

Health Reform

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Objectives

- Provide a general, condensed overview of the many issues surrounding health reform, beginning with examples of how some countries, including the U.S. began providing health care to their citizens.
- Review the history of health reform in the U.S.
- Understand the legislative process for passage of bills.
- Compare the main plans that are being debated in Congress.
- Listen to some physician views.
- Understand who the uninsured are and how the lack of access to health care impacts the uninsured citizens of the U.S.

Article by Atul Gawande “Getting There from Here” The New Yorker

- “Left” - end private insurance and replace it with national health insurance
- “Right” - end public and employer-controlled health benefits- everyone purchases their own coverage- and put market forces to work

How about building around the mess we have?????

“Yes, American health care is an appallingly patched-together ship, with rotting timbers, water leaking in, mercenaries on board, and fifteen per cent of the passengers thrown over the rails just to keep it afloat.”

But, provides:

greater than 35 million hospital stays

64 million surgical procedures

900 million office visits

3.5 billion prescriptions

“Path-dependence”

- **“History matters”** Choices made on the basis of transitory conditions can persist long after those conditions change. **Future possibilities get narrower as time goes by.**
- U.S. Examples: Transportation, Public Switched Telephone Network
- Great Britain’s National Health Service
 - Began in 1948 following WWII. Prior to the war, there was an evacuation of millions of people in preparation of “the Blitz”. The government rebuilt hospitals, supplemented health care, funded private hospitals to take care of war veterans and civilian casualties, and paid physicians with the development of the national Emergency Medical Service.

Path-dependence

- **France**

- Large manufacturers and unions with collective insurance funds for employees, **financed with self-imposed payroll tax**
- After WWII, expanded on existing payroll-tax funded, private, **not-for profit** independent insurance funds to cover all wage earners, families, retirees with self-employed added in the 1960's, **uninsured included in 2000**
- ***increased life expectancy, lower infant mortality, increased # of doctors, decreased cost than U.S.
- ***WHO in 2000 called the French health system #1 in the world

Path-dependence

United States

- WWII- workforce abroad to fight
- Roosevelt Administration imposed national wage controls to prevent increases in labor costs
- To compete for workers, employers were offered commercial health insurance

******History of private insurance obtained through one's place of employment.***

History of Health Reform

A Timeline of Health Reform in the
United States from the early
1900's to the Present

From the website of the Kaiser Family Foundation

Early 1900's

- **1912** Teddy Roosevelt “progressive party” endorse social insurance
- **1915** American Association for Labor Legislation drafts bill for health insurance... WWI...AMA initially supports idea then reverses position
- **1927** “**Costs of Medical Care**” formed- group of economists, physicians, public health specialists that endorsed idea of voluntary health insurance
- ***Great Depression Begins (1929-1939, worst 1933-34)***

National Health Insurance, FDR, and The New Deal

- **1930-1934** FDR appoints **Committee on Economic Security** to address old-age, unemployment, medical care and insurance. (Hard economic times called for social policies.)
- **1935 Social Security Act** passed (FDR did not risk passage of this act and national health reform is not advanced.)
- **1939** National Health Bill dies in the committee.
- **WWII** Roosevelt Administration imposes national wage controls to prevent increases in labor costs. Employers began offering commercial health insurance to compete for workers. *****For better or worse our employment-based health care system is born.**

President Truman and The Fair Deal

- **1946 Hill-Burton Act**: funds construction of hospitals and prohibits discrimination on the basis of race, religion, or national origin and required hospitals to provide a “reasonable volume” of charitable care
- Bills sent to Congress for national health insurance and government assistance to the poor not passed (Wagner-Murray-Dingell and Taft-Smith-Ball bills)
- **1947** Both bills reintroduced. Final outcome: voluntary health insurance.
- **1948 National Health Assembly**: endorses voluntary health insurance, need for universal coverage (opposition due to fear of socialism and to southern Democrats effectively blocking proposals due to belief that gov't involvement in health care might lead to desegregation)
- **AMA** launches national campaign **against** national health insurance proposals

1950's

- **1951 JCAH forms (Joint Commission on the Accreditation of Hospitals)**
- **Revenue act of 1954: excludes employers' contribution to employees health plans from taxable income**

Medicare and Medicaid

- **1961 Conference on Aging-** task force recommends health insurance for elderly under Social Security
- **King-Anderson Bill:** gov't health insurance for aged; supported by organized labor, **opposed by the AMA**, commercial insurance carriers
- **1962 Pres. Kennedy** televised from Madison Square Garden on Medicare; **AMA** televises rebuttal
- **1963 King-Anderson Bill** reintroduced
- **1964 Pres. Johnson** advocates for Medicare
Civil Rights Act passes!

Medicare and Medicaid

- **1965 The Medicare and Medicaid** programs are signed into law. **Medicare Part A** is to pay for hospital care and limited skilled nursing and home health care. **Optional Medicare Part B** is to help pay for physician care. **Medicaid** is a separate program to assist states in covering not only long-term care for the poor but also to provide health insurance coverage for certain classes of the poor and disabled. Signed into law by Pres. Johnson and incorporated into the **Social Security Act**.
- **Contributing factors to law passing:** large Congressional Democratic majority, public approval, support of hospitals, insurance industries, no gov't cost controls or physician fee schedules included in legislation.

1970's

- **1971** Wage and price freezes begin, with medical care singled out for specific limits on annual increases in physician and hospital charges.
-
- **1972 Supplemental Security Income (SSI)** program begins providing cash assistance to elderly and disabled.
- **1977 HCFA** established (now CMS)
President Carter proposes Medicaid expansion (Children's Health Assessment Program) for poor children under age 6; not passed

1980's

- **1983** Medicare introduces Diagnostic Related Groups (DRGs) as a payment system for hospital payment.
- **1986** Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals participating in Medicare to screen and stabilize all persons who use their emergency rooms regardless of ability to pay.
- **1987** Census Bureau begins annual estimate of health insurance coverage in the U.S. and finds 37 million uninsured (13% of the population).

1990's and The Health Security Act

- **1993 Health Security Act** (Clinton health care reform) introduced in Congress; every American would have a “Health Security Card” to ensure access to care- gains little support.

• **Vaccines for Children** program is established, providing federally purchased vaccines to states.

Other national health reform proposals are introduced in Congress, including a bipartisan bill to expand coverage without extensive reform, and all are unable to pass.

1990's

- **1996 Health Insurance Portability and Accountability Act (HIPAA)** restricts use of pre-existing conditions in health insurance coverage determinations, sets standards for medical records privacy
- **1997** Census Bureau estimates **42.4 million uninsured** (15.7% of the U.S. population).

Balanced Budget Act includes many changes in provider payments to slow the growth of Medicare spending. **Medicare + Choice** (renamed **Medicare Advantage**) established- a new structure for Medicare HMO's.

State Children's Health Insurance Program (S-CHIP) is enacted providing grants to states for coverage above Medicaid eligibility levels.

2000 to Present

2003 Medicare Drug, Improvement, and Modernization Act (MMA) creates a voluntary, subsidized prescription drug benefit under Medicare administered through private plans (drug plans and Medicare Advantage plans). (first major expansion of Medicare since 1965)

2006 Medicare Part D Drug benefit goes into effect.

2000 to Present

- **2006 Massachusetts** passes and implements health reform with the goal of universal coverage obtained with shared responsibility among individuals, employers, and the gov't. **Vermont** also passes health care reform aiming for near-universal coverage (**Catamount Health Plan, Blueprint for Health**). **San Francisco** creates the **Healthy San Francisco Program** providing universal coverage for residents as well as requiring a minimum amount per hour to be spent by city employers on employees health care.

Census Bureau estimates that **45.6 million are uninsured** in the U.S. (15.3% of the population).

2000 to Present

- **2008** Presidential campaign focuses on health reform- overshadowed by the housing crisis.
- **2009** Office of Health Reform established by Pres. Obama to coordinate efforts on national health reform.

The Children's Health Insurance Program is reauthorized, providing states with additional funding and new tools to reach 4.1 million children through Medicaid, estimated to be uninsured by 2013.

The American Reinvestment and Recovery Act (ARRA), investment to help develop health information technology, expand the primary care workforce, and conduct research on comparative effectiveness for health care treatment options. Developed to lower health care spending over the next 10 years as part of the **Obama Plan**.

Pres. Obama releases FY 2010 budget which outlines 8 principles for health reform and proposes a 634 billion in a health reform reserve fund.

Obama's Eight Principles for Health Reform

Protect families' financial health

Make health coverage affordable

Aim for universality

Provide portability of coverage

Guarantee choice

Invest in prevention and wellness

Improve patient safety and quality of care

Maintain long-term fiscal sustainability

Health Reform and the National Agenda

President Obama at the White House Forum on Health Care Reform, March 5, 2009



Health reform is unlikely to be adopted if it is not at or near the top of the national political agenda

House and Senate Committees with Jurisdiction Over Health Reform



House Committees



Energy & Commerce

Rep. Henry Waxman (D-Calif.)
chairman



Ways & Means

Rep. Charles Rangel (D-N.Y.)
chairman



Education & Labor

Rep. George Miller (D-Calif.)
chairman

Senate Committees



Finance

Sen. Max Baucus (D-Mont.)
chairman



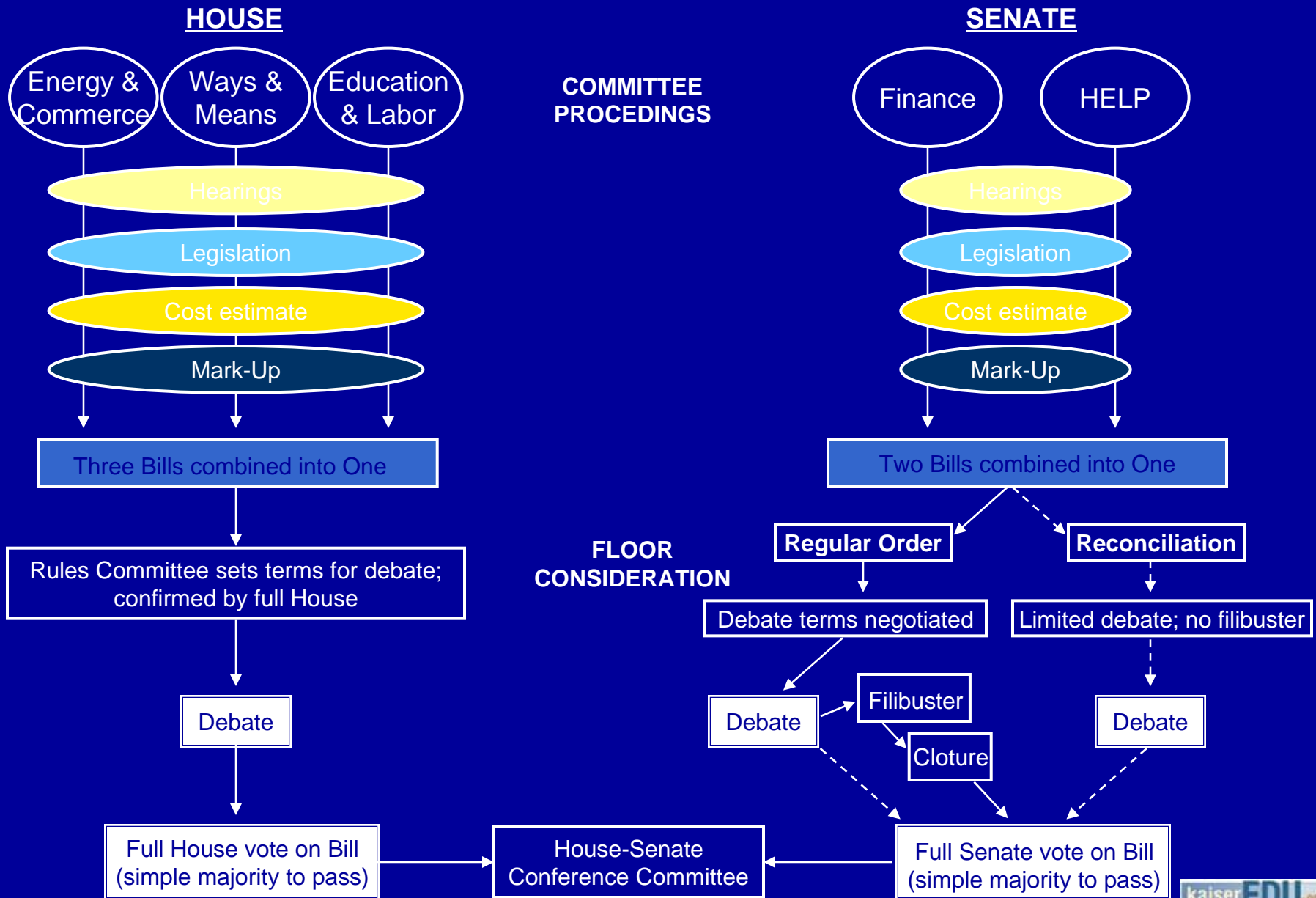
Health, Education, Labor & Pensions

(Late) Sen. Edward Kennedy (D-Mass.)
chairman

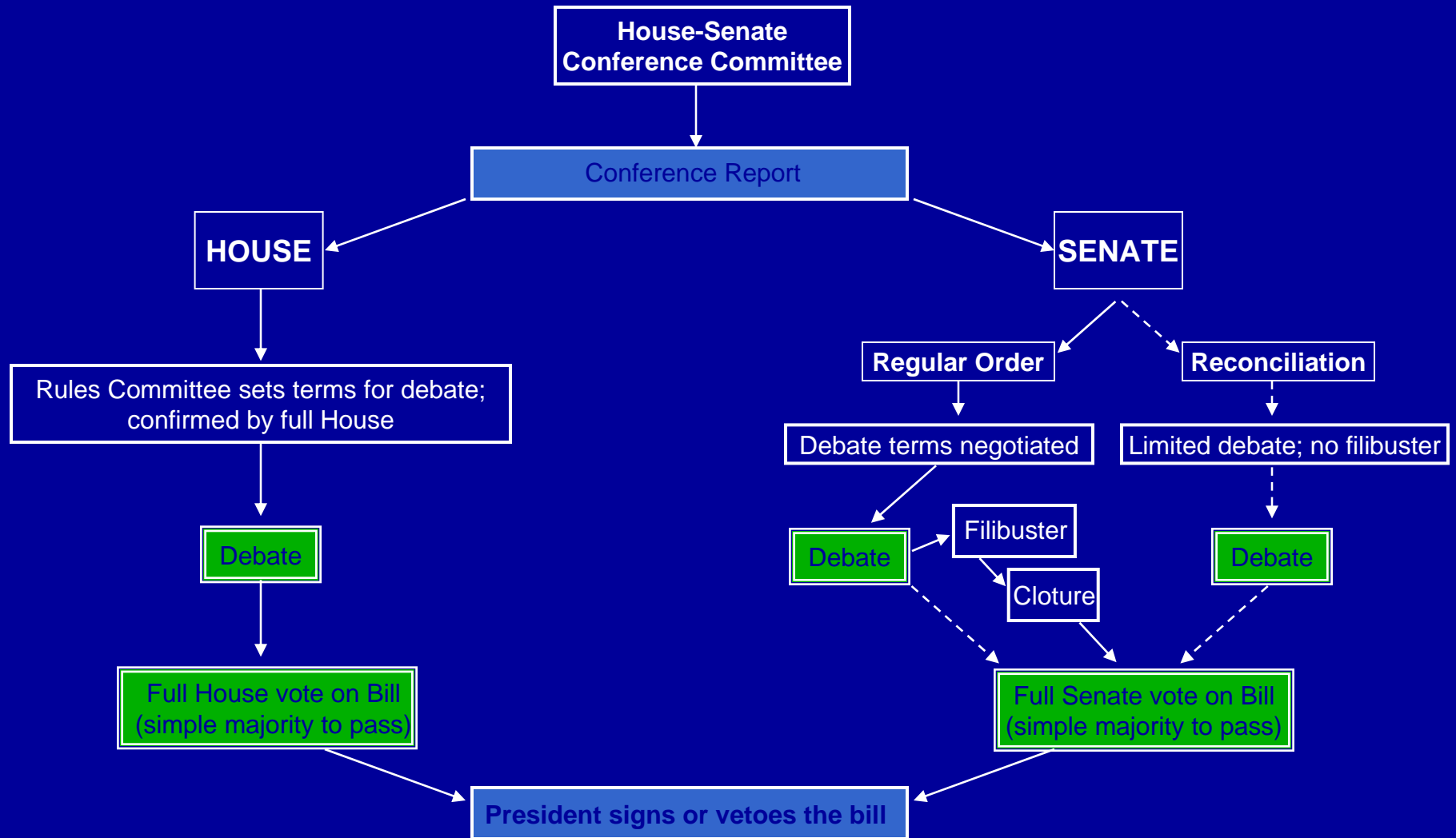
Oversight of Committees

Energy and Commerce	Health issues, public health & health programs funded by general revenue	National health insurance, Medicaid, Medicare (part B), CHIP, public health and quarantine, hospital construction, mental health and research, biomedical research and development
Ways and Means	Tax policy, health programs supported by payroll deductions,	Medicare Tax Policy
Education and Labor	Pension, health, employee benefits	Employee Retirement Security Act (ERISA)
Finance	Tax policy, federal health programs financed by a specific tax or trust fund, other programs under Social Security Act	Health jurisdiction, Medicare, Medicaid, CHIP
Health Education Labor Pensions	Pension, health and other employee benefits, ERISA, public health and biomedical research and development	Insurance coverage, prevention, quality

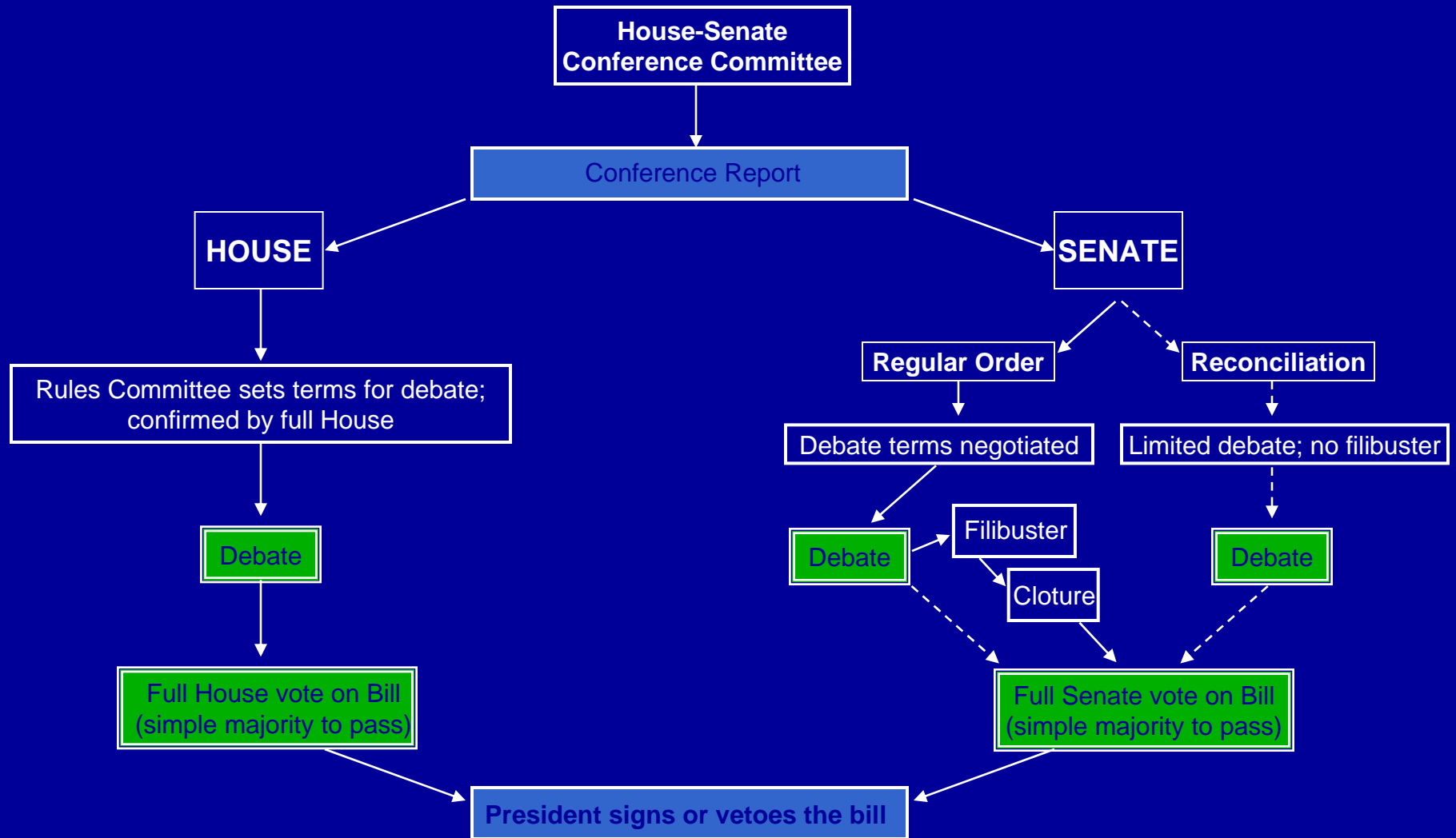
Overview – Committees and Floor Debate



Overview – Conference



Overview – Conference



Comparison of Plans

(Refer to Attached Hand-Out)

AMA's Vision for Health System Reform

- Health insurance coverage for all Americans
- Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions
- Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
- Investments and incentives for quality improvement, prevention, and wellness initiatives
- Repeal of the Medicare physician payment formula that would trigger steep cuts and threaten seniors' access to care
- Implementation of medical liability reforms to reduce the cost of defensive medicine
- Streamlining and standardizing of insurance claims processing requirement to eliminate unnecessary costs and administrative burdens

<http://www.thedoctorschannel.com/video/2446.html>

QuickTime™ and a
decompressor
are needed to see this picture.

NEJM Study of Physicians

- Physicians' Beliefs and U.S. Health Care Reform- A National Survey (Antiel, et.al)
 - Prior research suggests that physicians endorse a public role for the profession and believe they have an obligation to care for people with limited resources
 - Unclear whether physicians in 2009 see participation in the formation of health policy as part of their professional responsibility or accept potential consequences of reform
 - Individual physicians may have financial incentives to downplay responsibility for caring for uninsured and underinsured
 - Agree in the abstract that health care resources should be distributed fairly, may be unwilling to endorse policies that expand coverage for basic health care by limiting reimbursement for costly interventions

Characteristics of the 991 U.S. Physicians Who Responded to the Survey

Characteristic	Survey Response
	no./total no. (%)
Female sex	274/970 (28)
Age	
<50 yr	454/970 (47)
≥50 yr	516/970 (53)
Race or ethnic group	
White	756/972 (78)
Asian	139/972 (14)
Other	49/972 (5)
Black	24/972 (2)
American Indian or Alaska Native	4/972 (<1)
Region†	
South	322/991 (32)
Midwest	243/991 (25)
Northeast	216/991 (22)
West	202/991 (20)
Primary specialty	
Primary care	388/991 (39)
Surgery	209/991 (21)
Procedural specialty	197/991 (20)
Nonprocedural specialty	165/991 (17)
Nonclinical specialty	22/991 (2)
Other	10/991 (1)
Political self-characterization	
Moderate	413/978 (42)
Liberal	270/978 (28)
Conservative	276/978 (28)
Other	19/978 (2)

* Percentages may not total 100 because of rounding.

† Eight of the respondents were from Puerto Rico.



Agreement or Disagreement with Three Elements of Health Care Reform and Objection to Using Cost-Effectiveness Data to Limit Treatments, among 991 U.S. Physicians

Table 2. Agreement or Disagreement with Three Elements of Health Care Reform and Objection to Using Cost-Effectiveness Data to Limit Treatments, among 991 U.S. Physicians.

Survey Item and Response Options	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree
	<i>percent of respondents</i>			
Rate your degree of agreement or disagreement with the following statements:				
Addressing societal health policy issues, as important as that may be, falls outside the scope of my professional obligations as a physician.	34	44	17	5
Every physician is professionally obligated to care for the uninsured and underinsured.	10	17	35	38
I would favor limiting reimbursement for expensive drugs and procedures if that would help expand access to basic health care for those currently lacking such care.	11	22	48	19
	No Moral Objection	Moderate Moral Objection	Strong Moral Objection	
	<i>percent of respondents</i>			
Indicate the degree to which you object (if at all), for moral reasons, to the following medical practice:				
Using cost-effectiveness data to determine which treatments will be offered to patients.	45	40	14	

Antiel R et al. N Engl J Med 2009;10.1056/NEJM0907876



Odds of Endorsing Three Health Care Reform Principles and of Objecting to the Use of Cost-Effectiveness Data to Limit Treatments, According to Clinical Specialty and Political Self-Characterization, among 991 U.S. Physicians

Table 3. Odds of Endorsing Three Health Care Reform Principles and of Objecting to the Use of Cost-Effectiveness Data to Limit Treatments, According to Clinical Specialty and Political Self-Characterization, among 991 U.S. Physicians.*

Variable	Agree That Physicians Are Obligated to Address Health Policy Issues	Agree That Physicians Are Obligated to Care for the Underinsured	Favor Limiting Reimbursement for Expensive Treatments to Expand Access to Basic Health Care	Object to Using Cost-Effectiveness Data to Limit Treatments
<i>odds ratio (95% confidence interval)</i>				
Specialty				
Primary care	1.0 (referent)	1.0 (referent)	1.0 (referent)	1.0 (referent)
Surgery	0.7 (0.5–1.1)	0.7 (0.5–1.0)	0.6 (0.4–0.8) †	1.4 (1.0–2.0)
Procedural specialty	1.0 (0.6–1.5)	0.9 (0.6–1.3)	0.6 (0.4–1.0) †	1.0 (0.7–1.5)
Nonprocedural specialty	1.0 (0.6–1.7)	0.6 (0.4–1.0) †	0.8 (0.5–1.2)	1.3 (0.9–1.9)
Nonclinical specialty	1.3 (0.4–4.8)	1.0 (0.3–3.2)	0.3 (0.1–0.9) †	0.9 (0.4–2.3)
Other	0.8 (0.2–3.2)	0.5 (0.1–1.9)	0.5 (0.1–1.8)	3.4 (0.7–17.0)
Political self-characterization				
Conservative	1.0 (referent)	1.0 (referent)	1.0 (referent)	1.0 (referent)
Moderate	1.6 (1.1–2.2) †	1.2 (0.9–1.7)	1.9 (1.4–2.7) †	0.7 (0.5–0.9) †
Liberal	2.8 (1.8–4.5) †	2.0 (1.3–3.1) †	3.8 (2.5–5.6) †	0.5 (0.4–0.8) †

* Odds ratios are from multivariate logistic regression, with adjustment for age, sex, race, and region.

† $P \leq 0.05$.



Summary

- Most physicians see health care reform as part of their professional responsibility
- Controversial elements (may face opposition from segments of the medical profession)
 - Limiting reimbursement under Medicare
 - Using cost-effectiveness data in treatment decisions
 - Limiting reimbursements for expensive drugs and procedures

Potential reasons:

Little incentive to use evidence-based information such as cost-effectiveness data to guide treatment decisions under the current system which reimburses on the basis of quantity of services provided.

Use of cost-effectiveness data as rationing or intrusion on professional autonomy and the physician-patient relationship.

EVERY INDUSTRIALIZED
NATION EXCEPT THE
UNITED STATES HAS A
NATIONAL SYSTEM THAT
GUARANTEES
AFFORDABLE HEALTH
CARE FOR ALL ITS
CITIZENS

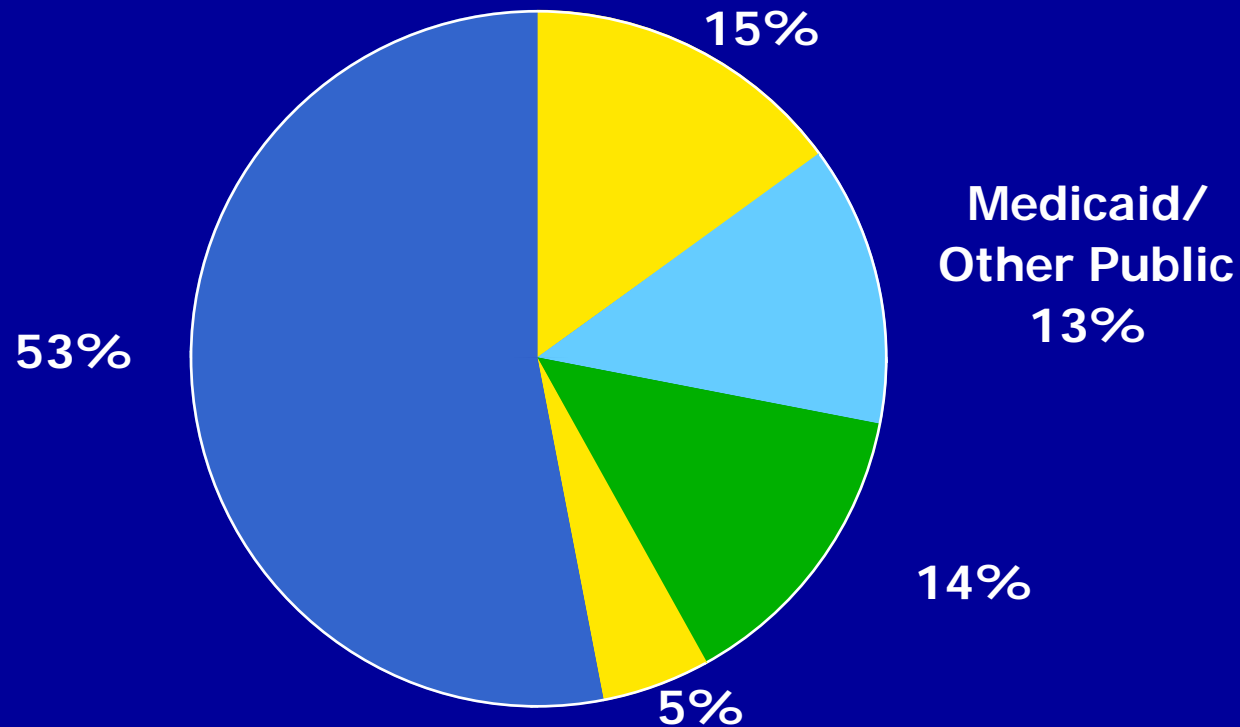
U.S. Health Statistics Compared to Other Industrialized Nations

- <http://www.mckinsey.com/mgi/rp/healthcare>

National Health Spending as a % of GDP

- <http://economix.blogs.nytimes.com/2009/07/08/us-health-spending-breaks-from-the-pack>

Health Insurance Coverage in the U.S., 2007



Total = 298.2 million

NOTE: Includes those over age 65. Medicaid/Other Public includes Medicaid, SCHIP, other state programs, and military-related coverage. Those enrolled in both Medicare and Medicaid (1.7% of total population) are shown as Medicare beneficiaries.

SOURCE: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of March 2008 CPS

Who Are The Uninsured?

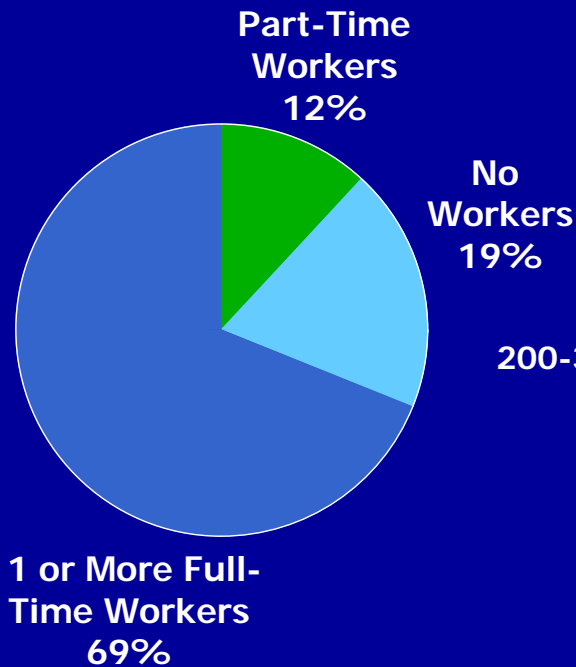
- 70% Uninsured Americans come from Families with 1 or 2 Full-time Workers (about 30 million)
 - Employed by small businesses that do not offer health benefits or offer coverage they cannot afford
 - Earn less than 2x the poverty level (\$44,000 for family of 4)
- Better Off (about 9 million)
 - Households of about \$75,000
 - Usually extended families, low-wage roommates “combined incomes
- Young Adults- ages 19-29 (about 13 million)
 - 10% college graduates; 5% incomes greater than \$60,000/yr; 50% family incomes less than \$16,000
- Already Eligible (about 11 million)
 - Low income children and parents
 - ER visit- leads to Medicaid ***lost out on routine care

Noncitizens

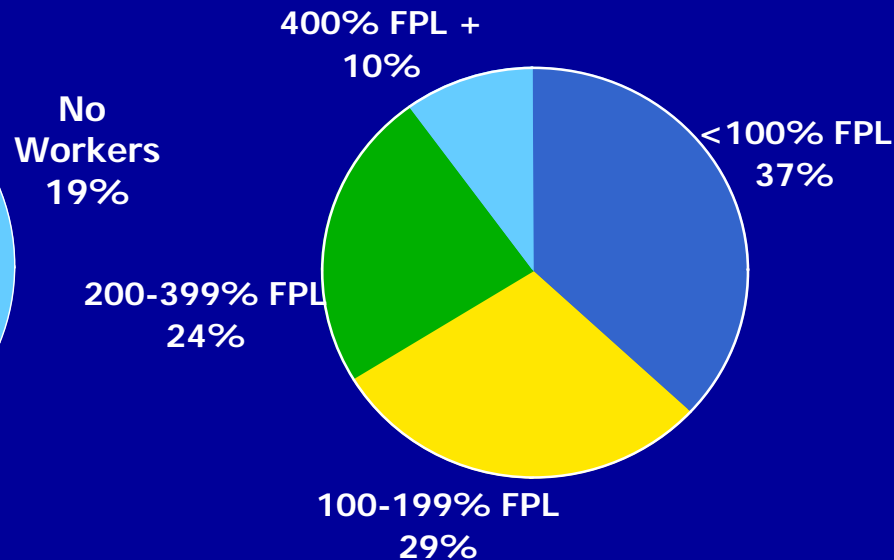
- About 9.7 Million
- Use emergency rooms
- House oversight committee reviewed 6 state Medicaid programs in 2007. Verification rules cost feds \$8.3 million and caught 8 illegal immigrants.
- Issue of lack of treatment- can infect legal residents/citizens (example H1N1)

Characteristics of the Uninsured, 2007

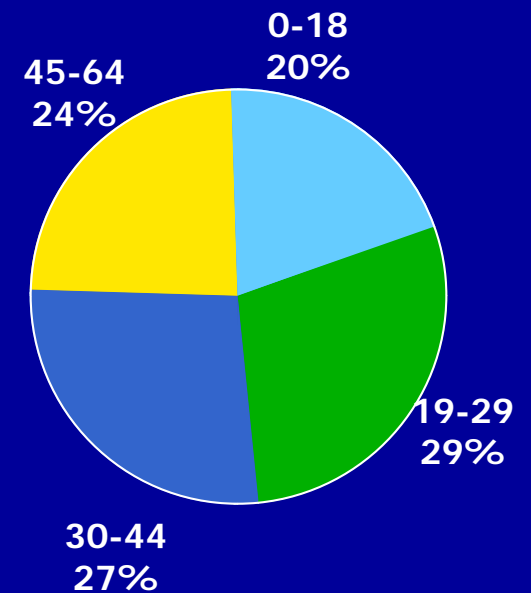
Family Work Status



Family Income



Age

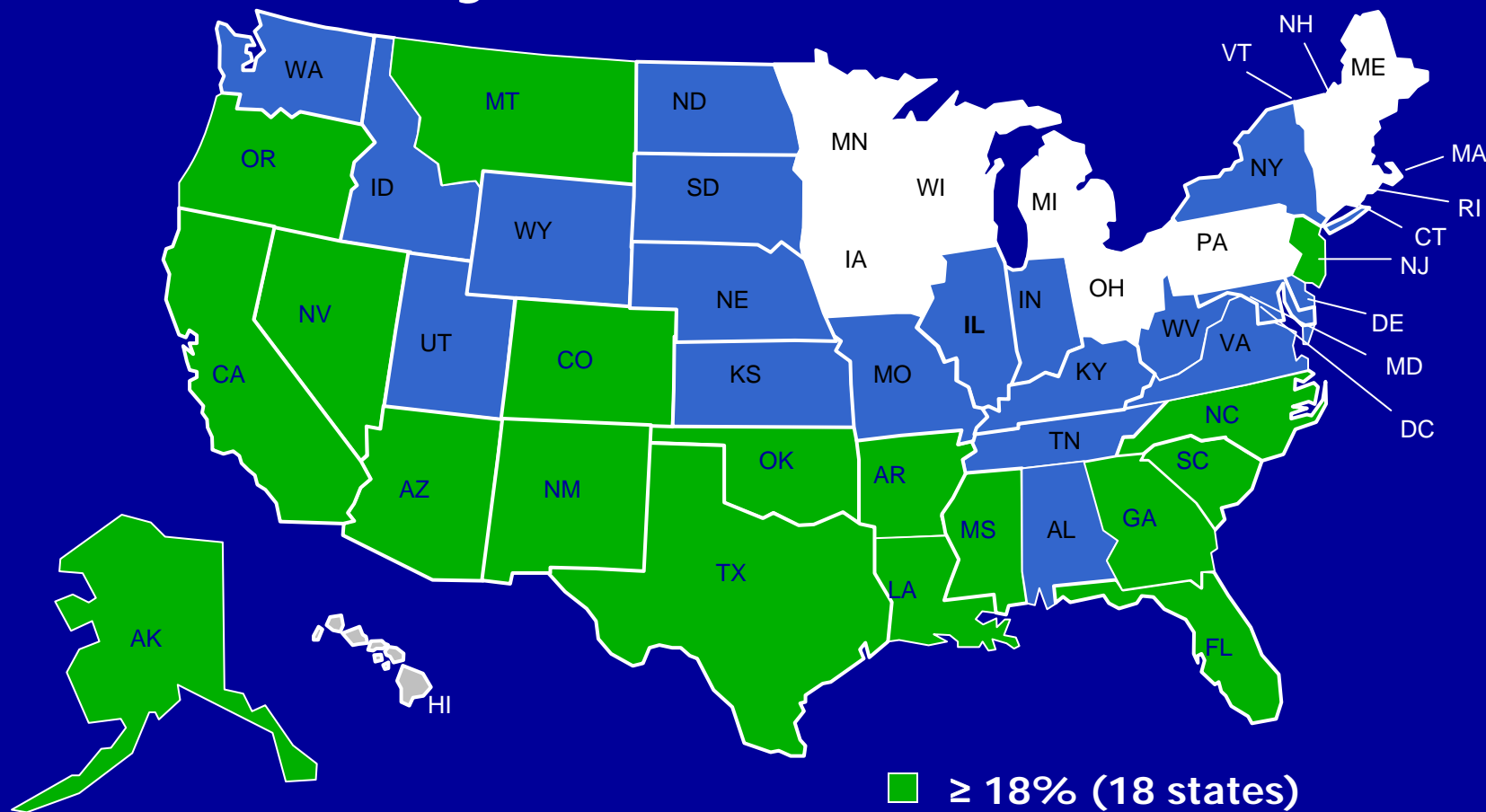


Total = 45 million uninsured

The federal poverty level was \$21,203 for a family of four in 2007.

SOURCE: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of March 2008 CPS.

Uninsured Rates Among the Nonelderly, by State, 2006-2007



US Average = 18%

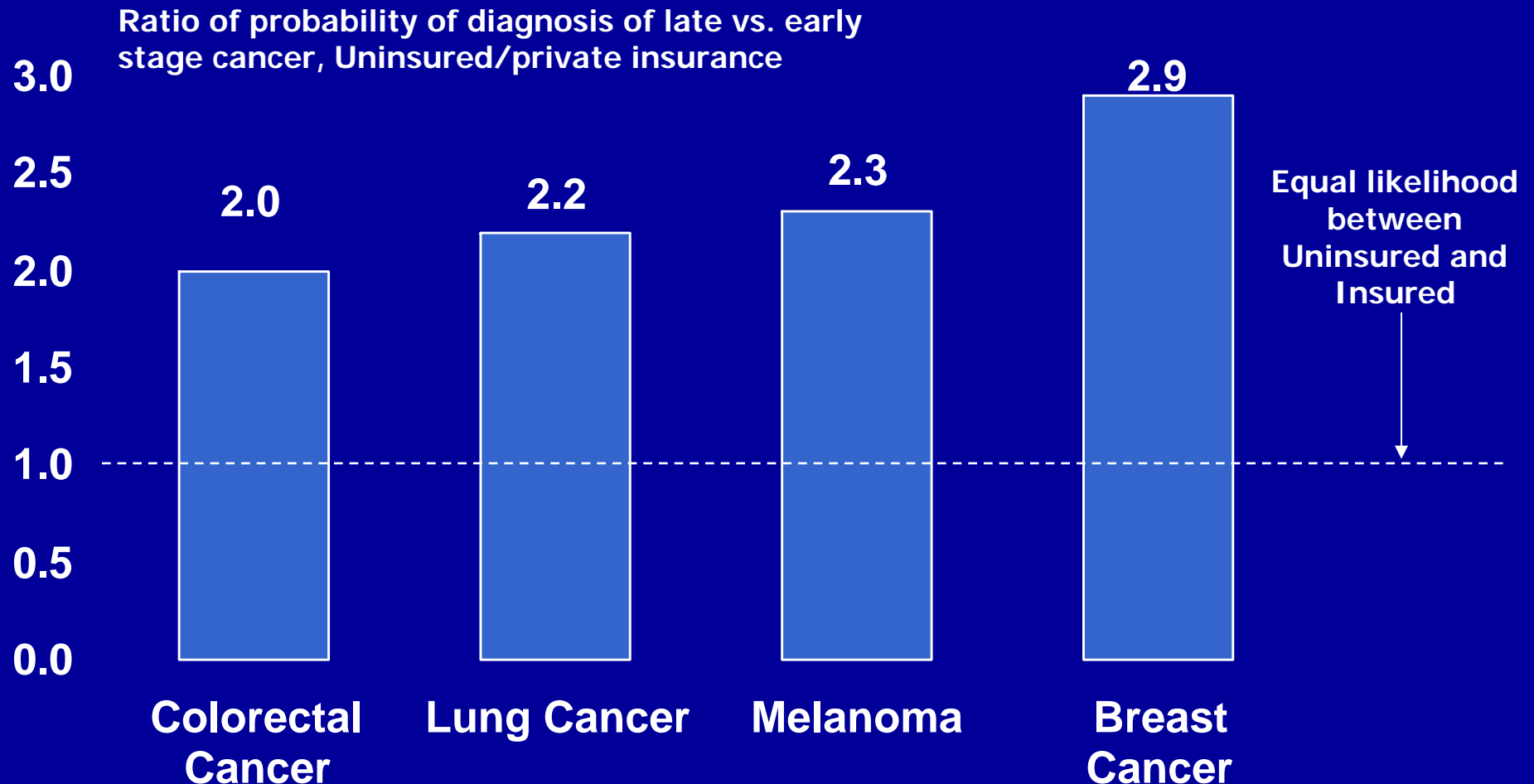
- ≥ 18% (18 states)
- 13-17% (19 states)
- < 13% (13 states & DC)

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of the March 2007 and 2008 Current Population Survey. Two-year pooled estimates for states and the US (2006-2007).

Morbidity of the Uninsured

- More likely to die prematurely
- Cancers diagnosed too late many times
- More likely to die from MI, stroke, severe injury
- Institute of Medicine (2004) estimated 18,000 deaths/yr among adults due to lack of insurance (roughly equivalent to the number of homicides in the U.S.)
- When seen in the emergency room, many times the uninsured are much sicker

Diagnosis of Late-Stage Cancer Uninsured vs. Privately Insured



NOTE: Odds ratios were adjusted for age, sex, race/ethnicity, facility type, region, and income and education on basis of postal code. They represent the odds of being diagnosed with stage III or state IV cancer vs. stage I cancer.

Analysis based on cases occurring between 1998-2004.

SOURCE: Kaiser Family Foundation, based on Halpern MT et al, Association of insurance status and ethnicity with cancer stage at diagnosis for 12 cancer sites: a retrospective analysis." *The Lancet Oncology*. March 2008.

Underinsured

- Estimated to be about 25 Million
 - High Deductibles
 - Restrictions
 - Postpone treatments
 - Go into debt to pay medical bills
 - Do not fill Rx's

Medical Bankruptcies

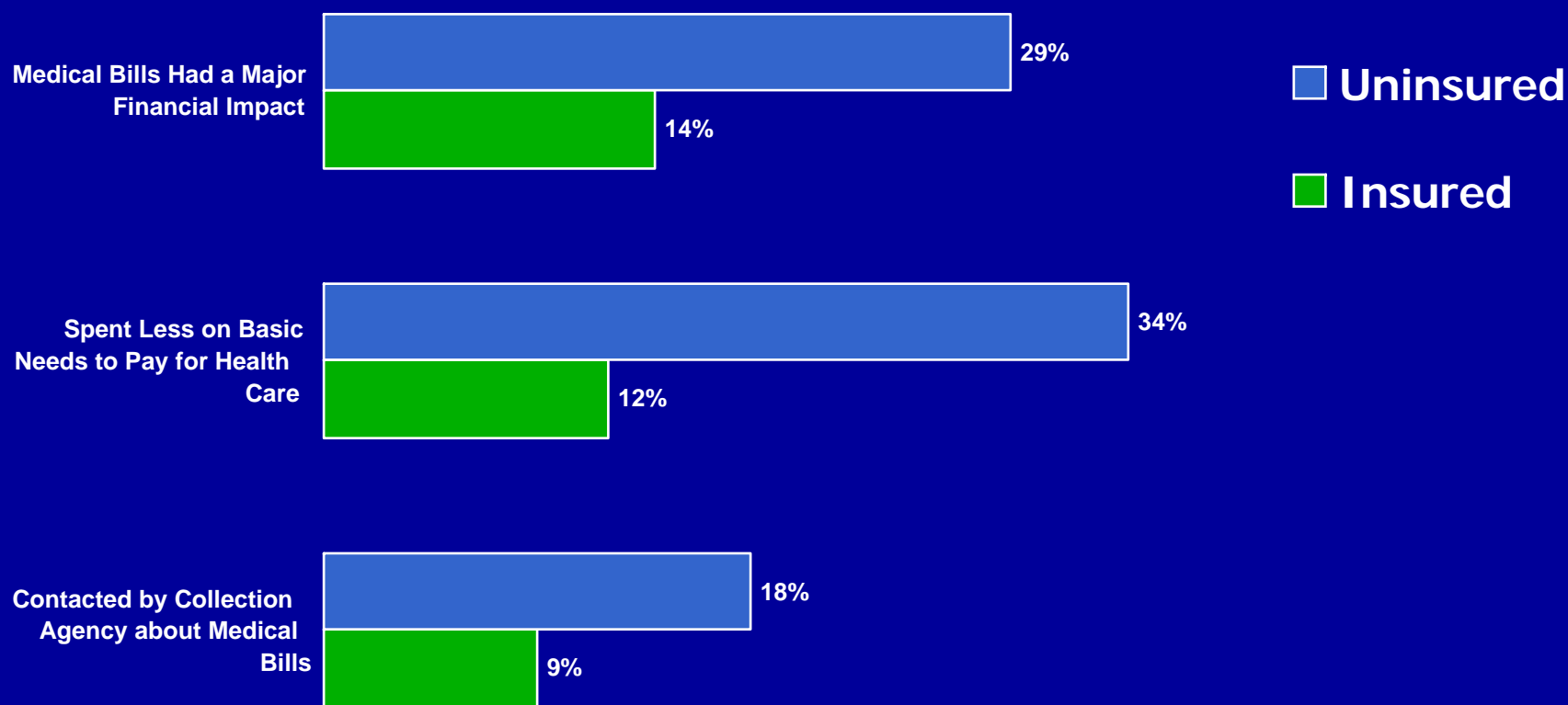
- 1.4 to 1.5 million bankruptcies- 62% of them related to health (900,000 cases)
- Every bankruptcy is estimated to have an effect on 2.7 people
- Six months later- great difficulty obtaining medical care, children most likely to have changed schools, disruption of care for elderly, utility shut-offs, poor nutrition (skipping meals)
- Insurance may not prevent bankruptcies
 - Lost jobs due to illness- may lead to loss of insurance
 - Coverage- loopholes, co-pays, deductibles

***Many more people (57 million in 2007) had difficulty paying medical bills

“Bills coming from health care when least able to pay them.”

Financial Burden of Medical Bills by Insurance Status, 2005

Percent of adults (age 19-64) reporting in past 12 months:



NOTE: Insured includes those with public or private insurance coverage.

SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of the Kaiser Low-Income Coverage and Access Survey 2005: National All-Income Sample.

In Summary:

- Health reform has been debated and attempted since our health care system was developed.
- The many complexities of our health care system and the high value we place on “choice” has led to polarization and limits on health reform.
- The cost of our health care, data on poorer health outcomes than many other industrialized nations, limited access to care of many U.S. citizens, and economic difficulty from health care bills for many more U.S. citizens reinforces the need for reform.
- Every American needs their health to reach their fullest potential- how we provide access to health care reflects the moral character of this country.

Internet Resources

- <http://healthreform.kff.org> (kaiser family foundation)
- <http://healthcarereform.nejm.org> (nejm)
- <http://www.mckinsey.com/mgi/rp/healthcare> (mckinsey global institute)
- <http://www.thedoctorschannel.com>
- <http://www.finance.senate.gov/sitepages/baucus.htm>
- <http://help.senate.gov>
- <http://www.healthreform.gov>
- <http://www.pnhp.org> (physicians for a national health program)

References

- Antiel RM, Curlin FA, James KM, Tilburt JC. Physicians' Beliefs and U.S. Health Care Reform-A National Survey. *N Engl J Med.*2009;361:e23.
- Blendon RJ, Benson JM. Understanding how Americans view health care reform. *N Engl J Med.* 2009:e13(1-4).
- Blumberg LJ, Holahan J. The individual mandate- an affordable and fair approach to achieving universal coverage. *N Engl J Med.* 2009;361(1):6-7.
- Brett AS. "American values"- A smoke screen in the debate on health care reform. *N Engl J Med.* 2009;361(5);440-441.
- Conway PH, Clancy C. Comparative-effectiveness research-implications of the federal coordinating council's report. *N Engl J Med.* 2009;361(4):328-30.
- Cooper J, Castle, M. Health reform: A bipartisan view. *Health Affairs* 2009;28(2);w169-w172.
- Gawande A. Getting there from here: how should Obama reform health care? *New Yorker.* 2009;Jan26:26-33.
- Iglehart JK. Baucus's bill and the long road to reform. *N Engl J Med.* 2009;361:e27.
- Iglehart JK. A bumpy road for reform. *N Engl J Med.* 2009;361:e7.
- Iglehart JK. Prioritizing comparative-effectiveness research- IOM recommendations. *N Engl J Med.* 2009;361(4):325-7.
- Iglehart JK. More checks than balances in the struggle for health care reform. *N Engl J Med.* 2009:e5(1-3).
- Marmor T, Oberlander J, White J. The Obama administration's options for health care cost control: hope versus reality. *Ann Intern Med.* 2009;150:485-489.
- McLaughlin N. Smells like team spirit. As Obama talks sacrifice for reform, providers, insurers return to '90s form. *Mod Healthc.*2009;39(10):23.
- Mitka M. Health care workers, others offer ideas on health care reform to Obama team. *JAMA.* 2009;301((9):922-3.
- Oberlander J. Great expectations-the Obama administration and health care reform. *N Engl J Med.*2009;360(4):321-323.
- Polsky D, Grande D. The burden of health care costs for working families-implications for reform. *N Engl J Med.* 2009;361(5);437-439.
- Robeznieks, A. AMA's moment. Obama visit makes news, but group's role unsure. *Mod Healthc.* 2009;39(25):8-10.
- Sutherland JM, Fisher ES, Skinner JS. Getting past denial- the high cost of health care in the U.S. *N Engl J Med.* 2009;361(13):1227-1230.
- Tumulty, K. Paging Dr. Obama. *Time* 2009;174(3):17.
- Vladeck BC. The landscape in 2009: a conversation with Bruce C. Vladeck, by Birnbaum Michael. *J Health Polit Policy Law.* 2009 34(3):401-15.
- Volpp KG, Das A. Comparative Effectiveness-thinking beyond medication A versus medication B. *N Engl J Med.* 2009;361(4):331-3.
- Wilensky GR, Satcher D. Don't forget about the social determinants of health. *Health Affairs.* 2009;28(2)w194-w198.

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