It's just the tip of the iceberg.

On Capitol Hill, we've already got a substantial head of bipartisan steam building up behind Democratic Senator Ron Wyden's Healthy Americans Act, including liberals like Debbie Stabenow and conservatives like Judd Gregg. They're both co-sponsors of that bill.

Downtown, there's a group of former Senate majority leaders also working on health reform consensus, including Republicans Howard Baker and Bob Dole and Democrats George Mitchell and Tom Daschle—yes, that same Tom Daschle who's about to be the Health and Human Services Secretary designate and White House health czar.

Then there was the return of Harry and Louise this summer. Those were the actors who helped sink the Clinton plan. Yes, Harry and Louise

were the names of the actors, not the characters. They were brought back calling for health reform, brought to you this time by former archrivals, the aforementioned NFIB, the National Federation of Independent Business, and Families USA, along with the American Hospital Association, the Catholic Health Association, and the American Cancer Society.

Of course, seeing Harry and Louise back on TV isn't the only way that it feels a little bit like 1993 out there. First of all, the state of the nation's health care system is, to use a technical phrase, kind of sucky. I presume you wouldn't be here if you didn't already know most of the statistics so I won't dwell on them: 46 million Americans without health insurance, 25 million more with inadequate coverage and the U.S. spends $2 trillion a year on health, about 16 percent of our GDP.

The $6,700 we spend, on average, per person, is almost two and a half times the OECD average of $2,800 and half again as much as the next highest spending country, which is Switzerland. Now, I must say that I've just been to Switzerland earlier this year. They cover everyone through mandated private insurance. They don't seem to skimp on care for the substantially less they pay but I digress.

You only have to look up at Capitol Hill to see the big three automakers begging lawmakers for a bailout to see what health care costs are doing to our manufacturing base—what there is left of it. Okay, the woes of the auto industry are about more than just health care cost but they've played much more than a minor role.

Still, while there are lots of ways you could say this is like 1993 but worse, there's one big difference: attitude. Back then health reform seemed, well, inevitable. It wasn't a matter of whether but what form it would take. Now, with many key players on Capitol Hill (likely about to populate the new Obama administration) still sporting scars from the aftermath of that spectacular Clinton failure, I'm going to coin this effort the new era of pragmatism.

To listen to people, legislators, lobbyists, and stakeholders alike, they might as well all be wearing the same t-shirt already emblazoned with these words—and I'll give you the G-rated version—let's not mess it up this time.

Just today the members of the Senate Finance and Senate Health, Education, Labor, and Pensions Committee met to talk about jurisdiction. That's always a touchy discussion. Yet, Republicans and Democrats emerged from the meeting to profess just how optimistic they are at their chances to get legislation not just passed, but passed early next year. They're talking January, not for passage but for getting a bill.

I must say I am surprised at how willing to compromise everyone seems to be, at least for now. After all, there's nothing quite like the first blush of everything seeming possible. But there's reason why every effort at health reform since Teddy Roosevelt has failed. A big one is the power

of the status quo. That $2 trillion we spend on health care every year, every penny of that is someone's income and the dirtiest word in health reform, it's not rationing, although that's a close second, is redistribution. Every time you take one of those dollars and give it to someone else the donor is going to yelp and hire a lobbyist.

A second problem is that the devil is always in the details. It is so much easier to get agreement on a broad outline or a set of principles, than it is to write actual legislation or to remake a system that accounts for a seventh of the nation's economy—or is it a sixth by now?

Then there's money. Yes, the $700 billion Wall Street bailout finally made health reform look cheap. It's about time something did but there's still going to be sticker shock and there's going to have to be the difficult discussion of who's going to pay and how much?

The next biggest obstacle is what I call the demagogue's delight. Let's face it; the public doesn't understand health reform because the public doesn't understand the health system as it exists today. Most seniors would have been far better off under the ill-fated 1988 Medicare Catastrophe Recoverage Act—and I know there are people in the room here who know this. It was specifically designed to create far more winners than losers but because, like virtually all health legislation, it was complicated to explain and easy to mis-explain, demagogues were able to churn up enough opposition to make Congress repeal it.

Another unanswered question is what the loyal opposition will do. As I already mentioned, Republicans, for the moment, seem to be all aboard the health reform express. They read polls and run for reelection too. But those who were around at this point in 1992 might remember that Republicans were also professing support for health reform. In fact, Republican opposition to the entire effort didn't really begin in earnest until late in 1993, after President Clinton sent his bill up to Capitol Hill. With minorities in both the House and Senate, the only real power Republicans will have over the next 2 years is the power to say no. We'll have to see if they end up using it.

Finally, there is what we in health policy circles know as Altman's law. It's named for Brandeis University health policy professor and longtime Washington policy maven, Stewart Altman. It holds that every stake holder's second choice for health reform is the status quo. In other words, when no one can agree on a change, nothing changes, which is pretty much where we've been in health care since the passage of Medicare and Medicaid—at least in terms of large-scale changes.

So where does that leave us? Well, I'm pretty confident there's going to be a health care debate in the relatively near future. The outcome? Your guess is as good as mine but I'm guessing it's going to be a pretty fun ride. Thank you for listening and I'll be happy to answer a few questions.

Discussion

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DR. FINEBERG: I'll moderate and help with questions so the floor is open for question or comment.

AUDIENCE QUESTION: (Off microphone)

DR. FINEBERG: Could you repeat the questions too because I think we won't pick it up otherwise?

MS. ROVNER: The question is where do I think the biggest divide will be between Republicans and Democrats. If you'd asked me this before the election I would have said probably the role of government, you know, who sort of provides. Do we go with a government-type plan or do we go with more of a private-sector plan? But, actually, right now what's shaping up as the biggest divide is whether or not this gets paid for.

I think the democrats are leaning toward trying to do some kind of a plan that perhaps is not paid for, that maybe they would suspend some of the pay-as-you-go requirements to do some deficit spending at least in the early years. There's no way that this will not be expensive, particularly at the beginning. You know, Max Baucus, Senate Finance Committee Chairman, is starting to use the word investment, starting to talk about well, maybe this is part of the stimulus, of getting the economy going. It's sort of his way of trying to prime the pump, if you will, for saying we don't really need to offset all of it as a way of not having that little redistribution chore that everyone knows is going to be so politically perilous.

Immediately today after this meeting Chuck Grassley walked up right

behind him and said, "I don't know about that not paying for it part." So I think there may be more of a possibility of finding an agreement on a fundamental plan for covering the uninsured and finding ways to change the health system. We may well come to blows over whether it's on-budget or off-budget or finding a way to pay for it. But it's so very, very early. You know everybody is going to be finding their way so it could be something entirely unpredictable now that it all comes to blows over.

AUDIENCE QUESTION: Two other issues that may be points of disagreement are whether there should be any cap on the tax exclusion and whether there should be mandates on individuals. Could you comment on those?

MS. ROVNER: Yes, two questions, things that are on the table, two big issues. One is the tax exclusion, which is a large source of spending and/or revenue. This is a fact when 160 million people who get their health insurance on the job do not pay taxes on the value of the insurance that is provided to them. This was something that John McCain had wanted to change in his health plan and President Elect Obama basically said over my dead body.

Well, the problem with that is that there are an awful lot of Democrats who think that maybe that would be a good place to get some of this money to finance health care. So the new president may have to have some dealings with Congress over that issue because it's an awful lot of money and there are ways, as some Democrats are already talking about, to perhaps maybe not make it go away but to make it go away for the very wealthy or to find some way to adjust that. It is, as I mentioned, a very large source of potential revenue. So I think that's probably more on the table than the president might have intended.

The other question is whether or not there will be mandates. Again, President Elect Obama ran on a plan that did not provide universal coverage. It only provided mandatory coverage for children. He was careful to say (at least his advisers were very careful to say) all during the campaign that he was open to the possibility of mandates down the road. I think I read that to say that if a democratic Congress really wanted to cover everybody that he would be happy to sign such a bill. So I think he's boxed himself into much less of a corner on that than he has on the employer tax exclusion.

AUDIENCE QUESTION: You've already mentioned this a little bit about the fraction of the health care dollar that goes toward administration of

health rather than delivery of health. What's the prospect of getting some of that money moved into the act of delivering health care?

MS. ROVNER: Well, that's certainly been talked about for an awfully long time. Having a multi-payer system with private insurers means that there's more overhead than we would have in a single-payer system. Certainly there is a lot of work going on and a lot of desire to have more electronic medical records (to reduce the amount of overhead) on the clinical side. No one has yet figured out exactly how to make that work, how to make those records talk to each other. There was a small move toward it last year when Congress mandated e-prescribing but that's just the tip of the iceberg on getting to full electronic medical records.

Unless the country goes toward a full single-payer plan, there's going to be duplicative administrative costs and as long as there's private insurance there's going to be administrative overhead and administrative burden. So you're not going to take that all the way down.

AUDIENCE QUESTION: How does the U.S. compare to a place like Canada, which has universal health care? What fraction of the dollar goes to administration versus health care delivery?

MS. ROVNER: Well, it's certainly a lot more in the U.S. because we're looking at things that they don't have. They don't have competing private insurers. They don't have advertising. They don't have a lot of the basic bureaucracy that gets duplicated in the U.S. system. But there's a lot of argument. Again there is a large percentage, a significant percentage, of the country that would like to have a single-payer system and probably a majority that would not.

I think certainly when you talk to members of Congress, even with large democratic majorities; the first thing they will say is that single-payer is not in the cards. Let us find a way to cover everybody first, perhaps go to single-payer at some point in the probably distant future.

AUDIENCE QUESTION: In many of the meetings that I've been in, one of the wedge issues, of course, around mandates is that the unions have said we're okay with individual mandates as long as there's an employer mandate. Employers have said that is an issue that is just dead on arrival. It seems like there has to be matched care there. Do you have any idea of what the political field has to give back to the business community in order to sell mandates?

MS. ROVNER: The question is about mandates and who's going to accept what kind of mandates. What was interesting in California is that some of

the big pushback on the individual mandate came from the people who wanted single-payer. They felt like the individual mandate was unfair because people were going to have to pay who might not be able to afford it.

So that's yet another level of political complication and of course the Obama plan did have both an individual—well, I guess it didn't have an individual mandate but it had an employer mandate. Certainly if you're going to mandate coverage for small business, you're going to have to have very large subsidies and I think that goes pretty much without saying. Even so it's going to be difficult. I mean, they saw that in Massachusetts. It's been very, very difficult and they've had basically to exclude people who cannot afford it. You know, they've got subsidies, they're very generous, up to 300 percent of poverty but there are still a number of—you know, they've gotten down the cost of some of those policies and there's still a gap between people who get subsidized and the people who they decide can afford those policies. So it is not an easy thing.

If you're going to have an individual mandate; if you're going to basically get everybody into the pool and somebody's going to have to have that hardship. It's either going to be the government in terms of having really big subsidies, or it's going to be small businesses in terms of what they can afford, or it's going to be the individuals, who are at that kind of cliff where they're just over the subsidy level but still that lower-middle class. So the question is who—you know there's going to be somebody in that really questionable area.

DR. FINEBERG: Julie, let me ask you a question on timing and strategy if you were advising the secretary, the president how to proceed. One model says the President Elect has already articulated the top five priorities: economic problems number one, energy number two, health number three, and so on. We know that the State Children's Health Insurance Program (SCHIP) bill, which was supported by majority and then not enacted into law, is kind of low hanging fruit to deal with—a particular part of the problem. Would you advise the secretary strategically to go for that early, building up the sense that we can solve more of the health problem or would you say, you know, if you spend energy on SCHIP, we're going to be distracting the focus on the real problem, which is getting in place a sufficient package for everybody, it's important for the economy, etc. How would you advise him?

MS. ROVNER: I don't give advice but I can tell you what people are already saying, which is to my actual surprise. Pete Stark, of all people, said that they have to do SCHIP early, the bill expires in March, which was something that Senator Grassley did, I think, very much on purpose. He

was probably thinking that the Democrats were going to win and giving sort of a little welcome gift to the new Congress and the new administration that you have to grapple with this right away when you get back. The Democrats really didn't want to have to deal with that in March but the Republicans insisted.

So it comes up right away and Rahm Emanuel said, very early on when he was appointed White House Chief of Staff, that they wanted to get that through very quickly. This is a model that goes back to the Clinton administration. One of the first things that President Clinton did was pass the Family Medical Relief Bill that had been kicking around in the Bush administration and had, again, gotten through the Congress but just couldn't override the veto. So that was sort of a slam dunk, get something popular and bipartisan through the Congress, get it signed, have an early victory.

SCHIP looks very much like that. My question for Stark was that, you know, yes, to get this bill to President Bush and to get all of those Republicans on it, they had to compromise away a lot of stuff that Democrats really believed in. They had to take most of the parents off the program. They had to really bring down a lot of the income limits. They had to dump an awful lot of Medicare stuff that they wanted that the House had passed in this bill. I was thinking that, boy, you could really have a fight early on if the House Democrats wanted to load some of that more popular stuff back now that they have a much bigger majority.

I wondered about that and I asked him just last week, will this be the House SCHIP bill or will this be the bill that got vetoed? Without missing a beat Stark goes no, no, we don't want it to get messed up, and maybe we'll add one or two little things to it—but this is basically the bill that got vetoed. That was a big change in attitude. I was really surprised. I think they're looking to do SCHIP quick, fast—though they may have a problem with funding and I mentioned it. He said no, we don't even need to do it 4 or 5 years because we're going to have health reform. So not my advice but I'm telling you what's coming down the pike.

DR. FINEBERG: That's actually the best kind of advice you can get.

AUDIENCE QUESTION: And the Medicare advantage?

MS. ROVNER: That's not that much money. It's about $50 billion and that may well get plowed right back into Part D. Well, the other thing that they're talking about in Medicare is they're looking down the barrel of the physician payment fix again, which I think is now up to 20 percent—another little going-away present from the last Congress—but there's talk about trying to perhaps forgive that debt, which I think Congress simply

has to do. That hole has just been dug so deep that you're just going to have to throw the dirt in over top of it and start clean.

For those of you who don't know, this is the payment mechanism that Congress did in 1997 and it worked for a couple of years. Well, it actually overpaid doctors for a couple of years and since 2001 it's been threatening to cut doctor pay every year and they actually let the cut take effect once. It's now gotten to the point where what you hear about the reductions and the increase, these are actual cuts to payments that doctors get from Medicare, and if they were to take effect in the manner in which they are now scheduled to take effect, basically doctors would stop seeing Medicare patients and then they wouldn't have a lot of choice. So no one believes they should be allowed to take effect but to make them go away really costs just staggering sums, hundreds of billions of dollars, basically at this point there's almost no way to offset them. The numbers have gotten just so stupendous so that at some point, there is really going to be no choice but to say that we made a mistake and have to wipe the books clean and start over, which I think they're getting ready to do.

DR. FINEBERG: Sounds like they're getting ready to do a lot of things.

MS. ROVNER: I'm not making any predictions; I'll predict that one.

DR. FINEBERG: I will take another question, last one.

AUDIENCE QUESTION: One big question is whether improving coverage, whether through mandates or universal coverage, will actually improve health outcomes and the health status of the American people. Are there any lessons to be learned from the Massachusetts example or other vehicles that might give us some insight?

MS. ROVNER: Well, it's a little bit early. I certainly have learned from reading the IOM reports that if you don't have health insurance, you don't do well and if you don't have health insurance, your community doesn't do well.

One interesting thing that we've learned in Massachusetts is that if a lot of people suddenly get health insurance, you may have trouble finding a doctor. They've had primary care shortages in Massachusetts. So your delivery system has to be up to par if you're going to suddenly enfranchise a lot of people, which is another issue that hasn't been looked at closely enough. One that Congress really needs to look at. I think they're so busy thinking about the finances and getting everybody covered that they're kind of ignoring the fact that we've got 78 million baby boomers about to qualify for Medicare and not nearly enough primary care doctors to deal with this. All of the students who are graduating from medical school

want to become interventional cardiologists, which I guess we'll need some.

DR. FINEBERG: Some want to be dermatologists.

MS. ROVNER: Yes, that too.

DR. FINEBERG: Although I know Julie could continue to respond to these very, very interesting questions, I know she also has her work cut out for her tonight. She's a working woman and with the announcement of today, there's a lot to try to tie up in a neat little bow for tomorrow and I am very impressed that someone who is professionally equipped to ask questions is so adept at answering questions. It is truly a great advantage for all of us, Julie, to have someone with your experience and talent in exactly the position you are, helping to keep all of us informed and alert to developments for health policy. Thank you very much for being here today.

Biosketch

Julie Rovner is a health policy correspondent for National Public Radio (NPR), specializing in the politics of health care. She is also a contributing editor for National Journal's CongressDaily. In 2005, she was awarded the Everett McKinley Dirksen Award for distinguished reporting of Congress for her coverage of the passage of the 2003 Medicare prescription drug bill and its aftermath.

Rovner has appeared on television on *The NewsHour*, CNN, C-SPAN, MSNBC, and *NOW with Bill Moyers*. Her articles have appeared in dozens of national newspapers and magazines, including *The Washington Post*, *USA Today*, *Modern Maturity*, and *The Saturday Evening Post*.

A noted expert on health policy issues, Rovner is the author of a critically praised reference book, *Health Care Politics and Policy A to Z*. Its third edition was published by CQ Press in September 2008. Rovner is also co-author of the book *Managed Care Strategies 1997*, and has contributed to several other books, including two chapters in 1995's *Intensive Care: How Congress Shapes Health Policy*, edited by political scientists Norman Ornstein and Thomas Mann.

Previously, Rovner covered health and human services for the *Congressional Quarterly Weekly Report*, specializing in health care financing, abortion, welfare, and disability issues. Later, she covered health reform for the Medical News Network, an interactive daily television news service for physicians, and provided analysis and commentary on the health

reform debates in Congress for NPR. She has been a regular contributor to the British medical journal *The Lancet*, and her columns on patients' rights for the magazine *Business and Health* won her a share of the 1999 Jesse H. Neal National Business Journalism Award.

Born and raised in the Washington, DC, metropolitan area, Rovner graduated with honors from the University of Michigan, Ann Arbor, with a degree in political science. She currently resides in North Bethesda, MD.

Previous Rosenthal Lectures Held at the Institute of Medicine

Providing Universal and Affordable Health Care to the American People: State Roles and Responsibilities

Providing Universal and Affordable Health Care to the American People: The Role of the Private Sector

Improving Access to Affordable Health Care

Improving Access to Affordable Health Care: The Provider Perspective

Looking at the Future of the Medicaid Program: A Safety Net for Mothers and Children

Developing the Basic Benefit Package: Issues and Challenges

Preparing for a Changing Healthcare Marketplace: Lessons from the Field

Looking Back, Looking Forward: "Staying Power" Issues in Health Care Reform

The State-of-the-Art of Measuring Quality: Key Perspectives

The State-of-the-Art of Measuring Performance in Health Care: Perspective of Purchasers

Measuring Performance in Health Care: Future Challenges

Crossing the Quality Chasm: Findings from a New IOM Report

Exploring Complementary and Alternative Medicine: Fostering Rapid Advances in Health Care

Keeping Patients Safe

Perspectives on the Prevention of Childhood Obesity in Children and Youth: Next Steps Toward Higher Quality Health Care

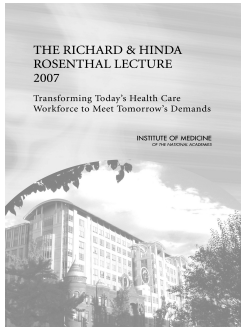
The Food and Drug Administration: Facing the Regulatory Challenges of the 21st Century

Transforming Today's Health Care Workforce to Meet Tomorrow's Demands

Prospects for Health Reform in 2009 and Beyond

2007

Transforming Today's Health Care Workforce to Meet Tomorrow's Demands



This very important lecture focused on the health care workforce, arguably the single most critical ingredient in the health care system, and a subject the Institute of Medicine continues to pursue.

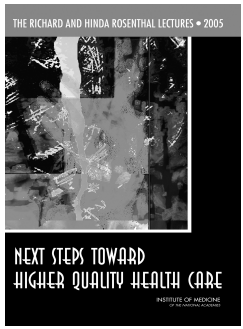
The three esteemed speakers addressed the nation's workforce challenges, discussing the changing roles of those involved in primary care and the importance of team-based care. As active and experienced practitioners, they were able to discuss the possible shortage of physicians in the United States from their vantage points.

Dr. Fitzhugh Mullan, in particular, delved further into the subject and addressed the U.S. workforce in the context of the global workforce, providing a strong case for the importance of addressing our domestic workforce concerns.

Presentations by Kevin Grumbach, M.D.; Marla E. Salmon, Sc.D., R.N., FAAN; and Fitzhugh Mullan, M.D.

2005

Next Steps Toward Higher Quality Health Care



The Institute of Medicine has had perhaps the greatest impact on public awareness and professional thinking through its work on the safety and quality of health care. IOM reports from the late 1990s, particularly *Crossing the Quality Chasm* and *To Err Is Human*, called attention to the challenge of improving the quality of care and laid out a blueprint for ways to approach the solution.

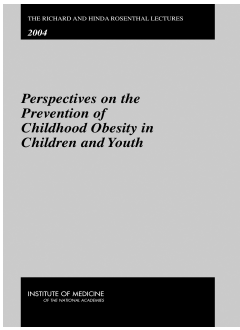
The speakers at this lecture addressed the following questions:

- How well are we doing as a nation?
- How much progress are we making?
- What do we need to do to make the kind of progress that will produce a quality of health care that we are capable of providing and that patients, the public, and our country deserve?

Presentations by Elliott S. Fisher, M.D., M.P.H.; George Isham, M.D., M.S.; and Lucian L. Leape, M.D.

2004

Perspectives on the Prevention of Childhood Obesity in Children and Youth



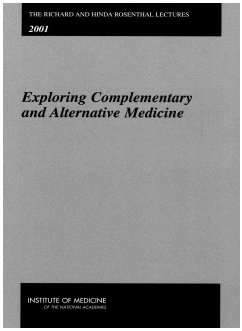
The obesity epidemic emerged so rapidly in recent times that it is stunning to think about its impact in demographic terms. From 1974 to 2004, the prevalence of obesity in the United States more than doubled in children aged 2 to 5 years and in adolescents aged 12 to 19 years. In children aged 6 to 11 years, it tripled. Despite continual advances in health and health outcomes, both for children and adults, and the progress made through vaccines, seat belt use, the control of tobacco, fluoridated drinking water, and decreased infant mortality, by this measure of health, we are headed in the wrong direction.

During this very important lecture, the speakers outlined various issues within the larger problem of childhood obesity and provided a framework for prevention.

Presentations by Jeff Koplan, M.D., M.P.H.; Shiriki Kumanyika, Ph.D., M.P.H.; Brock Leach; and William Dietz, M.D., Ph.D.

2001

Exploring Complementary and Alternative Medicine

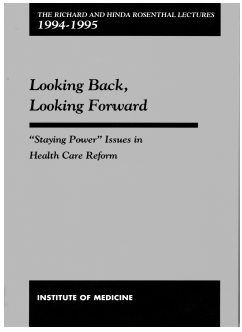


This lecture explored Complementary and Alternative Medicine (CAM) and Integrative Medicine research and discussed the challenges and opportunities facing the field. CAM encompasses a broad spectrum of practices and beliefs but may be defined functionally as interventions neither taught widely in medical schools nor generally available in hospitals. Integrative Medicine refers to ongoing efforts to combine the best of conventional and evidence-based complementary therapies while emphasizing the primacy of the patient–provider relationship and the importance of patient participation in health promotion, disease prevention, and medical management. Both can be controversial and provided a foundation for a robust discussion.

Presentations by David Eisenberg, Ph.D., and Catherine Woteki, Ph.D., R.D.

1994-1995

Looking Back, Looking Forward: "Staying Power" Issues in Health Care Reform



During this lecture, health reform experts stepped back from the heat of the battle to explore the new, creative directions for our evolving health care system:

- What should be the future role of the private sector and government in assuring quality in health care?
- What can the government do to contribute to patients' decisions about the kind of care that is best for them?
- How do health care delivery systems and provider groups translate research on clinical outcomes and guidelines into practice?

The contributions contained in this volume outline some of the critical challenges facing providers, regulators, and the public at this time of unprecedented change in the health care environment. Today's health care enterprise is filled with risk and uncertainty. However, as these pages attest, the new landscape contains rich opportunities for innovation and productive partnerships.

Presentations by Mark V. Pauly, Ph.D.; Uwe E. Reinhardt, Ph.D.; William L. Roper, M.D., M.P.H.; Helen L. Smits, M.D.; Michael D. Tanner; Brent C. James, M.D.; and Risa J. Lavizzo Mourey, M.D., M.B.A.