

**Getting Healthy: Looking Beyond Health Care
Alliance for Health Reform and The Robert Wood Johnson
Foundation
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ED HOWARD, J.D.: My name is Ed Howard. I'm with the Alliance for Health Reform. I want to welcome you to this program on how to improve Americans' health in ways not involving health care. On behalf of Senator Rockefeller, Senator Collins, our board of directors, thank you for coming.

Those of you on the congressional staffs, you're knee deep right now in the debate over how to reform our health care system, a lot of heavy lifting involved here. As important as that task is, we can't forget that only a small portion of our overall health is traceable to health care. That fact is at the heart of today's briefing.

Our partner and our co-sponsor in this enterprise, The Robert Wood Johnson Foundation, has a very strong interest in these non-health care factors. If you listen to NPR, you hear their name as a sponsor and their identification as working to, here I quote, "Help Americans lead healthier lives and get the care they need," unquote. So, that approach to improving overall health led the foundation to set up its Commission to Build a Healthier America, a group that issued its recommendations just a few weeks ago.

Our briefing today uses those recommendations as a jumping off point for a serious discussion about the policies we need to put in place to move us toward a healthier America. We are very pleased to have representing the Foundation today

Robin Mockenhaupt, who's the chief of staff at the foundation and will be co-moderating this afternoon.

Just so you will know, Dr. Mockenhaupt spent many years in Washington before joining the Foundation about a decade ago. She was working on health and aging issues for AARP among other things. We've asked her to not only be part of the moderating duties but to help us frame this discussion today. Robin?

ROBIN MOCKENHAUPT, Ph.D., M.P.H.: Great. Thank you very much Ed. Welcome, I'm really delighted to see everyone in the room today. I hope you'll find this briefing very useful. We're very excited about the recommendations from this commission that you'll be hearing about through the course of the next few hours. I am at The Robert Wood Johnson Foundation and chief of staff there but more important for today, I've had the pleasure over the last several years, of being the program officer from the Foundation who worked with this commission.

I think you'll hear from each of the speakers today that we really feel that we have an opportunity ahead of us in the next several months and years, to make an improvement in this country's health and well being. You'll hear this theme resounded through all of the speakers today that where you live, learn, work, and play has more to do with your health and with the health of this country than health care does. That's really what we're going to be talking about today.

We're going to be discussing the recommendations from the commission. We hope that this will serve as a call to each of you in this room to know what these recommendations are, but more importantly, to help us all collectively figure out how to put them into action so that we can have a healthier nation.

So why don't I start with just a little bit of background. We all know that America has a health care crisis but not all of us may know the reason why. We spend more on health care than any other nation in the world. We spend over two trillion dollars a year on health care. It's about 17-percent of our national economy but the very sad story that comes with all of that spending is that we are not the healthiest people in the world.

For the first time, we're raising a whole generation of children that are sicker and may die younger than their parents. About a third of Americans are obese. Nearly 17 million Americans have diabetes and thousands have heart disease diagnosed each day. Probably one out of every two of us in this room may experience or be diagnosed with cancer at some point in our life. There are many other ailments that affect our citizens.

So the Foundation began thinking about this several years ago. We've been working in health and health care for many years but we thought about the idea of putting together a commission that would really address two key questions that we

asked commissioners to help us understand, and then come up with recommendations to answer these questions. First, why are some Americans so much healthier than others? Why isn't this country one of the healthiest nations in the world with all the money that we spend on health care every year, why aren't we one of the healthiest nations in the world?

So we started thinking about the idea of putting together a national commission, which you'll be hearing about today, primarily to raise visibility about the issues that we're going to be talking about; issues that relate to the health of our country but more importantly, looking at how non-medical factors or factors outside our health care system affect the health of all of our citizens and the impact of social factors on our health and well being.

So first of all, we really wanted to increase understanding about these issues and the fact that there are many other factors that impact our health outside of health care. We wanted to look for ways to develop ideas and solutions to some of the problems that we see.

We all know what the problems are but what are some of the solutions that are working in different communities already that can be put into place in other communities around the country that would help motivate action? Then finally, we wanted the commission to make recommendations and move to

solutions that would be actionable in a relatively short period of time.

So why now? Why is it that this is a good time, first of all, to launch a commission and secondly as you'll see in your packet, the commission released its report in early April. Why is this the right time to make some action? What we believe with the current conversation, first of all, here in the city in Washington in terms of what's happening on the national discussion on health reform but also conversations that are happening in communities, in states around the country as well as internationally about the effect of these social factors and impact that they have on health that this was a particularly timely opportunity for us to take action.

As we began to do some background research and think about launching this commission, we had a lot of conversations with people here in Washington with policy makers, with people around the country and learned that there's really a lack of awareness about these opportunities that are outside the health care system that can have impact on our health. There's a lack of awareness about the problems and a lack of policy action on them.

There was a strong feeling that individuals are responsible for their own health and you will hear from the members of the commission that we still believe and feel strongly that individuals are responsible for their own health.

We believe that society is also responsible for allowing individuals to live healthy lives. So you'll hear that reflected that in commission recommendations.

Then finally, we felt a commission could really bridge some of the political and ideological differences and an approach, like a commission, with some recommendations might appeal to lots of people in the country.

So The Robert Wood Johnson Foundation launched the Commission to Build a Healthier America in early 2007 with really three goals. The first goal was to raise awareness of the shortfalls in Americans' health and highlight promising interventions and solutions that exist.

Secondly, we wanted the commission to recommend specific policy interventions in a relatively short to intermediate period of time over the next three to five years that would have impact in both the public sector and in the private sector and that would really improve Americans' health. Then finally, we wanted to have those recommendations, have specific meaningful steps that would move us towards action.

So we put together a commission. The Foundation was one of the partners. There were three other partners. The central office was here at George Washington University. The G.W. Department of Health Policy was the administrative home for the commission. We had a research arm and you'll be hearing from Dr. Paula Braveman from the UCSF Center on Social Disparities

in Health. They did much of the background work for us to launch the commission, as well as produce a variety of materials, research and materials along the way that you'll be hearing about.

We had two stellar communications partners that joined us in this effort, Burness Communications and Health 360 Strategies who helped us understand how to communicate and talk about what these key messages were.

So what is the approach that the commission took in getting set from the beginning? We really wanted to raise awareness and identify areas for action through a couple of key ways. First of all, to target decision makers, people like you in this room in both the public and private sector?

Secondly we wanted to, as I said, reach beyond health care to health and to non-traditional allies in other centers, in education, in income, in transportation, in housing, in nutrition, in areas that are traditionally outside the health care system that, as we know, have great impact on health.

We wanted to make research available and more broadly accessible to decision makers. We wanted to work in a nonpartisan and bipartisan fashion. You'll see that when you see the list of commissioners as well as hear about the work that we did. I think we did a good job in accomplishing that but we worked very hard to make this a very nonpartisan and bipartisan approach. Then finally we wanted to have a plan that

was sustainable that could be used for the next several years to move us forward to action.

So with that, I'd like to turn this over to my colleague, David Williams, who is at The Harvard School of Public Health and is the staff director for this project who will tell us a little bit more about what the commission did and how it was set up. David?

DAVID WILLIAMS, Ph.D.: Thank you Robin. Again I join Robin in saying welcome to all of you and taking time out of your busy schedule to join us. I want to give you an overview of what exactly was this commission, what we did, and what are some of the key lessons that we learned.

So let's talk about the leadership of the commission. It was headed by two very distinguished public servants, Mark McClellan and Alice Rivlin, certainly household names inside of the Beltway. Supporting them were several commissioners, each of them distinguished in their own area, each of them representing a different sector of society and bringing fresh eyes to this problem that Robin talked about of why Americans aren't healthier and what we can do about it.

So we had Kate Baicker, also of Harvard University but formerly under the President's Council of Economic Advisors, Angela Glover Blackwell from Policy Link, Sheila Burke, well known for her work with Bob Dole, Linda Dillman, the Vice President of Wal-Mart, Senator Bill Frist, who we are thrilled

is on the panel with us today, Allen Goldstein from the Gates Foundation, Katie Hickcock from The Education Trust, Hugh Pinero, well known entrepreneur, founder of XM Satellite Radio, Dennis Rivera, the Chair of SEIU Health Care, Carol Simpson, former ABC News Anchor, Jim Toohey, President of Saint Vincent's College but also previously worked in the White House office on faith-based initiatives, and then Gail Warden, former CEO of a major health system.

So it's really a rich and diverse background; not the usual suspects thinking about health but they brought fresh eyes to look at the evidence and looked at the problem and thought of what we could do to move forward.

Now the commission was launched of February of 2008. We have had a relatively short life given that the oral report was released in April of this year. I want to give you some of the research that motivated the commission in terms of understanding what the task was.

First of all, there's the evidence that Robin hinted at earlier; that is, that if you look at the major industrialized countries in the world, the United States does not lead the world in terms of health but really ranks at the bottom of the major industrialized countries. Not only are we doing poorly but we are losing ground so that if you look at where we were in terms of our standing in the world of health in 1980, we

have fallen from being 18th in the world in 1980 on infant mortality to 25th in the world in the year 2002.

If you look at data on life expectancy, you see a similar pattern. It's not that our health is absolutely getting worst but other countries are making more rapid progress than we are in improving health. To give you some other examples of the work that we did, here is data on life expectancy by income in the United States.

What you can see for both men and women, as income increases, life expectancy increases and it's not a problem just about the poor. At every level of income, life expectancy's higher than for those just beneath them in terms of income. A similar pattern is evident if you look at education, the same striking variations in health, every higher level of education associated with better health.

One of the products that the commission produced--Dr. Braveman will talk about a report on adult health--but before we produced a report on child health. For that report, we did something innovative. We not only showed the disparities by education, as you can see here--and I just picked one state. It's a state by state analysis and you can go to the report and go to the website and find the data for the District of Columbia and for every state.

So I picked the state of Maryland since we're close to the state of Maryland here. You can see the striking variation

by education. As mothers' education increases, infant death rates decline. You can also see the striking variations by race and ethnicity in the state of Maryland. What's also evident though is we identified a national benchmark, a level of health that a group of Americans are currently experiencing. There's no biological reason why all Americans should not have that same level of health.

If you look at the national benchmark, you see that everyone in the state of Maryland, persons of all racial ethnic groups, and even the most highly educated, are not achieving the national benchmark. That same pattern is evident in 49 of the 50 states where all Americans are not doing as well as we could. Some groups have much larger shortfalls than others and are much more vulnerable and need special efforts to improve their health.

One of the things we looked at was at the complex relationship between socioeconomic status and race/ethnicity. We find that these are two distinct things, although they are related so that within each racial ethnic group, you see socioeconomic variations. When you look across socioeconomic status groups, you still see a racial/ethnic effect, so both of them need to be understood together.

We were also interested, as we began our work, in the status of America's children. We looked at levels of poverty around the world and found that the U.S., among the major

industrialized countries as well, led the world in terms of child poverty. One of the things that emerges in our work and in our findings is the centrality of starting early in life in any effort to improve health. We learned that foundations of good health are really built in childhood.

This gives you the sense of what we are doing and how we are seeking to expand the conversation in our work. You will see health at the bottom of this chart and you will see medical care and personal behavior as much of the current focus of health and health care policy. We are trying to expand the conversation to understand the living and working conditions in homes and communities that shape health behavior and that shape access to care, as well as the economic and social opportunities and resources that also are drivers of health.

The point that Robin made is so important in our work. What we have learned is that where we live, learn, work, and play have a lot more to do with our health than going to a physician. Now medical care is important. Access to care is important and we are supportive of efforts to expand access to care, but medical care is a repair shop. It takes care of us once we get sick. This commission is focused on what can we do to keep Americans healthy in the first place.

So you see we need to expand opportunities and healthy futures for all. We need to look at policies that promote child and youth development and education in infancy through college.

We need to look at policies that promote healthier homes, neighborhoods, schools, and work places. So we talked about the initial research that was released by the commission, by the foundation to the commission at the outset of the commission.

Then the commission conducted research. The research prepared issue briefs on different topics. I mentioned a child health book that was also produced. We went on the road with field [unintelligible] where we tried to listen to real Americans and look at real American-grown solutions, solutions that are working on the ground right now in different parts of the country that could potentially be scaled up to address the problems that we were dealing with.

I think our key finding from all of the research that was done and from our field [unintelligible] is that although health reform is essential, improving the health of all Americans requires broadening the view and paying greater attention to the drivers of health that are linked to where we live, learn, work, and play.

So what makes us sick in the first place? Why are some Americans healthier than others? Remember that was the question and the answer that we came up with was where we live, learn, work, and play has a greater impact on how long we live and how well we live than on medical care. It is absolutely necessary for us to expand the debate and expand the conversation if we want to improve the health of all Americans to look at these

fundamental drivers of America's health. I will now turn to Dr. Paula Braveman, the Research Director for the commission who will share with you some of the specific findings from the most recent released commission product a state-by-state chart book on adult health.

PAULA BRAVEMAN, M.D., M.P.H.: Thank you very much David and greetings to all of you. Before I start, I just want to comment that although the research group was based at the University of California, San Francisco, we have a national network of scholars participating in this and David, in addition to his duties as Staff Director, was an important part of the research team contributing his sociologic expertise.

So I'm going to focus on the strong links between education and health that were highlighted in a report that we just released. David mentioned it. This one is called "Reaching America's Health Potential." This is the one focused on adults. So we examined data from the Census Bureau--very recent data from the Census Bureau, and from CDC for the 50 states and the District of Columbia. Our findings were quite striking.

We found that nationally and in every state, too many Americans are not as healthy as they could and should be and furthermore that the more education you have, the healthier you are. This slide, this next slide, shows on the right national data on racial or ethnic differences in the percentage of adults who lack optimal health. Now what do I mean by lacking

optimal health? The CDC survey that we used asked people how would you rate your health. Would you say it is poor, fair, good, very good, or excellent? We categorized people as having suboptimal health if they did not answer very good or excellent. People's answers to this question have been repeatedly validated against physicians' clinical assessments of people's health.

Now on the left on this slide, you see national data on the percentage of adults lacking optimal health according to their education going from the lowest education level, less than high school to the highest education level, which is college graduation.

So you can see going from left to right, as educational level increases, health improves. This is essentially the same pattern that we found in every state, although there were some variations in the size of the differences but not in the basic pattern. Nationally, people who don't complete high school-- that's the dark blue bar on the left--were over two and a half times more likely to lack optimal health as were college grads, which is the palest blue bar on the right side. But if you look more closely at this--and David was pointing this out also-- it's not just the people without a high school diploma who fare worse than college grads.

Health improves incrementally with each step you take up the educational ladder. Even people with some college but

who haven't graduated from college had worse health than college grads. In other words, even people who would be considered solid, middle class are less healthy than people who have more social and economic advantages. We found the same basic step-wise incremental pattern in every state and in D.C.

This slide also shows national data on how sub-optimal health varies by education but now broken down by race or ethnic group. David showed you an earlier slide that illustrates this but with a different health outcome. Here we had even more racial or ethnic groups to look at. You can see that in every single group the step-wise pattern is at least as striking as it was when we looked at the whole population. So this tells us that the health differences, by education, cannot be explained by racial or ethnic differences.

Racial or ethnic differences are certainly there as you saw in the first slide and for example, if you look closely at this one. You can see that Blacks have worse health than Whites at each educational level but racial differences do not account for the educational differences. We need to address both.

I want to point out something else here and David also mentioned this referring to the earlier report on child health. Here too, we set a national benchmark. So you can see that line labeled national benchmark. We set that benchmark for adult health by identifying the rate of sub-optimal health in the state with the lowest rate of sub-optimal health among college

graduates who exercise regularly and who didn't smoke. That was around 19-percent. We reasoned that that level should be achievable by everyone. So you can see here that nationally, even White college graduates fail to meet that benchmark.

Showing you this slide, look at that blue bar in the middle, which shows the educational levels of U.S. adults. We are not talking about small numbers of people here. So if 29-percent are college grads, that means that 71-percent of Americans are at risk for sub-optimal health compared with college grads. We know when we look at that national benchmark that too many college grads also fail to reach the benchmark rate.

So you won't be able to read the numbers on this slide. I will change the order here. This map gives a very rough overview of how different states did in terms of the size of the health gap. We grouped the states into three categories according to the size of the health gap. So the dark color stands for the slot the states with relatively large gaps, the lightest color means the smallest gaps and the in-between color is the in-between.

So states certainly did vary in the size of the health gaps but what was more striking than any differences between the states was the similarity in that all had large gaps and all had that incremental step wise pattern. So the bad news is that too many Americans are not as healthy as they could be and

that people lacking a college education are at increased risk of sub-optimal health. But the good news is that much better health should be achievable for the vast majority. As a physician, I can tell you that there is no biological reason why everyone should not be able to attain the level of health enjoyed by the 29-percent of Americans who are college graduates. We're not comparing people to Olympic athletes.

Now the report provides state-specific data on every state and on D.C. Since many of you probably live in D.C., I've just shown you the D.C. snapshot but keep in mind that there is a state snapshot, a three to four-page snapshot on every one of the states but now just looking for example at D.C., you'll see that around 38-percent of all adults in D.C. were not in optimal health. That would put D.C. seventh in the country on its rate of sub-optimal health but you can also see that around 23 to 24-percent of college grads in D.C. had sub-optimal health.

So the health gap in D.C. was around 15-percent, 14 to 15-percent, and that put it in 32nd place on the size of the gap or with what the potential was. No educational group in D.C. met the national benchmark. The entire report and all the state snapshots are available on the commission website, which is www.commissiononhealth.org. That's without any punctuation, middle commission on health.

Now there are other resources that I think you might find useful on the website including one we just like to show you briefly a little bit about, which we call the education and health calculator, which was developed by Dr. Stephen Wolf. The goal of the calculator was to let policy makers appreciate the magnitude of the difference it might make in health in their state or in their county because this goes down to the county level for most counties and shows the magnitude of the difference that you could expect in health if education levels rose.

So this slide shows an example of what the calculator does, in this case, comparing Arlington, Virginia with D.C. So as you can see here, 84-percent in Arlington County had at least some college education. That's 84-percent of adults compared with 69-percent in D.C. Okay but now look at this. Now see what happens if we move the education slider bringing the levels of at least some college education in D.C. up to the educational levels in Arlington. If you look on the right, you will see that the estimate is that 486 deaths would be averted in D.C. each year if the educational levels were brought up to the levels experienced in Arlington.

So what does all this mean? We are not saying that there's a simple or always direct relationship between educational level and health. Quality of education clearly is important as well as quantity. We know that from other

research, education can affect health through many different pathways; for example by determining whether someone gets a good paying job with good working conditions and with health insurance.

Education determines income, which determines whether you can live in a neighborhood where it's safe to exercise, where there are full service grocery stores that sell fresh foods. It also determines the health of the next generation. It's transgenerational because if you can afford to live in a good neighborhood, your children can go to better schools and probably complete more school.

So everybody knows that you need good education to get a good job but I think that many people, when they really look at these data from this report, the child health report, and the education and health calculator, they will be somewhat surprised to see the strengths of the link between education and health itself. I think that many people also will find it surprising that even people with some college education but who aren't college grads are less healthy than college grads.

So clearly the greatest need is among those who are worst off but these reports tell us that most Americans could be doing much better if we broaden our focus to include education and other social policies. We think that the results from this report, the child health report, and other commission products simply highlight dramatically what something that has

been previously demonstrated in in-depth studies; that education matters for health and that it matters a lot. It matters so much that one can say that education policy is health policy.

Health care is very important particularly when we're sick but health policy needs to address the social factors like education and income, which probably in the end, have more to do with whether or not we get sick in the first place. A large body of evidence from many sources shows that child care, particularly early childhood development, housing, transportation and urban planning and agriculture and nutrition policies along with education policy have profound effects on health once we start to connect the dots.

So we hope that policy makers will use this report and other resources on our website as a point of departure in efforts to improve health by improving education and more generally by improving the conditions where we live, work, learn, and play. Now Commissioner, Senator, and I should say Commissioner Doctor Senator, Bill Frist.

SEN. BILL FRIST: Dr. Braveman, if I can, can I exercise the prerogative of the Co-Chair?

ED HOWARD, J.D.: I'm not sure I want you to. Hey it's been far too long since our final presenter has graced the dais of an Alliance briefing. Those of you who are from a different planet may not know [laughter], that he is a heart and lung

transplant surgeon. He is a two-term U.S. Senator and Majority Leader, a Professor at Princeton and now at Vanderbilt and, most important to some people in the room, a former Vice Chairman of the Alliance for Health Reform and a valued member of the Commission on Building a Healthier America. As Dr. Braveman was saying before I rudely interrupted her, Senator Frist, as a member of the commission, is going to share with us some of the key recommendations from the commission and tell us what we do about all of this stuff that has been so well explained to us. Senator Frist, thank you so much for being here.

BILL FRIST: Ed, thank you. It's great to be back with everybody and again as most of you know for about eight years, I had the opportunity to co-chair the Alliance and the fact that I'm here today, I think, reflects the respect that I have for all of you, for Ed and his great team of people and shining light and helping all of us understand better issues that are fundamental to better health.

Now I go at health in lots of different ways. Most of you saw me in the United States Senate, which in truth, is just sort of a piece of my life but I've tried to address this health issue having grown up in a family with a dad and doctor and two brothers who are doctors, trying to hit health from every different way.

Yesterday I gave grand rounds at Vanderbilt University Medical Center on transplantation and a 20-year history. It was really great because patients that I transplanted 23 years ago were back. People I transplanted when they were six days old were back fully grown--so gratifying. But that's one way to do it; have good hospitals like Vanderbilt, have good nurses and doctors and social workers and systems and access in all the things that all of you are addressing here in the next two or three months in a momentous way. That's important.

Then I came to Washington to spend that 12 years, with many of you in the room, to address it through a policy standpoint. Whether it's health care disparities or the Medicare Modernization Act or HIV/AIDS, we did some good stuff but I look at this as an elevation, a one-on-one and then the policy but if you really want to go after health, it's not going to be just getting better doctors.

It's not going to be more heart transplants. It's not going to be even more legislation like the comprehensive health service legislation that all of you will be passing. It's this stuff, if you're interested mainly in health, health that is this. that's what this report is about. That's why the commissioners have come together, spent a year with excellent staff, best state-of-the-art research. Now it is recommendations. I'll lay out a few of those recommendations for you.

The call to action was that one line, and it may be in Robin's slides, that for the first time in history, for the first time in history in all likelihood, we're raising children who won't live as long as their parents in the United States of America. It's a fact. We see the data. One out of three kids are born today or the last 10 years are probably going to or will develop type II diabetes. It's hard to imagine.

Meanwhile, this is the stuff. That's what it's all about and that's why I'm here. That's why if we really want to go through health and address health issues, we need to do health services with a real impact--that is the stuff that this report is made of. You just heard from both Dr. Williams and Dr. Braveman that it's these factors outside the health care system; the doctors, the access, the universal health care are all of the things that we focus on.

Dr. Braveman, you can't help it when you go through the reports to look at your own state and if you work for a representative before a committee, I would do just that. I would highlight it. I'd put the state. Unfortunately, when you look at my state of Tennessee, you look at Dr. Braveman's data, we rank 47th out of 50. When it comes to that health gap between those who graduated from college and those with less than a high school education, my home state is 47th.

We rank 42nd, I see, out of 50 in terms of the overall percentage of our adult population that is not in good health.

Well, I don't live in Washington anymore. I live in Nashville, Tennessee. I live in Tennessee. That stuff matters to me, my children who will live in Tennessee as we go forward.

Just another side and David, I think you presented the data earlier for Tennessee, if you look at the infant mortality, that fundamental measure that we all use, if you look at infant mortality from families or from women who graduated from college versus those who did not graduate from high school and take that gap, infant mortality, from the educated and those who haven't graduated from high school, that gap is measured again for every state. Tennessee is 50th out of 50.

That was enough to stimulate me to go back and start a commission, a statewide commission, called Tennessee Score; statewide on education reform K through 12. It's a whole different issue but it shows how the data--even for somebody such as myself who has kind of lived health care, that's come from the research out of here--drives home what those independent variables, those levers are to improve health. And that little calculator, we'll come back to, is fun. Everybody needs to go home today and go to the website and play with the health calculator that we have.

Let me jump right in because my part really is the recommendation. We've sort of gotten to the why and the importance of it. The legislative process is all about setting

priorities. The priorities make it important for us to step back because everything's important, but some are more urgent than others. Some are more cost-effective. Some are more sort of value-laden than others.

After you know what's urgent, you have to prioritize all of those things into what you can act on, what you can do, and then what you just have to observe and let other people do. A problem without a solution is just going to stay a problem but a problem with a solution becomes a great opportunity. That's what our report is.

It's almost a listing of great opportunities that people don't normally come to because they're always thinking what the heart surgeon thinks about doctor/patient interaction that's going to make better health across the globe.

David Williams pointed out it was a diverse commission. We had all sorts of people coming together, not just the party in the right and left but the research people, people on the ground, child development people, people with all sorts of expertise and out of that, we came up with 10 recommendations. We're not going to go through each one of those recommendations but I will say that they're rooted in a fundamental philosophy that reflects the diversity that philosophy being that it takes two things.

It takes individual responsibility, that individual responsibility that, in this day and time, you may want

somebody to come in and take care of everything for you but that's not the way the world works. It really comes down to that individual responsibility, number one.

Number two--a broader commitment--we're in a business here in Washington about, or you're in the business in Washington about how society has a responsibility to remove whatever those barriers and those obstacles are that prevent Americans from making healthy decisions. People have personal responsibility to make the decisions but we have a society responsibility to lower those barriers so that you can have the opportunity to make those decisions as an individual. That's what really emanated from our report.

Starting early, we talk about it intuitively but boy, the data just drives it home. We got to start early to make sure that all children have high quality child care. A lot of times in Washington, it gets down more to the partisan rhetoric and all but we just have to flat out go to the science, go to the data, and cut through to that fact.

This is the one area that will require a commitment, I think, of new resources, just because the science is fairly new, the data is fairly new, and therefore people had not given it sufficient attention in the past. Obviously, attention's got to be paid to the low-income families in particular.

Again, I don't want to go through all the recommendations but let me also address the deficiencies of the

school lunch and nutrition programs. That's something that we can do and it is pretty easy to do. You can't just let the few people who happen to be on the committees doing it. We do have to have a much larger front pushing through on that to make sure that children, since they have that sort of teachable moment that captured moment, to make sure they get that healthier food in school.

Then also, obviously, on the exercise time, we all know especially in my studies of K through 12 education with standards, which I think are very good expectations, very good, we just have to force some period of exercise, of activity, in the school day. Remember, one out of three people, who have type II diabetes, aren't going to live as long as we are. It's not that hard to do and that's where these kids are spending six to eight hours every day.

Childhood obesity, this is where the medical [inaudible] link and if you have a childhood obesity, you're going to have adult obesity today. It's a major contributor to the disease that I focused my life on. I was talking about at Vanderbilt yesterday about heart disease, also diabetes, and a host of other chronic diseases. All of us know that chronic diseases ultimately account for about 70 to 75-percent of all the health care costs in our society today.

The good news is that there are simple things, there are simple steps that can be taken early in life through our

nutrition programs, through our education programs that can lessen this burden of these illnesses on our families and our nation budget, ultimately our nation's budget, and clearly the health.

Healthy foods, Congress has an opportunity this year that I encourage all of you to get involved with; again even if you're not a member who is on a committee. But one of our core recommendations is concerned with this whole reauthorization of the WIC program, the Women, Infants, and Children's program as well as the SNAP program, the Supplemental Nutrition Assistance Program. There are steps that can be taken to ensure that these programs do get nutritious, balanced foods to families.

The commission also recommends that a public/private collaborative is fostered to sustain full service grocery stores. When you go back to your local communities or get on the phone, because once you become aware of this, you see what a big problem it is, what a challenge is. It really comes down to the location of grocery stores--where they are. What kind of foods do they actually have? It's hard to eat healthy foods no matter what but if you can't buy healthy foods fairly conveniently, you simply are not going to have access to them.

We did a bunch of field visits and one of the most innovative things we saw during our field visits was in Philadelphia. There we learned about the Pennsylvania Fresh Food Financing Initiative. This program, a remarkable program

with remarkable leadership, has demonstrated that sustainable models for grocery stores can be implemented successfully and I should say economically in terms of the model they developed through these public/private partnerships. We've got to eliminate these fresh food deserts, which is probably the best way to capture it, that are out there, and to start watching for it and you'll see the need that is there.

Creating healthy communities, this is actually a great one as well: the smoke-free nation, we all know that taxation has had a huge impact there. There used to be an argument about it. There's no question that you raise taxes in smoking and that gets you down to a certain level. But then we have a long way to go in terms of total elimination. Looking at some of the new appointments that are coming through from the FDA and the CDC, I think, there's going to be a real emphasis on that. I applaud because we need to be a smoke-free nation. I should also add, globally, we have a responsibility there as well.

Second, integrating safety and wellness into every aspect of community life. One of the first things I did after we released the report, I went back and talked to our mayor in Nashville. In the appendix of our report, there's a whole list of things that a community might do to measure. It has to do with parks and it has to do with grocery stores. It has to do with all sorts of things. There are things that you can do locally.

One of the things is a health impact rating. All of us participate in green ratings, green buildings, green communities. We really need to start thinking about having a health impact at the local level whereby people come together-- it might be charitable groups, businesses, construction outfits, people building homes--and develop a health impact rating to rate a community or to rate a construction project or to even rate a large building.

Another great idea is to create and fund healthy community demonstration projects. All of us in Washington have participated in different economic development zones and there's absolutely no reason that we shouldn't, in some of the work that all of you are doing, help create empowerment zones of the sense of health empowerment and really health type. We call them healthy community demonstration projects but think about it as you go forward.

We had field visits, I think we mentioned, to Philadelphia, to Appalachia, to Colorado, and that's where we actually pick up and see many of these programs. I'll do one last slide and then I'll stop.

I mentioned the education calendar. Please go to the website. The website is up there, yes, www.commissionhealth.org I use it just about every talk I give. I take the community I'm going to go talk to, I take the little ruler, the little calculator there and bang, see where we are and then I think

the community, either Nashville because we don't do very well in Nashville, or you could take some place in Virginia and compare it, but it just clicks. It's dynamic.

Commissions usually stop or they produce a report and then they disappear. That's the way most commissions are; this commission did not. We finished and had our sort of final meeting in terms of presentation about a month ago but we're going to continue several months because, we're taking the recommendations out all over the country so we're available. Go to the website. The website is dynamic. You'll find all of the reports, all of the slides of useful information there.

Our research work continues as well as is demonstrated by Dr. Braveman. The data that she presented today is out for the first time. So it's going to continue to come out as we go forward. So access that data. It's live. It's dynamic. You'll find it useful and it'll maybe stimulate you to do things that I did. Go ahead and focus on education for a while.

All of you, in closing, have an awful lot on your plate. After this meeting, you'll go back and you'll be called on the access issues and the uninsured issue and the cost issue, all of which are critically important. I guess what I would ask all of you to do as you address universal coverage, as you address costs, remember stepping back is the goal of health. The fundamental goal is health. That's why these health services are important. So yes, we need to focus on them but

focus on overall health and that the most direct road to health not health services but health, and better health is to invest in how and where we live and learn and work and pray and play. That's what this report is all about. So with that, I'll turn it back to Ed but we'll be ready to answer any questions you might have. Ed?

ED HOWARD: That's terrific. Thanks very much Senator. Just the standard logistical boiler plate here, there are some microphones that you can use to come forward and ask questions. There are green question cards in your kits that you can write a question on. If you hold it up, they'll bring it forward and we'll get it asked.

Monday, we don't do Saturday, Monday you can view a webcast of this briefing. You can find the materials that are in your kits on the website of the Alliance, allhealth.org, as well as going to the website of the commission, commissiononhealth.org. There is also a blue evaluation form in your packets that we would appreciate it if you would fill out before you have to leave.

While you're coming forward, let me just clarify something and we have a couple questions that came in, in advance. Dr. Williams, you talked about the benchmark data showing that in 49 out of the 50 states, we didn't live up to those benchmarks. What was the 50th and how did they get there?

DAVID WILLIAMS: I think it was implied in Dr. Braveman's talk where she indicated how we calculated the benchmark. We looked at the state in which the college educated was doing the best for infant mortality. In some states, depending on the health indicator, we looked at a state where the college educated, among the college educated, those who followed good health practices were doing the best.

So the point is we are looking at a real group of Americans today and we are looking at the level of health they enjoy and there is no reason why all Americans could not enjoy the same level of health. So that's our national benchmark and define that way, it by definition, in 49 states then, even the best off, the college educated are not experiencing a national benchmark. So it's really an important point. We tend to think of health challenges in this country as problems of minorities and problems of the poor. What the evidence clearly indicates is that all of us could be doing better even though it is true that some have much larger shortfalls and we need to invest in helping the most vulnerable specifically.

ED HOWARD, J.D.: Good. You can see that we have folks lined up at the microphones, a short line. Obviously we would ask you to identify yourself and to try to be as brief as you can in your question. Go ahead Bob?

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health. I think it's very interesting

that this report is highlighting the health impact of lots of social determinants. We saw that in the PBS series, "Unnatural Causes," due to all sorts of inequalities. Yet I heard Senator Frist identify some policy recommendations in relation to food and early education, but it seems like there's a lot of discretion that lots of different actors have in society and it's not exactly clear who is responsible for making decisions in a planning capacity that address the inequalities in health.

What I didn't see in the report from the assumptions that you started with, namely that were going beyond the health care system, is that there are fiscal impacts on the health care system when you do the right thing. I'm wondering why you didn't highlight the cost savings to society when the social determinants of health are addressed because we know the government is responsible for those health care costs and it seems to me that the savings that the government could derive as the primary payer of health care needs to be available to address those social determinants.

We all know that poor housing creates poor health but what is the incentive for governments to address that when the resources are often limited?

ED HOWARD: Okay. Dr. Williams, take first crack at it.

DAVID WILLIAMS: Sure and others can help me on the response. In terms of the initial report released entitled, "Overcoming Obstacles to Health," we had two economists

calculate what are these shortfalls in health costing the U.S. economy. They estimated that if all Americans had the levels of health, the levels of illness and the death rates of the college educated, the U.S. economy would save one trillion dollars annually. So that's a specific number that actually exists within the first report that that was released.

The work of the commission, though having begun by looking at what the problem, was focused heavily on the solutions. What exactly can we do about it and what can we do now? That's what our recommendations focus on.

PAULA BRAVEMAN: I will just jump in on the beginning part of your comments, which are really true. There are many people that work on many of these issues. I think one of the things that the report does is a call to all sectors to take consideration of these factors that are outside the health care system and incorporate them in their work whether it is the health care system, those in public health communities, those in a housing community, those in the education community, et cetera. That we all have responsibility for incorporating this and by doing so will all have a healthier nation in the long run.

ED HOWARD: The question is--is the long run in the 10-year CBO window? Yes Tom?

TOM MILLER: Thank you, Ed. Tom Miller, American Enterprise Institute. The question's primarily for Paula about

just how tight the fit is between better education, and better health. What are the causative factors as opposed to what might be actionable. I think the review of the better research suggests we measure in numbers of years of education because we can't measure what we're really looking for but it really involves a pathway, which is a longer time horizon, deferred gratification, people who stay in school a long time, learn how to succeed.

They get used to doing the hard work and that spills over into the way in which they make their decisions across their span of life. That engages the health care system as well. We might be on a path to, at least, rhetorically say we're going to give everybody a college education or at least a loan to get it but my colleague, Charles Lowry [misspelled?] would suggest some of those folks in college shouldn't be there. They could be leading more productive, useful lives, more fulfilling for them without necessarily going through the college process.

So my real question is, given that we've got an installed base of people who are older, who have health conditions, and although we can marginally say that education might improve their health, a lot has already gone on. So what do we know about the type of interventions for that slice of the population? They've already been educated or miseducated but are there other ways like education to get them more

engaged in their health decisions, to navigate the system more effectively, to better engage and manage their own health.

The flipside of that is what we know about the long tailed consequences of early childhood development, these chronic conditions 40-50 years later, got baked in a cake before somebody showed up in elementary school, what are the interventions on that side to get to what is the health production we're looking for with the better tools as opposed to crudely saying well if we have 12, 15 years, that's good enough for us.

PAULA BRAVEMAN: You raise a very important issue and the years of education here are clearly a rough proxy for a lot of things that basically education is a proxy for a whole array of resources and opportunities. The commissioners chose to focus primarily on children and what would make a difference for children because of the evidence that that's going to be where the biggest payoff is going to be.

It certainly is very important to have prescriptions for older adults, certainly the older and older I get, the more important I think that is but the commission did not get into those. It sounds as though you have some very good ideas about interventions that should be there. I frankly was amazed at our findings. Now I'm someone who has, for a long time, thought that education was linked with health but because the measure that we're using, the years or the level of completed education

is so crude, as you've pointed out, I was shocked that in every single state, we saw that stepwise pattern. It's really quite remarkable considering how crude it is.

If we hadn't seen that pattern all over the place, I wouldn't necessarily have said oh education doesn't matter. I would have said we've got too crude a measure. So I think it is important to keep that in mind. I think with this research, with a lot of the commission research, we are relying a lot on much more in-depth and subtle research that has been done by others for years. I think you can look to that huge body of information to tell you that education matters.

DAVID WILLIAMS: Can I add to Dr. Braveman's excellent answer? I think many of the commission's recommendations deal with adults where they are right now. If you look at our recommendations that talk about healthy community demonstration projects, that will benefit all persons in the community and think of the ways to integrate safety and wellness into all context of community life.

By the way, this is the executive summary of the report that you can read. On the website you can get a copy of the full report. It gives you a lot of the background and the evidence. We looked at a field hearing on work and looked at what can be done in work environments to improve health, so there is a lot that can be done, even for adults today that have been shown to be effective in improving health.

JAKE GLOVER: Hello. Jake Glover, America's Health Insurance Plans, I'm a former state physical education grant writer and grant administrator and I've been part of both successful and failed programs. And while all include altruistic process goals, and include increasing physical activity for students, improving school lunch programs, the common theme of successful programs were finite outcome goals related to moderate to vigorous physical activity collected on downloadable heart rate monitors, with students being mandated to get 30 minutes in their zone and teachers being held to 85-percent of their students reaching that goal.

So, both the teachers and students can be evaluated on if they are actually creating an environment in which physical activity is promoted and with school lunch programs, with aggregate data reports on how often students are accessing fruits and vegetables, to look at reports and send reports home to parents including one school district where we took our obesity rate from 63-percent in 2002 to zero last year in Grundy Center, Iowa, so with published reports.

So, what I am asking is with technology available to collect this type of data and as all of you are probably data people like myself, is there traction being gained from a legislative standpoint to start increasing opportunities and programs like this across the state and other states beyond Grundy Center, Iowa? So, what do you think? I guess my

general question is mandates, and evaluating not only students but also teachers and schools the same way we evaluate academic subjects related to physical education.

BILL FRIST: You know I just don't know enough about it to comment intelligently. I think if you look, as usual the Alliance has done a great job in putting papers and making papers and abstracts and copies in your folders of papers, and if you look at things like what Mike Huckabee did in Arkansas, you see someone who is driven by something personally which is why ultimately we have to change this culture of health.

We just don't have the culture of health in this country. It's been easy not to in the past. Only right now is data, like we are talking about today, the diabetes, type II diabetes, that data, what the impact really is projected out. We have never had to address it before and what we realize now is that our culture of health with our fallen infant mortality, deterioration of infant mortality compared to international standards or when you compare Appalachian regions to the rest of the United States of America. Now that data is coming online, the policy makers are going to have to be made aware.

Going back to that first question about the cost benefit, it's very dangerous to political people to rely upon that. We see it with prevention right now. Prevention is not very cost effective in the big scheme of things.

Now, it is but it depends on how sophisticated your prevention program is. We are at the stage where we are really learning. People are healthier, and just because it is not cost effective doesn't mean it's the right thing to do, it's the health. That's why I keep saying health is what we are after, not necessarily cost effectiveness.

That's why we also focus mainly on kids. The payout is 30 or 40 years from now, and even from the policy maker's standpoint, I have got a Medicare budget greater than 65 years of age and a Medicaid budget which affects a little bit more, but all of what we are talking about with school lunch programs and better exercise, is a 30 or 40 year payout, as Ed said, outside of the tenure window, and so it gets a little bit dangerous to do that.

But, if you look at Arkansas, what has happened there to a certain extent, I think a good impact will be to get parents involved. A lot of them don't like it initially because that culture of health has to be established. Progress looks like it is being made and then you have new political figures come in and say well, that was somebody else's project. Let's undo it.

The only way you can get it undone is if you have a grassroots movement, you've changed the culture, number one, and number two you have scientific data, which is what you are saying. Do those pilot programs right where you are. Where we

come through, with much of our big document, you will see is best practices around the United States of America, if you will read our overall report, and the 200 best practices in there and as you are glancing through you will say well I am not sure. That's in Iowa.

Will it work in Tennessee? That is not for a politician at the federal level to decide, but it is for that mayor back there in a comparable county to decide if it will work or not. There are some best practices there, in the middle of the Appalachian Mountains, in these hollows that we visited, Dave Williams and I went back there, we saw the most beautiful programs that worked among people who don't write or read; just through song, in singing, in story telling, but they get it.

So anyway, it's complicated. The data is exactly right. That is kind of what we are doing. Dr. Braveman is pushing it forward. It is still early, but it's changing that culture of health with a payout that is 30 and 40 years down the line.

ROBIN MOCKENHAUPT: I will just add on to that, now I'll add onto it, I think the point that you are making is that children need to be active and there are ways to do that. There are various organizations that focus on exercise who have very prescriptive outlines of what works and what doesn't work.

I think what our commission tried to do is to raise the call that so many schools still do not provide physical education and calling for getting kids active in K through 12 years. We wanted to raise it to a higher level of urgency and to get all kids who are in K through 12 active. There are lots of different ways to do that.

There are a lot of very innovative programs in schools, in certain areas, that have much more active, not only P.E. programs, but also after school programs, et cetera. And I think what we were trying to accomplish was to add to the growing voices about the needs to keep kids active.

MARY PARADISE: My name is Mary Paradise and I work for the National Education Association. However, I'm a former school nurse and so I can't tell you how grateful I am for you to make that connection between education and health. I am also here to tell you that when school budgets get tight, I'm the first one cut. P.E. teachers are the next one cut. Health education teachers are the next one cut and then the cafeteria foods are the next one cut.

And so given what your research has shown, those probably are not the 1st, 2nd, 3rd, or 4th things that should be cut and I just want to encourage you to continue to get this out. It really makes me incredibly happy that finally when people ask for data, I now have data and I am in a position

that can make a kind of difference in education systems around this country. So, thank you.

PAULA BRAVEMAN: That was eloquent and I think it underscores a major area of discussion during the commission's life, in discussing what the obstacles are to moving forward with an agenda to build a healthier America and to reduce health disparities. Senator Frist mentioned it, that 10 year window of time for the CBO and that we evaluate the outcomes of efforts short-term.

That is the way it is done, and it's not who is going to get the credit if the outcome occurs 20 or 30 years later, and so you can cut the school nurse and you can cut the P.E. teacher and you can cut the nutritious school lunch, because the effect of that is not going to show up for quite awhile.

And so actually one of the commission's recommendations did have to do with the notion of accountability and that there needs to be the capability for ongoing monitoring of progress toward a healthier America with a healthier America for all. The report discusses the importance of some change in that time window that is used for the evaluation of the impact of policies.

HARVEY SLOAN: Harvey Sloan, with Eurasian Medical Education Program. I have also done some work in early child development and Dr. Frist, you mentioned one in three children who will not live their potential as they should and we go back

to early brain developed and add zero to three, zero to five period is absolutely the foundation. If you get on the wrong track there, it's very difficult.

So, my question is what are we doing in terms of the parents? The parents are the first teachers and sometimes the best teachers, not only from a nutritional standpoint but from the standpoint of appropriate nurturing and the appropriate stimulation of that child in those early years. It is very important for the schools to come in at an appropriate time, but they are not there when that child is three, four, five months. And the only person or persons that are there are those parents and they need to have the tools to be able to provide the best development we all want.

ROBIN MOCKENHAUPT: And that underscores the importance of education.

BILL FRIST: We kept coming back to exactly that and the data is so good, fairly new but it is so good that we kind of moved beyond, didn't move beyond it, but basically didn't speak directly to it other than things like the sort of child care exposure, but even that is beyond where you are talking about. You are talking about really where the neural hookups are really taking place and a fascinating science.

I think there are tricks that you use and from a policy standpoint this whole changing the culture, we know how hard that is, whether it's obesity or whether it's overall, more

generally, health, but I think a good focus for all this is schools.

And that is why I was glad that we heard from the nurse NEA person as well, because things are going to have to be done in schools. That is too late you say, initially, but it's not, because you have everybody going, not everybody but most people going through this eye of the needle for a period of eight years, maybe eight years, and I think we can do a better job at including parents and having them come to the schools and making that the source of information in changing this culture.

The problem is--the education association has this problem and I spent a lot of time in Tennessee with them in the school initiative--how do you get the parents in when our society is so different? And there are tricks that are used, again they are almost little case studies, little anecdotes, but by doing things, by having tasks that will bring a parent into a school where you can have that teachable moment on health care, where you say that there are 20 things and every parents should spend one hour volunteering at a school.

And when they come to the school you tell them right up front, listen, if you're a teacher, or you're the principal, you basically say listen, you had to take off from work or you had to leave other kids at home, this is important. If you need a note from the school, here is a note, and take it back

to your employer or to your family to show how important this is. And then use that as the source.

That is about the only way, other than general education and the media, we can really educate those parents but then it means we need to focus as our last speaker said, it can't be schools, just standard academic and math and science. We really have to get this more holistic view there. But I think it fits together and comes back to a lot of this relationship between education and the health, using that as the lever to bring parents in who do control that next child coming along at one year, two years, and three years of age.

ACONO NEFATEMIA: Good afternoon. My name is Acono Nefatemia [misspelled?]. I work for the Executive Intelligence Review and I also do work on research under health care policy right now, since it's now a very hot topic.

I believe that health care should not be a privilege, it should be a right for every American, and I just wanted to thank your panel. But I wanted to also try to take a step back to how we got to the situation whereby the health care situation in the United States has deteriorated right now.

Prior to 1973, before the HMO law was enacted, we had what is called the Hill-Burton Act and it was a bipartisan support and not only did the Hill-Burton Act work, it increased the number of doctors for patients, it also increased public health care workers for rural county in United States and it

also increased the number of hospitals in the United States. By 1980, you had about 7,000 U.S. hospitals all over the United States.

Now, contrast that with the HMO Law, which was enacted in 1973. We have now had a take down or a worse situation whereby we now have a situation where you now have the number of doctors per patient is reduced. You also have a number of public health care workers per rural county reduced, and we also have situation whereby the number of hospitals since 1980 now has reduced to less than 5,000.

So what I was trying to say was that I think there should be some kind of radical face shift and rethinking of how we should come about health care reform and I was trying to see the panel. Right now, what do you think about repealing the HMO law, because in order to eradicate the overhead costs, administrative costs, if you are going to really see a really sensible health care for all, I think rebuilding HMO law will be the first step, will be the right step and right direction.

And also I wanted to ask the panel what do you guys think about restoring the Hill-Burton Act, which was enacted in 1946?

ED HOWARD: I have to say that's a question or two questions that I didn't anticipate. [Laughter]

BILL FRIST: I'd love to take them on, all of them. [Laughter]

ACONO NEFATEMIA: Thank you, Senator.

BILL FRIST: But I'm not going to, actually, because it's really not on topic but I disagree with both of those just absolutely. I think the real shift, again, change of culture of health and a culture of sort of health services sort of extending into it, is that the overall movement has to be away from, which is the fundamental problem and not HMOs or Hill-Burton reimbursement.

I think they kind of run their course. It really is moving to what President Obama says and we will see how it plays out because it's not going to take place over at the White House, it's going to take place right here in the United States in the House of Representatives, but moving towards a system that centers on value rather than a system that reimburses trains on quantity of services.

And I think that is going to be the fundamental shift and it shifts a lot, a little bit where we said today if you start looking at value, you are looking at data, you're looking at outcomes, you're looking at results, you're looking at transparency, that's all the numerator of the equation. The denominator is dollars invested and it's not cost effectiveness, but it's value itself.

And I think making that the end of the goal of prevention, you are looking for value; not necessarily the cost effectiveness of access issues, of the cost issues looking for

value of reimbursing on care delivery value chains instead of just the surgeon and the cardiologist and the rehab. So we will talk later because that's not what this conference is about but I think that is where the movement has to be and I hope that is where Washington goes, but they are great questions, just a little bit off topic here.

ED HOWARD: Let me try to make a connection. We actually have a question card that asks what part of this discussion if any really should be integrated into the health reform conversation that is going on?

BILL FRIST: Let me jump in and then I will be quiet, but on the stimulus plan, whatever that fancy name that they changed it to that you all know, recovery act or whatever it is, it focused on nutrition and it focused on a lot of the topics. In fact didn't you have your sheet in the Alliance of what was actually in that proposal, and it comes back and it looks at education, and it comes back and looks at the nutrition in schools, so that's kind of the good stuff.

The second thing that was talked about, actually, in the budget and then last week with the announcements out of Washington is the whole prevention and wellness end of things, and consideration being given here in Washington on wellness, social determinants of health care, prevention, wellness here, health services over here. And the proposals that are on the table are things like tax credits to employers who have

wellness programs that are there, maybe look at deduction abilities and elimination of deduction abilities for certain preventive testing coming in.

All that is on the table in the finance committee now, but that is sort of two examples. Then I think others can have lots of examples coming through. And then of course I mentioned the legislation with the WIC reauthorization that is on the table as well, which is not part of the health service agenda but is more part of the overall health agenda. But what others, there are probably lots of others people could name.

ED HOWARD: Anybody else want to take a crack at it?

AYANNA NAJUMA: Hi, my name is Ayanna Najuma, I'm with Lincoln-McCloud, we are a communications firm here in the D.C. area, the question that goes on in my head kind of came up last summer when I was in Oklahoma. I grew up in Oklahoma City and a newspaper there started doing some, revealing some studies that had been done about Oklahoma, one of which was that unlike many states that were overwhelmed by the mortgage issue and having financial problems.

Oklahoma was not in a recession and still is not in a recession. Even though they are not in a recession and I looked at the statistics in terms of education, they had one of the highest percentages of - they are number five on the obesity list. There are more fast food restaurants per capita in the state of Oklahoma than any place else in the country, there is

a very high percentage of teenagers, over 25-percent, that are smoking, so when restaurants are thinking about opening in other places in the country, they come to Oklahoma to do their test marketing.

What concerns me, and I am sure you all have done a lot of work that is honorable, and I am sure that you have gone to the national league of cities, you have probably spoken to the U.S. Conference of Mayors, and a long list of organizations that address the issues in their communities. What do you envision the combination of commerce?

Oh, and the other thing is there are hardly no grocery stores in Oklahoma City. It was embarrassing by far. When you ask people well, where do you shop? And I have had this conversation with people not only in Oklahoma City and Tulsa and other places in America, the big thing comes up and I am sure your commissioner from Wal-Mart probably had a lot of input in terms of talking about where they fit into the process, but people were saying we shop at Wal-Mart.

Growing up in Oklahoma City, there were community grocery stores where you could get healthy food, but that is not happening anymore. So you have got this long list of if there is no place to eat in terms of buying healthy food, then my only other option is to eat out.

What could you recommend or what have been the recommendations, or where has been the thought from a commerce

perspective that speaks to how do we combine commerce and healthy eating where it's a win-win situation? Not to mention that there are about 82 casinos in the state of Oklahoma that is generating a lot of money for the state of Oklahoma.

ROBIN MOCKENHAUPT: I will start and I will let my other panelists jump in on that. One of the things from the very beginning of setting up this commission, what we were interested in was having this be both a public and private sector initiative and speak to decision makers in both the public and private sectors.

So you will see some of the recommendations--and this actually answers one of the other questions up here is I didn't see any work place reform recommendations--is that there are a number of recommendations that do relate to trying to create healthier communities within work places that employers need to help create those healthy environments for where we spend a lot of our days as adults in our work place.

And so, for instance the Smoke Free Nation, employers can have a major role there. In the safety and wellness aspects of community life again, employers can have a role there, so I think the general sense was that we really wanted this to be on the private sector really and an opportunity for employers and employees to look at ways to create healthy environments.

I will pick up on your comment about the grocery stores, though, because the commission highlighted one particular area around creating grocery stores in communities that not only would lead to healthier outcomes for the residents in the community, but also was a great opportunity to bring public and private together to work on the common goal of creating a healthy community in the whole area and stimulate economic development.

So I think that there are a number of different ways through all the recommendations but those in particular that it really focuses on bringing the private sector into the equation and we really, the commission I know calls on the private sector as well to have a role in all of these areas to try to create a healthier nation.

AYANNA NAJUMA: Just one more thing, while I was out there, the mayor of Oklahoma City launched, I'm sure you all know this already, called "The City is Going on a Diet," trying to make people more educated around health care issues.

When I called the mayor's office, because I have a communications firm, I was very concerned about what was happening in the African American community because when I was growing up there it was very segregated and I am somewhat dating myself, but there was no money even designated. When I called to talk about what are you doing in this area, how can we help? He said we don't have a budget for that.

This is just something the mayor decided to launch himself and he wanted to lose weight himself and he identified some partners to be able to address the issue. But it seemed as though it wasn't even a priority in terms of the city identifying something that was really important, to dump a lot of revenue into it to address the issues they were confronted with, so thank you very much.

DAVID WILLIAMS: Let me just comment that certainly we need policy changes, but I think one of the things we learned in terms of the work of the commission as we looked at different parts of the United States and looked at programs that were working. We really learned that leadership matters and the bully pulpit matters and a lot can be accomplished by in terms of what Senator Frist talked about, what we need is to change the culture, a lot can happen by leadership.

Certainly that has to be supported by redirecting our priorities and spending money in ways that would ensure the level of health and wellness that we want for the society.

BILL FRIST: I will defer to a written question if we have time.

PAULA BRAVEMAN: What I would like to add is, and we will see whether Senator Frist says no, you are all wrong, Paula, but I think that probably more important than what the details of each specific recommendation were, was the message loud and clear from the commission that all, that everyone in

every sector, decision makers have to be asking the question as they make their decisions how will this affect health?

That people in transportation, people in housing, people in education, and at the highest level of government that goes across all those sectors, the highest level of government is going to have to set in motion processes that will make that happen and that institutionalized the reality that education policy is health policy, et cetera.

Before I give over the mic, I just wanted to respond to a few questions back about early childhood development. Someone had said well isn't the game up, basically, after a few months because how important the early brain development is, and the game isn't up.

There has been some very exciting research in the last 20 years and it definitely shows differences in brain development by markers of social class, like parents education and parents income, and it definitely shows that the brain is very plastic and that high quality, early childhood development programs like high quality head start, I'm not talking about budget version of early head start, can make a difference.

And these studies have shown the brain development of the kids from the disadvantaged backgrounds actually catch up to the brain development of the kids from the more advantaged backgrounds. So the evidence was so compelling on this and on the possibility to intervene in childhood. That is why the

commission took such a strong stand about early childhood development and the need to fund it even if it meant resetting priorities.

ED HOWARD: Very good. You have been patient. Let me ask you to be patient for 30 seconds longer as we finish up here, our last couple of questions. I will just remind you that we would be very grateful if you would fill out an evaluation form to help give us some feedback on how we tackle this topic and other topics could be useful to you in the coming months. Yes, go right ahead.

ERIC EISEN: My name is Eric Eisen. I am a pediatric resident at Miami Children's Hospital and an advocacy intern with the American Academy of Pediatrics. I think it was about seven years ago that Duke put out some information on the impact of faith, prayer and religion on length of stay in a hospital. So if you extrapolate this to prevention, what is the impact there? Does participation in a church, or a local synagogue, improve or influence a child's, a teen's, a young adult's participation in certain lifestyle decisions?

Our current culture enforces immediate gratification, which is not conducive to good lifestyle choices, so one; do you have data on that? And two, do other countries have data on that? And three, what is your opinion on that?

ED HOWARD: Dave, you want to start? That is an area that you have paid some attention to.

DAVID WILLIAMS: Yes. I mean, there is certainly a lot of research, most of it in the United States, but a growing body of research from other countries that suggests that religious involvement is associated with better health, that the best evidence is linked to religious attendance and mortality.

In the United States and national data, if a person aged 20 or over, persons who attend religious services frequently will live six years longer than those who don't attend. That's the national picture. So there is affect showing that the multiple pathways by which religious engagement affects health, one of them is increased behaviors, even in areas where religious organizations have no specific teaching.

There is evidence of religious communities being a source of social support and social engagement that facilitates helping individuals cope with stress. There is evidence that religious beliefs can enable, give people frameworks to cope with stress and reduce some of the negative effects of stress and health.

I think a balanced look at the evidence also shows that there are conditions under which religion adversely impacts health. There are negative ways of using religion to cope, for example persons who deal with stressful events by thinking that God is punishing them for their sins or they've been abandoned

by God do more poorly, have higher rates of cancer patients who believe that, have higher rates of mortality than those who don't. So I think it's a robust area and a growing area of work, looking at multiple ways in which religion can have both positive and negative effects on health.

We did not specifically focus in our recommendations or didn't spend a lot of time focusing on the role of religion and health, although our call for all sectors of society to work together to improve the health of all Americans includes faith communities.

And there is certainly a lot of innovative programs taking place right now within faith communities addressing wellness and addressing improvements of health and that is certainly faith communities included in our call for moving to this culture of health and moving to this better health for all Americans will require every sector to work together and that includes faith communities.

BILL FRIST: Just on the culture of health, most of you know by now, that is where I spend most of my time. I think and I mentioned schools because I think schools right now are a place that we can move because we have the lunch issue, we have the activity issue, we have the connection with family and parents potentially, and we have teachers who are under lots of pressure to do lots of different things. We value that as a

society. Teachers are willing to step up. They understand the importance of it and they see it every day.

But I tell you the parallel is with HIV/AIDS globally, because that is something I work at from here, my first case I saw in 1984 and then I watched a million people die, then 10 million, then 20 million, then 23 million people, and I have worked through two presidencies here and lots of different meetings about it.

The tipping point didn't occur because it was stigmatized. Changing culture, this is where I'm going, it was stigmatized globally and then once the faith community took it on, not necessarily here but around the globe, predominantly in Africa but also Latin America, once the faith based community took it on, the culture radically changed.

And it kind of makes sense and out of the whole list that David mentioned and very inclusive, the whole idea of that is where you have that teachable moment, that opportunity to change culture where people come for meaningful things about life. If you have, again going to what David said, the leadership there, you can change culture pretty quickly.

PAULA BRAVEMAN: Dr. Khalil Johnson asked a question directed to me and the question is clinically speaking what would an adult in less than very good health, suboptimal health, from your study look like? And, we looked within the national data and we found that when we compared the people who

we categorized as having suboptimal health, less than very good health with those with very good or excellent health that the suboptimal health group was five times as likely to have heart disease or diabetes, so we thought we had a good measure and a meaningful cut off point.

ED HOWARD: A very tangible and definable answer to questions that we have been wrestling with that sometimes didn't obtain to that kind of level of specificity, so I think we have come to the end of our time. Let me reiterate the request for the evaluations to come back to us and let me just say thank you.

Thank you to you for grappling with one of the larger topics that the Alliance has had on its plate over the years. Thank you to Robin and her colleagues at The Robert Wood Johnson Foundation for doing all the work that made this event possible, to the commission for its good work, and particularly to the panel who handled a variety of questions, handled tough data in a way that I think is going to help folks in the room grapple with some of these big questions over the next couple of years. So, thanks very much and get to work.

ROBIN MOCKENHAUPT: Thank you. [Applause]

[END RECORDING]