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MAKING HEALTH CARE WORK FOR AMERICAN FAMILIES: THE ROLE OF PUBLIC HEALTH

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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MAKING HEALTH CARE WORK FOR AMERICAN FAMILIES: THE ROLE OF PUBLIC HEALTH

TUESDAY, MARCH 31, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:06 a.m., in Room 2232 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. (chairman) presiding.

Members present: Representatives Pallone, Dingell, Eshoo, Engel, Green, DeGette, Capps, Schakowsky, Baldwin, Matheson, Harman, Gonzalez, Barrow, Christensen, Castor, Sarbanes, Murphy of Connecticut, Waxman (ex officio), Deal, Whitfield, Shimkus, Pitts, Burgess, Blackburn, Gingrey, and Barton (ex officio).

Staff present: Andy Schneider, Chief Health Counsel; Sarah Despres, Counsel; Tim Westmoreland, Consulting Counsel; Naomi Seiler, Counsel; Anne Morris, Legislative Analyst; Virgil Miller, Legislative Assistant; Jon Donenberg, Fellow; Camille Sealy, Fellow; Alvin Banks, Special Assistant; Alli Corr, Special Assistant; Miriam Edelman, Special Assistant; Lindsay Vidal, Staff Assistant; Aarti Shah, Minority Counsel; Ryan Long, Minority Chief Health Counsel; and Chad Grant, Minority Legislative Analyst.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. The hearing of the subcommittee is called to order. Today the subcommittee is meeting for the fourth hearing in the Making Health Care Work for American Families series. To date, we have heard about the failings of our current health care system, the need to increase access to care and improve our primary care work force, and the mechanisms that can make health care coverage affordable for all. In today's hearing, however, we are going to explore a less often discussed, yet extremely vital aspect of health reform and that is public health.

Health reform isn't just about improving coverage and access. It is also about making our Nation healthier. We spend more than any other country on health care and still we have higher morbidity and mortality rates than any other industrialized Nation. More than half of our population suffers from at least one chronic condition, which not only increases our health care cost but also

lowers our productivity, and this is simply not sustainable especially in these difficult economic times. What is frustrating is that these diseases for the most part are preventable. Too many people are dying of illnesses such as cardiovascular disease, respiratory diseases, and diabetes-related illnesses, and if the current obesity epidemic continues on the path it is on now, we will see even further increases in many of these diseases.

In my home State of New Jersey, 14 percent of our children are clinically overweight and this epidemic is obvious nationwide. A report conducted by the Trust for America's Health in 2008 highlighted all potential problems these children will have to face during the course of their lifetime. Childhood obesity can lead to a myriad of health problems, including high blood pressure, Type II diabetes, joint problems, and depression, just to name a few. And this epidemic alone has the potential to cripple our health care system if we do not take measures to address it. Providing all Americans with health care coverage and improving access to care will address some of these issues. However, bolstering the public health system will be the vital component to making health care reform sustainable and to improving health outcomes.

We must start investing in the prevention of these horrible diseases rather than just focusing on those who are already sick. This shift in our resource allocation could potentially save the system billions of dollars per year, not to mention the benefits to patients. Public health really means improving the quality of life for individual people, communities, and our society as a whole. Many of the federal, state, and local public health initiatives have already had huge impacts on out society's health. Diseases that once were life threatening are now all by extinct thanks to vaccination efforts, for example.

Smoke-free environments have already had an impact on the rate of smoke-related illnesses, and the community-based prevention initiatives supported by the Centers for Disease Control have already shown great results and increasing healthy lifestyle awareness and adherence. It is our responsibility in Congress to ensure that they have the resources they need to continue and expand the work that they are doing. In short, if I could sum up, public health ensures that individuals in communities are able to lead healthier lives. We will hear from witnesses today who have dedicated their lives to this noble goal, and I want to welcome all of them. I know we have two panels today. I want to thank everyone for coming.

I especially wanted to mention our New Jersey Department of Health and Human Services Commissioner Heather Howard. She has worked on the Hill previously with then Senator Corzine, now Governor Corzine. It is wonderful to see you again, Heather, and all that you do, and I am looking forward to your testimony and that of all the others today. And I will start now by recognizing Mr. Deal for an opening statement.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you, Mr. Chairman. I too want to welcome both panels to our discussion here today, especially to thank Dr. Besser for being here and to congratulate him on his acting role as acting

director of the CDC, a facility which all of Georgians and all of the people of this country, I think, can be very proud of. Thank you for being here. And, also, Dr. David Satcher, who is here representing the Morehouse School of Medicine, another facility in my great State of Georgia that we are very proud of, and thank him for the continuing contribution that they make to the delivery of health care in our Nation.

Today we will focus on the role of public health and disease prevention which are critical components of our Nation's health care delivery system. From specialized research on infectious diseases, wellness, and prevention that is taking place at the CDE community outreach programs which promote health conscious behaviors, the role of the CDC in fulfilling the needs of the public is indeed substantial. As we move forward with health care reform this year, we must ensure that we continue to support those programs and activities which have proven to be successful. They provide a critical role, and we must ensure public health efforts are provided with the tools that they need to do the job well. In conjunction with these efforts, an equally important objective must be to incorporate incentives for individuals to make responsible choices about his or her health and thus adding value to prevention efforts in an avoidance of costly medical care in the future.

The best way to ensure patients take proactive steps to improving their health, I think, is by taking their prescription medications as directed, by engaging in regular physical activity and by maintaining a healthy diet just to name a few. And it is well-placed incentives such as this that reward positive behavior and give individuals the opportunity to share in the savings generated by their prevention-minded efforts. The impact of establishing value-based incentives in the health care arena would take a significant positive step forward in maintaining healthy lives, not merely treating the sick once a condition presents itself.

Another key component is coordination of patient care. All too often we hear of health care dollars being wasted by duplicative testing and unnecessary referrals, which are all a result of our silo system of health care delivery. Fortunately, with the incorporation of health information technology and patient electronic medical records and improved coordination among providers access to necessary information to administer the best care is vastly improved. Prevention efforts can be coordinated through the use of this technology. Home care can be assessed and patients can receive a continuum of care which our current system fails to support many times.

Furthermore, as we continue to debate health care reform in the coming months, I hope we maintain focus on one of the most fundamental components of a well-performing health care delivery system, personal responsibility, giving patients and providers the freedom and responsibility to manage their care, not bureaucrats in Washington. It is critical to making improvements in our Nation's health care delivery system. Again, Mr. Pallone, I thank you for holding the hearing today, and thank all of our witnesses and look forward to your testimony. I yield back.

Mr. PALLONE. Thank you, Mr. Deal. Next is Chairman Waxman.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman. Over the past month, we have had several hearings on health insurance and how to get it to all Americans, but as valuable as it is health insurance can't do everything necessary to make our Nation healthy. Even if we make it possible for everyone to be insured, there will still be a major role for public health. Moreover, there will be an ongoing need for funding for these public health activities. I should begin by clarifying some basics. Public health includes many different things. It is working with groups and whole communities to improve health often more effectively than can be done between a provider and a patient.

Fluoridation of water for a town is, for instance, vastly better than simply filling every citizen's cavities. Exercise programs to prevent obesity are better than having to treat diabetes among people who become obese. It is tailoring health insurance and health care to prevent and diagnose disease early rather than simply treating it in its later stages. Immunization is always better than outbreaks. Screening for hypertension is better than simply waiting for strokes. It is providing for safety net services where the insurance market alone fails to do so. Community health centers, HIV service providers, and family planning clinics provide care to people who might not otherwise be able to find a provider.

Health profession's education programs can add to the primary care work force when the market might produce only specialists. And least glamorous, but critical, it is the infrastructure of daily disease control and health promotion. Closing down on sanitary restaurants is better than treating food poisoning. Compiling and studying epidemic trends can prevent major waves of disease. Public health is all of these things and more. It might be clear if I use an analogy. No community would be well served if all of its homeowners had fire insurance but there were no fire departments, firefighters, fire hydrants, or smoke detectors. That very well-insured town would still burn to the ground. Insurance is necessary but it is not sufficient.

As we approach health reform, we must consider what aspects of the Nation's health are based on public health and make these investments at the same time as we invest in coverage. We need to provide as firm a funding and organizational base for these services as we do for insurance because they are essential in making insurance efficient and productive and in making the Nation healthier. We will continue to debate insurance plans, Medicare Advantage health savings account and acute care on other days, but today's hearing is about these public health activities that we seldom think about and we even more rarely provide for. I hope health reform will make us change that. Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Waxman follows:]

Opening Statement of Congressman Henry A. Waxman
At Hearings on Public Health in Health Reform
March 31, 2009

I want to thank Chairman Pallone for holding this hearing. The subject—public health—could not be more important to the health of the Nation.

As the Institute of Medicine has made clear, the lack of health insurance is hazardous to the health of individual Americans and their communities. It is essential that all Americans have affordable coverage.

But as we will hear today, health insurance is not enough. Even if we insure everyone, there will still be a crucial role for public health and an ongoing need for funding for public health activities.

Public health is working with groups and whole communities to improve health. Fluoridation of a town's water supply makes much more sense than simply filling every citizen's cavities.

Public health is health care that prevents and diagnoses disease early rather than simply treating it in its later stages. Immunization campaigns are always better than outbreaks.

Public health is providing safety-net services where the health insurance market does not do so. HIV-service providers and family planning clinics provide care to people with insurance who may not otherwise be able to access care.

Finally, public health is the infrastructure of daily disease control and health promotion. Closing down unsanitary restaurants is better than treating food poisoning.

In short, health insurance is necessary, but it is not sufficient. It needs to be coupled with a strong public health infrastructure.

It would not do a community much good if all of its homeowners had fire insurance but there were no fire departments, firefighters, fire hydrants, or smoke detectors. That very well-insured town would still burn to the ground.

As we take up health reform, we must identify what aspects of the Nation's health are based on public health, and we must invest in those activities at the same time as we invest in coverage.

We will continue to debate health insurance issues such as Medicare Advantage and HSAs. But those debates are for another day.

Today's hearing is about public health. We have with us today some of the most distinguished public health professionals in the country, including the former Surgeon General, Dr. David Satcher, and the Health Officer for Los Angeles County, Dr. Jonathan Fielding.

I look forward to their testimony.

Mr. PALLONE. Thank you, Chairman Waxman. The gentleman from Pennsylvania, Mr. Pitts.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. Thank you, Mr. Chairman. I would like to thank you for convening this hearing. Within the larger context of health care reform, I think it is important for us to focus on two areas, chronic illnesses, which account for a major portion of health care expenditures, and prevention and wellness activities. There is a place for government programs and community services but if we are truly serious about reining in health care cost and transforming how we deliver health care in this country, I believe that we must focus on personal responsibility for lifestyle and health choices. We should empower citizens to change their behavior and incentivize responsible choices. There are great successes in the private sector such as the grocery chain, Safeway, which has cut its health care cost by covering all preventive care services appropriate for a patient's age group.

It offers other benefits such as a 24-hour hot line staffed by registered nurses, services to help people manage chronic conditions, and incentives designed to promote healthier lifestyles. Where there are barriers to small group plans offering incentives such as these, we should re-evaluate current law and make necessary changes. Also, patients must be more involved in their own care and treatment. Health savings accounts can play a key role in active patient participation. We know that when people's own money is on the line they make wiser decisions. Mr. Chairman, I look forward to hearing the thoughts and testimony of our witnesses today, and I thank you and yield back my time.

Mr. PALLONE. Thank you. The gentleman from Texas, Mr. Green.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, for holding this fourth hearing today on the health care reform and the role of public health. Disease prevention and good health promotion are important community issues we all support. Sadly, Congress has allowed the funding for disease prevention and community health programs to fall flat over the years, and we have not made much of an investment in prevention and wellness programs or disease prevention programs. The lack of funding for prevention and wellness and disease prevention programs is especially troubling in districts like mine where you rely on community-based prevention programs because of our population.

The Houston area is an international city and state where we have some of the highest rates of tuberculosis in the Nation and need a very strong disease prevention program. Houston has the third largest Hispanic population in the country, and I represent an area that is 65 percent Hispanic in a medically underserved district. Unfortunately, most minority populations have higher rates of disease like diabetes, cervical cancer, HIV AIDS, and heart disease in our community. In fact, Mexican Americans are twice as

likely as Anglos to be diagnosed with diabetes. These diseases are mostly preventable but lack of access to care is still a barrier to the minority communities, and part of that probable cause to the many health problems for the Hispanic community as a whole. We rely on programs at the YMCA for our children who participate in sports to help reduce our obesity levels in children. We also rely on partnerships in our community health centers in the hospital district to monitor and help treat diabetes in our population.

These programs are crucial in reducing our high diabetes and obesity rates. I am particularly pleased the American Recovery and Reinvestment Act included funding for prevention and wellness programs. These programs are key to reducing rates of chronic diseases in our communities. I would hope any health reform package we work on in this committee will take into account the importance of prevention, wellness, and data monitoring in disease prevention. Thank you, Mr. Chairman. I yield back my time.

Mr. PALLONE. Thank you, Mr. Green. The gentleman from Georgia, Mr. Gingrey.

Mr. GINGREY. Mr. Chairman, I am going to waive my opening statement.

Mr. PALLONE. The gentleman from Kentucky, Mr. Whitfield.

Mr. WHITFIELD. Mr. Chairman, thank you very much for holding this hearing, and we look forward to the testimony of the witnesses today. I would just point out that it is my understanding that less than 3 percent of all money spent by the federal government in health care is used for public health activities. And I know that in Kentucky for every 6 people admitted to the hospital in Kentucky last year one of them was admitted because of diabetes, so this whole issue of prevention has to be a vital part in our reform, and I look forward to working with the committee in addressing that issue. Thank you.

Mr. PALLONE. Thank you. Our subcommittee vice-chair, Mrs. Capps.

Mrs. CAPPS. Thank you, Chairman Pallone. And I am so pleased that we are addressing public health needs in our hearing today as we endeavor to bring real health reform to Americans. It is in my DNA as a public health nurse that an ounce of prevention is worth a pound of cure. In my home State of California and throughout our country there needs to be a major shift in how we address health care. Instead of just talking about treating illnesses, we need to talk about preventing it as often as we can and educating and promoting healthy behaviors and decision making. We need to talk about the role that the public health community will play in achieving that goal, so I look forward to our witnesses. I welcome our first panel and know that we are going to have a lively discussion today. I yield back.

Mr. PALLONE. Thank you. The gentlewoman from Tennessee, Mrs. Blackburn.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and welcome to our witnesses. We are looking forward to the hearing today. And, Dr. Besser, I want to thank you for your testimony and point out one thing that I think is so important that we focus on. When you say we are not achieving an acceptable return for the investment we made on health care despite spending more than any other nation,

and I think it does point out the importance of personal responsibility. We have some good pilot projects that have taken place in some of our states. Some of them have been successful. Some have not, but it does give us some good evaluated data and outcomes that we can look at, lessons that should have been learned, and I think it also points out how one size does not fit all in health care delivery. And I look forward to the testimony and the discussion today. Thank you, Mr. Chairman. I yield back.

Mr. PALLONE. Thank you. The gentleman from Utah, Mr. Matheson.

Mr. MATHESON. Well, thank you, Mr. Chairman. I concur with what our full committee chairman said that while access is an important issue, we also need to look for ways to reform our system to make it more efficient and preventive care and the public health system clearly create a venue where there are great opportunities to make more progress in this regard. If we don't find a way to make our system more effective for all the money we are putting into it, we are kidding ourselves. We have to find a way to be more efficient, find a better system than we have right now because we spend more than anyone in the world. We are not getting the best outcomes. And if we increase access for America into the current system it drives us off a financial cliff that much more quickly.

This is a very important hearing today because this panel can give us some good ideas about where we can improve on important front end investments to have long-term benefit to our country. I yield back, Mr. Chairman.

Mr. PALLONE. Thank you. The gentlewoman from California, Ms. Harman.

Ms. HARMAN. Thank you, Mr. Chairman, and thank you again for holding all of these thoughtful hearings. I want to recognize one of our witnesses this morning, Dr. Jonathan Fielding, who is the director of LA County's Department of Health, and who is a dear and valued advisor to me on health care issues. He oversees one of the Nation's largest public health departments and is charged with protecting LA County residents, especially in the realm of emergency preparedness, something always on the mind of this lawmaker. I just want to focus for 25 seconds on the need for developing surge capacity in our country as we consider health care reform.

The only level 1 trauma center near LAX and the ports of LA and Long Beach, both top terror targets, which could be attacked simultaneously, is Harbor UCLA Hospital, a first class teaching hospital. Harbor's emergency room was cited for overcrowding and no terror attacks have even been contemplated yet. It has tried to address this problem but I worry that we are not ready and that should something like this happen in any city in America or near simultaneously in many cities in America, we won't be ready so this has to be part of health care reform. Level 1 trauma centers will have to take care of huge numbers of victims should we have near simultaneous terror attacks. And just as we think about the rising waters in Fargo, North Dakota, let us think about the rising numbers of people who will need health care and we are not ready. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. The gentlewoman from the Virgin Islands, Mrs. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. Also coming from the Homeland Security Committee like Ms. Harman, we have been calling for more attention and funding to our public health system for the past 6 years, and also the issue is terrorism my interest is also in enabling the system to fulfill its responsibility to protect the public health every day and particularly in poor communities where it is most neglected and deficient. Homeland Security still has a role but the President's vision and determination provides us with an opportunity to ensure that the public health system in our country is strong and intact everywhere because it will only be as strong as its weakest link. As we approach reform strengthening public health in its broadest definition and eliminating health disparities must go hand in hand with expending coverage.

And while prevention and individual care will produce some savings but mostly through a healthier, happier, and more productive and competitive populous as we heard at the last hearing it is primarily through community prevention approaches, public health approaches, that we will reap the most savings, reduce our Nation's soaring health care costs, and recapture our role of leadership as we improve our health standing among the nations of the world. So welcome to all of our panelists. Thank you for your leadership, and I look forward to the testimony.

Mr. PALLONE. Thank you. Our chairman emeritus, Mr. Dingell.

Mr. DINGELL. Thank you. I commend you for this hearing. I ask unanimous consent to put my entire statement into the record.

Mr. PALLONE. Without objection, so ordered.

Mr. DINGELL. It is an excellent one and it bears considerable attention, I hope everyone will understand. But your holding of this hearing is extremely important. There are significant benefits from public health investments and that includes investments in prevention. The American Recovery and Reinvestment Act of 2009 allocated a billion dollars for prevention and wellness, and even though the Congressional Budget Office has been hesitant on cost savings and prevention measures non-partisan studies have shown significant health cost savings from public health spending. According to the Trust for America's Health private insurers and individuals could save more than $9 billion annually within 5 years if we would just spend $10 per person on public health.

I would urge, Mr. Chairman, that this hearing be used as a mechanism to enlighten the Congressional Budget Office and doubters about the need for the kind of prevention and wellness concerns that you are showing in having this hearing. With that, I yield back the balance of my time.

Mr. PALLONE. Thank you, Mr. Dingell. Thank you, Chairman Dingell. Next is the gentleman from Connecticut, Mr. Murphy.

Mr. MURPHY of Connecticut. Thank you very much, Mr. Chairman. I join my colleagues in looking forward to the testimony on this very important subject. I hope today that we explore a number of subjects but at the very least these two. First, as Mr. Pitts has pointed out, there are enormous opportunities to look at the private sector for the work that they have done in public health. In my district the company, Pitney Bowes, has been a leader in this respect.

I hope that we talk about both the opportunities for public health within the private context but also the limitations. It works well if you are at a large employer but relying on the private sector certainly has limitations for those people who work for smaller employers or who have individual insurance.

Second, I hope that we will be able to explore who is doing it right out there and who is doing it wrong. In Connecticut, we have done a wonderful job of using public funds to pay for breast cancer and cervical cancer screenings. And I think one of the things that we need to talk about is how we go out to different either political subdivisions or private employers who have done this right, get that information disseminated out to others so that we can standardize best preventive practices across this great country. Thank you, Mr. Chairman, for the hearing today, and I yield back my time.

Mr. PALLONE. Thank you, Mr. Murphy. The gentlewoman from California, Ms. Eshoo.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. ESHOO. Thank you, Mr. Chairman, for continuing on with a series of hearings relative to health care to help shape our thinking on I think one of the most long awaited bills by the American people, and that is to reshape our entire health care system. I am very pleased that we are focusing on public health. Public health has a long arm. It has a long reach. And I think it is one of the areas of health care that might be the most taken for granted in the entire system in the country. I came to understand and appreciate the role that public health plays before I came to Congress when I was in county government on the board of supervisors in San Mateo County in California, and whether it was on the prevention side for the county or on the side that had to react to say the removal of dangerous things off the shelves or markets, they moved very swiftly and in a very limber way to protect the public.

I have often wondered why we have not progressed over the years to strengthen public health. And just as a physician would say to a patient, you can't starve yourself in order to lose weight, that is exactly what has happened to the public health system in our country. We have not funded it properly for it to go forward and do the magnificent work that it is capable of that it already has done and the role that we want it to play. So this is more than appropriate to have this hearing. I look forward to hearing from the very distinguished witnesses that are at the forefront of the public health system and our country, and I look forward to a bill that is going to strengthen the arm, that long arm that has a great reach to the American public to prevent bad things from happening, and when we do that we promote wellness at the same time.

And what I hope we will also look at, Mr. Chairman, in terms of policy, and that is that I think in one fell swoop we could do so much in terms of obesity if we look at what food stamps will actually buy and pay for. If we continue to allow food stamps to buy junk and bad foods in the supermarkets or the small markets in

the neighborhoods in the areas where poor people live then it is the federal government that really is promoting the worst. We can't just beat our chests about obesity in our country. We should just do something policy wise that really overnight could revolutionize what poor people ingest and what they buy with the food stamps that we provide. So thank you very much.

Mr. PALLONE. Thank you. The gentleman from Texas, Mr. Gonzalez.

Mr. GONZALEZ. I waive opening.

Mr. PALLONE. Thank you. Next is the gentlewoman from Florida, Ms. Castor.

Ms. CASTOR. Thank you, Mr. Chairman. Bolstering our public health prevention and wellness initiative simply must be a lynch pin of our health care reform effort. Many community based prevention initiatives are working well already. We all have participated or know about them in childhood obesity or smoking cessation or diabetes screening. But I think it will take our renewed efforts in this health care reform effort, a modernization, additional resources that will ultimately help make Americans healthier. I want to thank all of the witnesses. Your testimony is very good. I trust that we will incorporate a lot of your recommendations into the health care reform effort that Americans are clamoring for. I yield back.

Mr. PALLONE. Thank you. The gentleman from Maryland, Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman, for holding the hearing. I am looking forward to the testimony today. Last year in the Ed and Labor Committee we had a hearing on the pension system in America, and a number of us questioned the premise of the hearing because we didn't believe there was actually a system in place but more of a patchwork arrangement. And I notice that this doesn't—the name of this hearing talks about the role of public health. It doesn't assert necessarily the public health system. And I would question whether we really have a system in place. I think we have strong public health advocates across the country and places where it is working very well. But to suggest that we have a system, I think, is a poor diagnosis, frankly.

And one of the hopes I have for the health care reform effort that is under way is that we will emerge from this debate with a public health system in place. Many have critiqued the way we approach health in this country as having developed a sick care system rather than a health care system. Obviously, prevention is critical to changing that orientation, and public health is critical to that. So I look forward to your testimony. I am particularly interested in this notion of place-based initiatives. In other words, what do you do in schools, what do you do in clinics, what do you do in employment, in work places, and so forth, going to where people are to provide the kind of prevention, wellness, and fitness services that really will represent a true public health system is absolutely fundamental. So I look forward to your testimony. I thank you, Mr. Chairman. I yield back my time.

Mr. PALLONE. Thank you. Ms. Schakowsky.

OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. I do want to assert the centrality of a public health infrastructure but we certainly do need to do more to help bolster it and create it. I am going to soon reintroduce the Health Promotion First Act, which I first sponsored last Congress with bipartisan support including members from this committee. My bill recognizes that we need to improve research into health promotion, coordinate activities across agencies, and develop a strategy to improve public health. I want to mention two specific areas of concern to me. It has been mentioned before, but we need to reduce obesity among children and across all populations.

A small example. There is an organization called Mainstay in Illinois where I am from, estimates that Illinois could save over $160 million a year by adjusting obesity in people with developmental disabilities who live in group homes, a setting really amenable to that kind of effort. STDs, we all were shocked, I think, or some anyway, earlier this month when the D.C. health department reported over 3 percent of the city's population, 7 percent of African American men, infected with HIV AIDS. Local experts put that number closer to 5 percent because of under reporting. And we have measures today that would help to stop STD transmission that need to be implemented.

And, finally, it is hard to overstate the importance of increasing public health resources for research, public education, and treatment. Our public health work force is being stressed to its breaking point, and we have to do all that we can to repair that as well. So I thank you, Mr. Chairman, and I look forward to hearing from our witnesses. Yield back.

Mr. PALLONE. Thank you. The gentleman from Texas, Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. In the interest of time, I have a statement that I will submit for the record. I am just very pleased to hear from our witnesses today. I am particularly looking forward to hearing from Dr. Satcher, and recognize his work that he has done on behalf of Alzheimer's patients in this country. Certainly, genomic medicine is a game changer. In medicine we are indeed on the threshold of a transformational time where it will be possible to identify individuals at risk, and now with newer monoclonal antibodies perhaps be able to offer some treatment options prior to the clinical manifestations of the disease, so this will become a much more long-term management problem and ultimately there are significant savings in our system that can be gathered by this type of activity. So, Dr. Satcher, we are grateful to you for your service and your work on that behalf. With that, Mr. Chairman, I will yield back the balance of my time.

[The prepared statement of Mr. Burgess follows on p. 160.]

Mr. PALLONE. Thank you. The gentlewoman from Wisconsin, Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman, and before I begin, I would like to request unanimous consent to submit for the record

testimony prepared by the Human Rights Campaign that addresses the issue of access to health care for LGBT Americans.

Mr. PALLONE. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Ms. BALDWIN. Thank you, Mr. Chairman. If we are going to meet the serious public health care challenges of today and tomorrow, we must help our states respond to these challenges. Many parts of our state and local public health system are fragmented and outdated. With my colleague on this committee, Congressman Terry, I sponsor the Strengthening America's Public Health Systems Act, a bill specifically that focuses on public health infrastructure. It invests in state labs of hygiene, improves surveillance and reporting systems and empowers the future public health work force. We also must rely on evidence-based prevention efforts and fully fund our federal agencies so that they can conduct community-based interventions to prevent diseases like HIV.

If we can more closely align federal funding with recommendations of the U.S. preventive services task force and the task force on community preventive services, I think we can see a real return on our investment in public health, a critical part of comprehensive health care reform. And, thank you, again, Mr. Chairman, and to our witnesses for this hearing and your testimony today.

Mr. PALLONE. Thank you. And I think that concludes the opening statements by the members of the subcommittee, so we will now turn to our first panel. First of all, welcome. We have with us today on my left Dr. Richard Besser, who is Acting Director of the CDC, and Acting Administrator of the Agency for Toxic Substances and Disease Registry. And we also have Dr. Jonathan Fielding, who is Chair of the Task Force on Community Preventive Services, Director and Health Office of the Los Angeles County Department of Public Health. And, again, thank you for being here. We have 5-minute opening statements. They become part of the hearing record. And I will start with Dr. Besser.

STATEMENTS OF RICHARD E. BESSER, M.D., ACTING DIRECTOR, CDC, ACTING ADMINISTRATOR, AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY; JONATHAN E. FIELDING, M.D., M.P.H., CHAIR, TASK FORCE ON COMMUNITY PREVENTIVE SERVICES, DIRECTOR AND HEALTH OFFICER, L.A. COUNTY DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF RICHARD E. BESSER, M.D.

Dr. BESSER. Good morning. I am Richard Besser, and I am honored to be serving as the Acting Director for the Centers for Disease Control and Prevention at the time our national focus turns to ways we can improve our health system. As a practicing pediatrician and leader of the Nation's principal prevention agency, I recognize both the urgency of solving the problems in our health system and the opportunities we have to improve the health of Americans as we do so. I would like to thank Chairman Pallone, Ranking Member Deal, Chairman Waxman, and members of the subcommittee for your support of prevention and public health, and for holding this important hearing today to turn the spotlight to the role of prevention and wellness in health reform.

Today, it is evident that our health system is not fully achieving its primary goal, protecting and improving our health. If our vision for health reform is too narrow, we still won't achieve our ultimate goal of health for all Americans. For too long, in discussions of health reform, health care delivery and public health approaches have been treated separately, as if they were disconnected and mutually exclusive systems. With a discussion of health reform currently a focus for the Nation, it is time instead to start talking about solving our national health needs through a comprehensive system that seamlessly integrates health care delivery, prevention, and public health.

CDC and our public health partners are already working to create these connections, connections between patients, providers, and public health officials. By creating more seamless integration between clinical care, which focuses on the health of a single person, and the public health system, which focuses on the health of an entire community or population, a truly reformed health system could increase access to needed health care services in the short term, and reduce demand for treatment services through prevention over time. For Americans to truly be healthier, we must not only have access to treatment when sick, but they should receive recommended screenings to detect the risk of disease early, have access to evidence-based interventions to prevent disease and injury before they occur, be supported by care systems that minimize progression of disease once it occurs, and live, work, and play in environments that promote healthy choices and behaviors.

We move into a health reform discussion with strong evidence that prevention and public health interventions work, both in communities and health care settings, preventing illness, increasing years of healthy living, improving work or productivity, and often saving health care costs. While much remains to be done to improve our evidence base, we have clear documentation of the success of these approaches. My written statement draws example from immunization, tobacco prevention and cessation, community interventions to prevent and reduce obesity, and interventions that reduce health disparities, prevent the spread of HIV, reduce the impact of health care associated infections, and prevent costly and disruptive falls among older adults.

We are pleased to be able to work closely with Dr. Fielding and the task force on community preventive services, which has conducted exacting reviews of the evidence and success to help guide our programmatic and policy interventions, something that will be particularly critical in a reformed health system. I am also happy that the committee will have the opportunity to hear from other public health leaders to help assess the value that can be delivered from these types of interventions. We are anxious to continue and accelerate this work with funding provided to HHS under the American Recovery and Reinvestment Act to address immunization, health-care associated infections, and prevention and wellness.

Turning to what can be done to advance the public's health through reform of our Nation's health system, it is our goal that all Americans live in communities that create positive opportunities for health, including opportunities for physical activity and ac-

cess to healthy food choices, live in communities that provide greater access to effective, evidence-based clinical and community prevention interventions, provide effective support for management of health conditions, starting with costly chronic diseases, so that the consequences, both cost and health, are minimized, and protect citizens from harm, including from tobacco use, environmental hazards, contaminated food, hazardous work sites, risk of injury, and unsafe medical practices.

We can put prevention to work across America. This can be accomplished through a broad, national prevention agenda through which we will need to provide tools and support the individuals to enable them to take responsibility for their own health, provide solid evidence upon which personal community, and policy decisions that promote prevention and wellness can be made, ensure rigorous tracking, monitoring, and evaluation so that we can measure performance and ensure accountability, more effectively support state and local health agencies with the tools and technical support to achieve positive health outcomes in communities across the United States, tailor interventions to reduce health disparities and improve health outcomes for populations most at risk, use policy levers to improve health, including those in areas not traditionally recognized as health-related policies, such as food, education, and transportation to create greater opportunities for physical activity and improved nutrition, address the health crisis caused by tobacco use through policy interventions, as well as comprehensive tobacco control programs, and reform the delivery system to promote a more seamless integration of individual, clinical, mental health, and community approaches that in combination can make us healthier.

Mr. Chairman, and members of the committee, the problems in the health system remain a fundamental concern of families, communities, businesses, and policymakers. A deepening recession adds urgency to already recognized shortcomings in the current health system. I share the President's commitment to reform that makes health care affordable and accessible, and I look forward to working with the subcommittee to help make prevention a practical reality as part of this national health reform effort. Thank you very much.

[The prepared statement of Dr. Besser follows:]

Testimony Before the
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives

Making Health Care Work for American Families: The Role of Public Health

Statement of
Richard E. Besser, M.D.
Acting Director
Centers for Disease Control & Prevention
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 10:00 a.m.
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Good morning, I am Richard Besser, M.D. and I am honored to be serving as the Acting Director of the Centers for Disease Control and Prevention (CDC) at the time our national focus is on ways to improve our health system. As a practicing pediatrician and leader of the nation's principal prevention agency, I recognize both the urgency of solving the problems in our health system and the opportunities we have to improve the health of Americans as we do so. I would like to thank Chairman Pallone, Ranking Member Deal, and members of the Subcommittee for your support of prevention and public health, and for holding this hearing today to turn the spotlight to the role of prevention and wellness in health reform.

Prevention, Public Health, and Health Care Delivery – An Integrated Approach

Today, it is evident that our health system is not fully achieving its primary goal – protecting and improving our health. We are not yet achieving an acceptable return on the investment we make in health, despite spending more than any other nation. The concerns with our health system are easily enumerated – millions of Americans lack health coverage or access to care; our delivery system too often does not ensure quality, efficiency, and continuity of care; increasing health costs are burdening families, businesses, and governments; and efforts to prevent disease and promote health are implemented unevenly.

As President Obama has articulated, reforming our health system is fundamental to our economic future. If our vision for reform is too narrow, we still won't achieve our

ultimate goal of health for all Americans. It is essential that we move toward the goal of covering all Americans. In a system where all Americans are covered, we hope the cost-shifting and fragmentation of our system will end. At the same time, we will continue to bear a huge economic burden for treating preventable diseases if we don't make prevention and wellness a cornerstone of a reformed system. In effect, we need to ensure all Americans have access to preventive services and essential public health that are critical to long term health. President Obama has made prevention a priority, including an explicit health reform principle for investing in prevention and wellness.

For too long, in discussions of health reform, health care delivery and public health approaches have been treated separately, as if they were disconnected and mutually exclusive systems. With a discussion of health reform currently a focus for the nation, it is time instead to start talking about solving our national health needs through a comprehensive system that seamlessly integrates health care delivery and prevention.

CDC and our public health partners are already working to create these connections--connections between patients and the resources in their communities that can improve their health, connections between doctors and nurses within the health care setting through better information technology, and connections between clinicians and public health officials who can provide evidence-based information to address patient and community needs. By creating more seamless integration between clinical care (which focuses on the health of a single person) and the public health system (which focuses

on the health of an entire community or population), a truly reformed health system could increase access to needed health care services in the short term and reduce demand for treatment services through prevention over time. For Americans to truly be healthier, they must not only have access to treatment once sick, but they should also receive recommended screenings to detect the risk of disease early; have access to evidence-based interventions to prevent disease and injury before they occur; be supported by care systems that minimize the progression of disease once it occurs; and live, work and play in environments that promote healthy choices and behaviors.

We have also learned the importance of tracking the impact of major changes in health policies. It is crucial to have the right information to monitor changes in health following prevention initiatives or changes in service delivery. Data collected by CDC allows us to: document the health status of our population; monitor trends and disparities in health status, access to care and use of health services; and evaluate the impact and effectiveness of health policies and programs developed to improve the health of our people.

Evidence-Based Prevention Works

We have evidence that prevention and public health interventions work, both in communities and healthcare settings – preventing illness, increasing years of healthy living, improving worker productivity, and often saving health care costs. CDC is committed to basing our actions on solid evidence and rigorous evaluation, and though

much remains to be done to improve this evidence base, we have clear documentation of the success of these approaches. A few examples of demonstrated prevention successes:

Immunization: Clinicians, health systems, and public health officials have worked together to save lives and health care costs through immunizations. Through childhood immunization programs this Committee has fostered, most childhood vaccine-preventable diseases have been reduced by 95% from levels before we had vaccines, and newer vaccines are already having substantial impact. For each birth cohort vaccinated with 7 routinely recommended childhood vaccines, society saves approximately $9 billion in direct health care costs over a lifetime, approximately 33,000 lives are saved, and 14 million cases of disease are prevented. Improving access to childhood vaccinations has also significantly narrowed minority and economic health disparities in the occurrence of vaccine-preventable disease. CDC is working to continue progress on preventing disease and health costs through childhood and adult immunizations, including strengthening uptake of newer vaccines licensed for adults in the past few years. We can improve quality and lower costs at the same time.

Tobacco Prevention & Cessation: Tobacco use among adolescents has been significantly reduced in several states through comprehensive media campaigns grouped with school and community education programs and policy change. Decreased tobacco use was also achieved through the use of "quitlines", health care

provider education and reminder programs in a variety of health care settings including HMOs, private practice physicians' offices, and public health clinics. Congress recently raised the excise tax on tobacco products, a singularly important policy change that will likely further reduce tobacco use. Other policy changes under consideration at the national, state, and local levels have the potential for further impact.

Tackling Obesity through Community-Based Action: Through the "Healthy Communities" program, CDC has supported local communities in implementing evidence-based interventions in community-based settings including schools, workplaces, community organizations, health care settings, and municipal planning, and in achieving local changes necessary to prevent obesity and related risk factors. Special focus has been directed toward populations with disproportionate burden of disease. Communities receive funds to spark local-level action, change community conditions to reduce risk factors for obesity, establish and sustain state-of-the-art programs, test new models of intervention, create models for replication, and help train and mentor additional communities.

Health Disparities: Gaps between racial and ethnic groups do not narrow without an intense focus or specific policies to bring about change. An example of a CDC initiative has been the Racial and Ethnic Approaches to Community Health Program, which has made significant gains in changing behaviors to reduce health disparities in communities where interventions were implemented. Tailored interventions

reduced smoking rates in Asian-American communities, increased use of blood pressure medication in American Indian Communities, and increased cholesterol screenings in African American and Hispanic communities. In Choctaw County, AL the percent of African-American women who received mammography screenings increased from 29% to 61%, and totally eliminated a previous black/white screening gap. In Dallas County, AL a lower mammography screening rate among African American women (30%) compared to white women (50%) was virtually eliminated within the same time frame.

HIV Prevention: There is a strong and growing evidence base for behavioral interventions that have shown significant effects in eliminating or reducing sex- or drug-related risk behaviors, reducing the rate of new HIV/STD infections, or increasing HIV-protective behaviors, and the magnitude of the HIV epidemic and its disproportionate impact on minority populations makes it essential that we implement these interventions. These include approaches to reducing HIV or STD incidence or HIV-related risk behaviors or promoting safer behaviors. The testing and treatment of HIV and other STD's can also be an effective tool in preventing the spread of HIV, and CDC has promoted routine HIV screening for adults, adolescents, and pregnant women in health care settings in the United States. This allows individuals that test positive to take advantage of the therapies that can keep them healthy and extend their lives and prevent them from infecting their partners.

Healthcare Associated Infections (HAIs): On a national scale, hospitals participating in CDC's National Healthcare Safety Network (NHSN) have decreased central line-associated bloodstream infections in intensive care units by 4-5 percent per year from 1997 to 2007. Through CDC supported community-wide efforts in southwestern Pennsylvania, local hospitals have successfully reduced bloodstream infections by as much as 70 percent by fully implementing CDC's evidence-based prevention recommendations. Subsequent collaborations with AHRQ, the Veterans Health Administration, and a variety of healthcare organizations and foundations have shown similar impact. These substantial decreases in healthcare-associated infections, if replicated on a national basis have the potential to yield results in reducing disease, deaths, and consequent healthcare costs.

Prevention of Falls Among Older Adults: Rates of elder falls have been reduced in communities through evidence-based interventions, including home modification, prescription drug review, vision checks, and exercise programs. We know that health costs due to falls are significant, and that individuals who fall are at a higher risk for an earlier death. According to a study by Stevens et.al. published in *Injury Prevention*, research has demonstrated that elder fall prevention programs produce significantly higher benefits in medical and economic cost savings than is required to implement them.

We are confident that dissemination of proven preventive health interventions can result in major health gains as well as significant cost savings in future health care costs. The

modeling work of Dr. Jeffrey Levi and his colleagues at the Trust for America's Health (TFAH) shows a nearly six to one return on investment to investments in community preventive interventions. Building on this work, we need on a continuous basis to demonstrate the cost savings in future health care costs and return on investment for evidence-based programs to ensure that these investments can be an integral part of reforming our health system.

These interventions are also evaluated and documented by the Task Force on Community Preventive Services, which is chaired by my colleague Dr. Jonathan Fielding. The Task Force documents evidence-based intervention successes in the *Guide to Community Preventive Services,* providing information and recommendations on more than 200 proven programs and policies that communities can implement to improve health. The Task Force conducts systematic reviews of interventions before making recommendations, so communities can consider the effectiveness, cost, and return on investment before deciding how to tackle their specific health issues. More broadly, the public health community is eager for additional comparative effectiveness research to focus on documenting the effectiveness of community level interventions, similar in scope and approach to research being generated to compare medical treatments.

As demonstrated by these examples and the excellent work being done by our colleagues here today, the potential for significant health impact exists when we disseminate interventions we know work and more seamlessly integrate the health care

delivery system with state, local, and community-based organizations that deliver prevention interventions.

Accelerating Prevention through the American Recovery and Reinvestment Act

The Department of Health & Human Services (HHS) is utilizing the funding through the American Recovery and Reinvestment Act (ARRA) to accelerate the implementation of these proven prevention efforts in both healthcare and community settings. In addition to helping stimulate jobs, this funding will provide the nation with a foundation on which to build its prevention activities as part of health reform. The ARRA provided $1 billion under the Prevention and Wellness fund in three critical areas: improving access to immunizations, reducing health care associated infections, and implementing evidence-based clinical and community-based prevention and wellness strategies that target chronic disease rates.

These new investments will allow us to pursue initiatives in the following areas as a "down payment" on health reform:

- **Immunizations:** With a new investment of $300 million under the ARRA, we will work with our partners to expand access to vaccines and vaccination services through vaccine purchases, improving the infrastructure for immunization programs; and expanding efforts to educate the public and health providers about vaccines.

- **Healthcare Associated Infections**: With $50 million under the ARRA, we will make the first significant direct investment in state efforts to monitor and reduce healthcare associated infections
- **Prevention and Wellness:** With a new $650 million in ARRA funding, HHS is developing an investment strategy for evidence-based clinical and community interventions to reduce chronic disease rates. This Department-wide signature initiative will develop and implement community approaches with targeted evidence-based interventions that address known determinants of chronic diseases. This initiative will support prevention efforts across the lifespan (children, adolescents, adults, and seniors) and will seek to address issues such as geographic, racial and ethnic disparities.

The ARRA also includes important investments in health information technology and comparative effectiveness research, and we are working with our colleagues in HHS to develop these initiatives. As in other areas I have discussed, there is tremendous potential to use these new investments not only to improve the clinical care system, but to address the full range of information and evidence needed to support a reformed health system. Similarly, we are hopeful that we will be able to work with other federal and private sector partners on plans for implementing the ARRA to leverage opportunities to improve health through investments in workforce development, transportation, education, nutrition, and other areas.

A Prevention and Wellness Agenda for Health Reform

Health reform will be developed in an inclusive and collaborative process that considers all serious ideas that, in a fiscally responsible manner, achieve the common goals of constraining costs, expanding access, and improving quality. As articulated in the President's February budget blueprint, one of the principles guiding the Administration's efforts includes investing in proven public health measures and ensuring access to proven preventive interventions. This will involve changes to our health care delivery system, expanded adoption of proven community-based interventions, and efforts across all sectors that promote health.

The goal of public health is that all Americans live in communities that:

- Create positive opportunities for health, including opportunities for physical activity and access to healthy food choices – shifting to a greater focus on wellness.
- Provide greater access to effective, evidence-based clinical and community prevention interventions (along with support needed to ensure their use) as well as evidence-based community health interventions.
- Provide effective support for management of health conditions, starting with costly chronic diseases, so that the consequences (both cost and health) are minimized.
- Protect them from harm, including from tobacco use, environmental hazards, contaminated food, hazardous worksites, risk of injury, and unsafe medical practices that lead to healthcare associated infections.

We can put prevention to work across America with approaches that lead to a healthier population, diminish health disparities, and reduce health costs. This can be accomplished through a broad national prevention agenda, building on proven interventions. Building on interventions currently in existence this will allow us to:

- Provide tools and support to individuals to enable them to take responsibility for their own health, and opportunities for individuals to help improve the health of their communities.
- Provide solid evidence upon which personal, community, and policy decisions that promote prevention and wellness can be made
- Ensure rigorous tracking, monitoring, and evaluation so that we can measure performance and ensure accountability.
- Work more effectively with state and local health agencies and other key elements of the public health infrastructure to ensure that we can provide the tools and technical support needed to achieve positive health outcomes in communities across the U.S.
- Tailor interventions to reduce health disparities and improve health outcomes for populations most at risk.
- Use policy levers to improve health, including those in areas not traditionally recognized as health-related policies. As an example, we can use multiple approaches to address obesity, where it is important that we create greater opportunities for physical activity and improved nutrition.

- Eliminate tobacco use through policy interventions as well as comprehensive tobacco control programs, we can have a major impact on this leading cause of chronic disease and health costs.
- Reform the delivery system to promote a more seamless integration of individual, clinical, mental health, and community efforts – including those in immunization, protection from HIV and STDs, and prevention of violence – that in combination can make us healthier.

Conclusion

The problems in the health system remain a fundamental concern of families, communities, businesses, and policymakers. A deepening recession adds urgency to already recognized shortcomings in the current health system: families feel the health consequences of decreased economic opportunity along with insecurity in their coverage for medical care; and businesses increasingly face competitive pressures. Health care costs are a growing part of state and federal budgets. The President is committed to reform that makes health care affordable and accessible.

We look forward to working with the Subcommittee to help make prevention a practical reality as part of this national health reform effort.

Mr. PALLONE. Thank you. Dr. Fielding.

STATEMENT OF JONATHAN E. FIELDING, M.D.

Dr. FIELDING. Chairman Waxman, Chairman Pallone, Ranking Member Deal, members of the committee, ladies and gentlemen, thank you very much for the opportunity to talk with you today. My name is Jonathan Fielding. I am Director of Public Health for Los Angeles County, and I chair the Community Preventive Service Task Force, and also chair the Secretary's Committee on 2020 Objectives for the Nation. And I am here today to talk about a very well-developed tool and process that tells us what policies and what programs have been proven to improve the health of the U.S. population and how to assure this and that we use this information to increase our national productivity, particularly important in these economic times.

As a background, health reform is very important to assure everybody has access to quality, affordable health care. However, the World Health Organization ranked the health system of the United States 37th in the world despite the fact that we spent 50 percent more of our GDP on health care than any other country. We need to pair health care reform with health reform, which requires changes in personal habits that relate to health and underlying causes of preventable health problems. The majority of the incredible, unprecedented 37-year gain in life expectancy during the 20th Century occurred because largely we had policies and programs urged by the public health community, including purer food and water, better environmental protection, occupational health laws, improved housing standards, better nutritional standards, and more sanitary waste disposal, as well as a general increase in the standard of living.

But serious opportunities to improve health and reduce the terrible disparities in health among subgroups remain. Today, ⅓ of all deaths in the United States are caused by tobacco use, physical inactivity, poor nutrition, and abuse of alcohol and other substances. In addition, we increasingly understand that poor education, low income, problems in our physical and social environments are the underlying causes of many diseases, and we have opportunities not only at the retail level, which is what we do in the health care system, but to work wholesale, which is working at the determinants of health in all of us where working on one can affect many diseases.

Fortunately, we are learning what works to keep Americans healthy, to make improvements in their health behaviors, and to address the underlying causes of ill health in the physical and social environment. This progress is due to the work of great CDC staff with the independent external task force that I chair that develops the guide to community preventive services. We do systematic reviews and make recommendations that are based on the best evidence. Over 200 reviews and recommendations have been completed and we know that these recommendations make a difference. For example, our recommendation to reduce blood alcohol concentration limits for drivers to 0.8 helped to spur congressional legislation to limit access to transportation funds to states that per-

mitted higher alcohol level. That contributed not only to safer roads but we saved many lives.

The recommendation can also assist HHS in determining the best use of the Recovery Act funds. For example, to prevent smoking and increase cessation the guide has shown that social marketing campaigns are very effective. A public-private partnership could rapidly apply the Recovery Act resources to a national tobacco media campaign that could substantially reduce the one behavior, smoking, that causes the greatest number of preventable deaths. The guide also provides essential recommendations for how the health care system can increase its efficiency and effectiveness. Its companion clinical guides tells us what preventive services individuals should receive like mammography, while the community guide tells us how the health care system can most efficiently and effectively organize itself and deliver the services that maximize uptake continuity and health impact.

Nonetheless, we face major challenges. First, because of insufficient core funding the 210 completed reviews and accompanying recommendations represent only a fraction of the highest priority opportunities and topics identified. Second, the recommendations are of little value if they are not used. The guide has been passively disseminated so awareness of its recommendation remains low and they have not become part of standard practice. Third, the guide often finds insufficient evidence to make a recommendation because the needed studies that could answer that question have not been done. One major gap is lack of information on how to reduce health disparities.

Another priority opportunity is to quantify the health effects of decisions that are outside the health sector such as an education and transportation and criminal justice. Health impact assessment is an effective tool for such analyses that could basically help every congressional committee understand how the decisions they are considering would effect the health of all of their constituents. I have four recommendations for your consideration. First and foremost, the guide to community preventive services needs full, financial, and personnel support. A one-time infusion of $50 million would allow us to provide recommendations for all the high priority topics and intervention needed by communities within 3 years.

These resources would also allow us to rapidly and efficiently expand and proactively disseminate the recommendations so they become standard practice for users in both the public and the private sector. The ongoing work of the task force will require $15 million annually on a continuing basis so that we can keep the recommendations current, assess the effectiveness of new policies and programs and continue active dissemination to assure that these recommendations are being followed and to evaluate to make sure. Second, the major gaps in evidence need to be filled with robust, targeted, funding for research with CDC as the lead agency. Third, we need support to use the best science to address the health effects where many disciplines need to interact.

Global warming is one example and other policy issues through health impact assessment and other novel approaches. Fourth, the guide and these initiatives need evaluation to make sure recommendations are being implemented and determine if the ex-

pected health improvements are being realized. Finally, Healthy People 20–20 currently under development will provide health objectives for our Nation. These objectives need to be fully informed by the guide recommendation and results of the studies that we have looked at so that the objective set can be realistic and based on the best evidence. These two major initiatives need to be tightly linked to maximize the value of both. Thank you again for providing the opportunity for me to talk with you, and I look forward to discussing these issues and responding to your questions.

[The prepared statement of Dr. Fielding follows:]

Testimony of Jonathan E. Fielding, MD, MPH, MBA
Los Angeles County Department of Public Health, Director and Health Officer
Task Force on Community Preventive Services, Chair
Secretary's Advisory Committee on National Health Promotion & Disease Prevention Objectives for 2020, Chair

March 31, 2009

Chairman Pallone, Ranking Member Deal, Members of the Committee, Ladies and Gentleman:

Thank you very much for granting me the opportunity to speak to you today about evidence-based prevention and why it is critical to improving our nation's health. My name is Jonathan Fielding and I am the Director and Health Officer for the Los Angeles Department of Public Health as well as the Chair of the Task Force on Community Preventive Services and the Chair of the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020.

In my testimony this morning I would like to make the following three points:

1. Our country will not be able to maintain a high level of economic productivity unless we can maintain a healthy workforce and a healthy population. The greatest opportunities to improve our country's health lie in population-oriented policies and programs.
2. Research and evidence to guide the proper development and implementation of these policies and programs are essential if we are to fully capitalize upon these opportunities for health improvement.
3. We are not starting from scratch. The Task Force on Community Preventive Services already has a process and an organization that can be expanded to meet this need and to actively disseminate the results so they become a part of standard practice. That organization is greatly underfunded, and we now have an opportunity to leverage a small investment to fill in the research base to let us know what works.

It is not news to members of this Committee that health reform is needed to assure everyone has access to quality affordable health care. However, the World Health Organization currently ranks the United States' health system 37th in the world despite the fact that we spend 50% more of our GDP on health than any other country. In 2007 we spent 16.5% of our GDP on health care, a number that the CBO projects will rise to 25% of GDP by 2025 and to 49% in 2082. We spend more than any other nation on health yet we still experience poorer health than most other developed nations and some developing countries. Furthermore, epidemiologic trends show that we will likely be facing large increases in the number of Americans living with diabetes, Alzheimer's, and other debilitating and costly chronic diseases in the near future. In fact, if current obesity and diabetes trends go unchanged, for the first time in modern history our children may be facing a time when their life expectancy is actually shorter than that of their parents. It is evident that the status quo approach is not working. We cannot medicalize our way to becoming one of the world's healthiest nations. For both moral and economic reasons we must ask ourselves if there is a better way to ensure our nation's health.

As you discuss the framework for our future health and health care systems, I urge your committee to remember that *health care* reform is not the same as *health* reform. I recommend that your

Committee take advantage of this historic opportunity to expand the debate beyond insurance coverage and the health care system, and recognize the various ways in which a stronger focus on prevention and other population health strategies can contribute to our nation's health for generations to come. Health reform should lead not only to greater effectiveness and efficiency for our health care system, but to better health outcomes as well. And better health outcomes mean a healthier and, therefore, more productive work force. And a more productive workforce translates into greater competitiveness in the world economy. In the current weakened economy we must carefully consider every chance we have to boost our long-term economic prospects, and therefore we must recognize how improving our country's health is central to improving the well being of our economy as well.

The Value of Population-Based Health Activities

When we look back at the enormous strides that have been made in longevity – we gained 37 years of life expectancy in the last century—most of that gain has occurred as a result of action by the public health community at the population level, much of it in concert with the health care system. Population health interventions range from communicable disease programs like sexually transmitted disease prevention and treatment, influenza immunization, and tuberculosis control, to the development of policies that curtail tobacco use and support the creation of healthy homes and communities. What distinguishes population health approaches from clinical care approaches is that clinical services are intrinsically delivered one service at a time from a provider to a patient – a retail approach if you will. Population health services are those that can be delivered to a group of patients, a community, or within an organization to affect the health of multiple individuals – a wholesale approach. These population-based approaches are an essential complement to the clinical preventive services that target individuals.

Health promotion and disease prevention can reduce both the rate of onset and the severity of disease, allowing people to lead longer, more productive lives. Diabetes disease management, for example, can reduce amputations and hospital admission while use of helmets reduces head injuries. Furthermore, activities that prevent or postpone disease also have the potential to yield major cost savings to our country's health system, yet today we spend less than five cents of each health dollar on interventions designed to keep populations healthy rather than treating individuals once they are sick.

This is not because our job is done. Far from it. Obesity is rampant, our cities and suburbs are poorly designed for physical activity, highly effective clinical preventive services like pneumococcal vaccination are badly underutilized, we confront multi-drug resistant tuberculosis, and pollution occurs at unacceptable levels exacerbating asthma and chronic lung disease and decreasing life expectancy and quality of life. Over one-third of all deaths in the U.S. are caused by tobacco, physical inactivity, poor nutrition, alcohol and substance abuse. These are some of the factors that are driving a wide variety of our nation's leading causes of death such as heart disease, cancer, stroke and diabetes. Reducing these unhealthy behaviors, even modestly, will yield enormous health benefits to the nation. For years our country has been spending the vast majority of our health dollars on medical care that seldom addresses these behavioral causes of death. There is no pill that I can prescribe that will make someone exercise more. The only way to effectively address these actual causes of death and the other environmental factors which contribute to premature death is to find solutions at the population level.

We know that our country has been spending too many dollars on services that do not add value. Thankfully you and your colleagues have recognized the importance of understanding what works to

improve health. The landmark comparative effectiveness legislation will provide the basis for understanding what technologies work for which patients at what time. We require a similar initiative to compare health interventions that operate on the population level. As we embark on this initiative to review comparative effectiveness research, I urge you to recognize the great value that population-based interventions offer to improve our nation's health and to add these interventions to the comparative effectiveness agenda.

Establishing the Evidence Base in Population Health: The Guide to Community Preventive Services

So how do we know what works to improve population health? Fortunately there is already an organization and a process that can help us determine what works. For over a decade the Centers for Disease Control and Prevention has worked with an independent, external task force that I chair to develop the Guide to Community Preventive Services. This Guide has adapted the well-established methods pioneered by the US Preventive Services Task Force for Clinical Preventive Services to analyze community-based interventions. Over 200 reviews have been conducted, with findings and recommendations made for each review. The reviews span areas from vaccine preventable illness to promoting physical activity through behavioral and social as well as environmental and policy approaches. We have touched upon domains as diverse as mental health, housing development, and diabetes management. The reviews address diverse groups from health care systems delivering clinical preventive services, to employers' wellness programs, school physical activity programs, and population health media campaigns. These reviews are not just academic exercises and they have been used to shape the allocation of federal funds. They are intended to inform decision makers and we know that these recommendations make a difference. For example, our recommendation to reduce Blood Alcohol Concentration limits to 0.8 bolstered the evidence base to enable legislation to limit access to transportation funds to states that permitted higher alcohol levels, contributing to safer roads and saving lives.

The recommendations can also guide the deliberations in the Department of Health and Human Services about the best use of the Recovery Act funds. For example, the Guide has shown that social marketing campaigns are some of the most effective interventions we have to prevent smoking and increase cessation. A public-private partnership could rapidly apply the Recovery Act resources into a national tobacco media campaign that could substantially reduce the behavior that causes the greatest number of deaths in the United States.

The Guide's work began in 1996 under the auspices of CDC. An internal staff was recruited, an external Task Force created, and liaisons identified. The independent, external Task Force has 12-15 members who represent the many relevant disciplines, including epidemiology, statistics, and the social sciences. Many are active public health practitioners from state and local health departments as well as academia. Others work with employers, communities, foundations and within the health care system, including managed care plans. The target audiences are people and organizations that deliver population-based services, including employers, schools, governmental public health agencies, health care systems, medical groups, community organizations, and policy decision makers.

Establishing the Evidence Base in Population Health: The Process

The Task Force oversees the work and makes recommendations. It has been responsible for developing a rigorous set of methods to assure a high level of certainty when making recommendations, assure consistency, and avoid conflicts of interest. It has codified the processes for doing this work. The first step has been to identify suitable topics based on potential impact and

need – that means one must assess the importance of the problem in terms of health burden on the population, availability of interventions to impact the problem, and the value to different user groups. The Guide has identified and worked on 18 general topic areas. Some are disease areas, such as cancer, mental health, and diabetes. Some are behaviors, such as alcohol or tobacco use. Still others are preventive services such as immunization. And others cover target areas like worksite or specific populations such as adolescents. One topic, the social environment, has been structured to assure that the underlying socioeconomic determinants of health are addressed as well.

Once a topic has been identified the Task Force creates a conceptual model for each topic to enable it to identify the interventions and select among them. This process identifies possible interventions at multiple levels, from behavior change interventions, to system changes, to intersectoral interventions, or infrastructure changes. For tobacco interventions, for example, we have examined behavior change interventions such as education and media, system changes such as processes to assure that clinicians provide counseling and medication, policy changes such as the impact of taxation or laws restricting access to minors, and infrastructure changes such as the availability of quitlines. Once specific interventions within each topic area are identified they are prioritized and the review process ensues. It is important to note that to date the Guide has only covered a small subset of the potential interventions within each of the broad topic areas, due primarily to budget constraints.

A systematic review of the evidence is conducted for each of the selected interventions. This requires identifying all the relevant studies, assessing their relevance and quality, synthesizing the information from all of those studies, and organizing it in a consistent manner so that it can be interpreted. This work is accomplished by a review team consisting of Task Force Members, CDC staff, and external experts. While a simple topic may be completed within a few months, the process more commonly takes a year or more. The results are reviewed by the entire Task Force and a recommendation is made based on the strength of the evidence. The scientific reviews and recommendations are then published and disseminated.

Throughout the process, a group of over 25 liaisons provides input and also anticipates the release of recommendations that can be used by their organizations. Among the liaisons are representatives of other federal agencies, such as AHRQ, NIH, VA, and DOD; professional organizations, such as the American Academy of Family Practice, the American Academy of Pediatrics, the American Academy of Nurse Practitioners, and American Association of Physician Assistants; state and local health departments, through ASTHO and NACCHO; as well as academic and other not-for-profit organizations. These groups are also critical to the translation of the Guide findings into practice.

It is important to recognize how the Guide complements the work of other organizations. The US Preventive Service Task Force, for example, tells us what works in the clinical realm. They have said that delivering a clinical preventive service like mammography can reduce breast cancer mortality and we expect the clinical care system to deliver that service. What the Guide does is tell us *how* we can better deliver that service to assure that the health care system effectively and efficiently reaches the women who need it. So the Guide assesses the effectiveness of small or large media education efforts, patient reminders, professional reminders, use of financial incentives, and the organization and structure of care. The Guide's recommendations are intended to guide health care systems as well as public health organizations to select interventions that will increase the utilization of these effective services.

To date the Guide has produced 210 recommendations. The staff deserves an enormous amount of credit for accomplishing this work despite scarce and diminishing resources. Important as this work has been, there are many outstanding opportunities upon which we have yet to capitalize.

Establishing the Evidence Base in Population Health: The Challenges

First, while the 210 recommendations we have already completed represent substantial progress, they represent only a small fraction of the high priority topics the Task Force has identified. The gap between identified and completed reviews has developed because core funding has been very scarce. Guide staff has had to be opportunistic and seek funding from programs that had a mission that benefited from evidence-based recommendations and had the funds to support the work. Hence you find great depth in some of topic areas, such as immunization, and little about others, such as substance abuse (other than tobacco). It is unfortunate when users turn to the Guide only to find that it does not address the questions that they have. We have an enormous amount of catch-up work to do to make sure that all major topics and interventions are addressed. The work also needs to be kept current. The recommendations must be updated on a regular basis as well as when major new studies are published, and resources need to be devoted to that task. Among the important topics that deserve a new or more in-depth review are emergency preparedness; the built environment – including the impact of community design and transportation systems on physical activity and exposure to environmental pollutants; substance abuse; mental health; the socio-cultural environment – including interventions to reduce disparities and strengthen communities; public health systems; primary prevention of chronic disease; occupational health; and health care systems—including improving the delivery of clinical preventive services through the use of financial incentives and coverage, quality improvement systems, education, and reminders.

Second, the recommendations are of little value if they are not used. Efforts to disseminate the Guide have been confined to passive dissemination of results through publications, the website, sharing with key partners, and the incorporation of recommendations into some federal grants programs. As a result, awareness of the Guide remains low and the use of recommendations has not become a standard practice in most governmental public health agencies or by other users. What has been done are important steps, but a vigorous proactive program is needed so that there are active processes to help employers, communities, state and local public health departments, and others users actually develop the skills to adopt and implement these recommendations.

Third, the Guide reviews identify the information gaps that need to be filled. The finding of "insufficient evidence to make a recommendation" occurs all too frequently, largely because the needed studies have not been done. One of the major gaps has been the lack of information on how to close health disparities. The research gaps that are part of every review should form the core of a directed research agenda. As for other parts of the research enterprise, studies should be driven more by user needs than researcher interests.

The Guide provides essential information about effectiveness and efficiency. Incorporating population health interventions into the comparative effectiveness initiative will allow us to make better choices both within a topic area as well as across multiple topic areas. We know that multi-component interventions, (interventions that use multiple intervention strategies to address problems), are usually much more effective than individual strategies employed in isolation. However, the most appropriate mix of interventions and policies to address particular health problems remains largely unknown. An example of particular importance in the private sector is health improvement in the workplace. Many employers are deeply committed to the health of their employees and have developed many approaches, including designing insurance plan benefits to

cover clinical preventive services, improving nutritious food availability in their cafeterias, encouraging physical activity, using health risk appraisals, providing counseling for tobacco use, and many more. Recent Guide reviews have begun to show how health risk appraisals alone are of uncertain benefit, but when combined with health education and other approaches, they can reduce smoking, excessive alcohol use, blood pressure, cholesterol, and fat consumption.

Beyond the Guide

We will not become a truly healthy nation unless we address the real underlying determinants of health – the socioeconomic and physical environments. Let's look at education as an example. We know that education and income are primary determinants of health. Improving education positively affects all health conditions and quality of life. When one takes a disease-by-disease approach one can make inroads in each; but the health impact achieved by improving education occurs across the entire spectrum of conditions and improves general well-being. Improved education leads to higher incomes, which also contribute to improved health. Interventions focused on individual conditions like heart disease, cancer, or arthritis in isolation are important but cannot address the underlying reasons for ill health nor the sources of the enormous disparities in health outcomes.

The Guide has assessed some of these intersectoral issues such as street and community-scale planning to shape the physical environment and influence physical activity; early childhood development programs; and the use of tenant-based rental assistance to reduce violence and social disorder. The Guide's reviews have found that many of our most important challenges and opportunities to improve population health lie outside the traditional health sector. Partners in non-health sectors play critical roles in assuring a healthy food supply (e.g., Agriculture), restoration of people to productive lives in society (e.g., Criminal Justice), fairly compensated and available jobs (e.g., Labor), and walkable communities (e.g., Transportation). Working across sectoral boundaries requires expertise from many disciplines that are outside the skill sets of those of us in public health – they include experts in city planning, criminal justice, agricultural policy, and many more subjects. I strongly believe that health consequences need to be considered when decisions are made in these other sectors. The information to inform them, though, has been minimal.

New research tools and methodologies are needed to help policy makers understand how these health determinants in other sectors operate, and how decisions in these other sectors can positively and negatively affect health. One tool to quantify these likely health effects is health impact assessment (HIA). HIA employs a combination of methods to systematically examine the potential health effects of proposed policies, programs, and projects. HIA can be used to inform policy and decision-makers about potential health benefits and harms of a proposed policy or project, as well as alternatives for improving the ratio of benefit to harm. HIA is particularly useful for highlighting the health impacts of policies outside the health sector, where the potential health impacts may be poorly understood or unrecognized. We need to make it easier for people to live healthy lives – to breathe clean air, to eat healthy foods, to stay physically active, and to lead less stressful lives. We must increase the resources dedicated to intersectoral research and the refinement of tools such as HIA to help us understand exactly how we can achieve that goal.

Challenges to Implementing Best Practices at the Local Health Department Level

Let me change hats and talk to you about my role as a user of evidence-based recommendations. The Los Angeles County Department of Public Health serves a diverse population of 10 million people and we need to work effectively and efficiently. I have instructed my 43 program directors to structure their programs around interventions that have a strong evidence base. We have provided training for the staff to learn the principles of evidence-based population health and develop the skills

to apply the principles to their programs. The Guide serves as a primary source of information for them and I hold them accountable for applying evidence-based recommendations. We are, however, unusual in that regard.

At the same time, it is clear that many of the major opportunities to improve the health of Angelenos have not been part of our traditional programs. I have therefore strengthened our chronic disease programs and built greater policy and advocacy capacity within my organization. These staff members are bringing increased attention to the natural and built environments – I have a working group on climate change as well as the socioeconomic environment. These groups are helping set our policy agenda. We rely on CDC and other organizations to provide evidence-based recommendations on what works– to globalize the evidence – that allows me to adapt that evidence to my county – to localize the decisions.
Information from the Guide is critical to this task. But many of the questions I face are not simply does an intervention work, but how does it work in comparison to the alternative strategies I can bring to bear? Should my sexually transmitted disease program emphasize school education, partner notification, counseling, or surveillance? Which ones and at what levels? I must also understand the trade-offs among programs – how should I balance the need to reduce salt in the diets of the residents of Los Angeles compared to perinatal and early childhood activities? This requires information on the relative value of alternative strategies. We need to assure that the comparative effectiveness tools and resources are applied to population health to allow us to make better decisions about these choices.

Recommendations
So what can this Committee do? I have several suggestions.

Full Support for the Community Guide
First and foremost, the Guide to Community Preventive Services needs full financial and personnel support. A one-time infusion of $50 million would allow us to provide recommendations for all the high-priority topics and interventions needed by communities within three years. We now have enough experience that with those additional resources we can rapidly and efficiently apply what we've learned. I can foresee an expansion of the Task Force to 25 to 30 members as well as a rapid ramp-up in the size of the CDC staff. We have experience in training new members and staff to rapidly bring them up-to-speed. Because of the large number of topics that remain to be addressed, I expect that we would divide up the work by creating three sub-Task Forces each tasked with addressing a third of the remaining topics and interventions. For interventions that are straight-forward to assess, the work can be done solely by each of the sub- Task Forces and brought to the entire Task Force for final review and the final recommendation. For interventions that raise major new methodologic challenges or have many complexities and nuances, the sub-Task Force would work with the whole Task Force throughout the process. For the intermediate category, for example those interventions that raise one or two issues, the sub-Task Force would bring those specific issues to the entire Task Force but would otherwise complete the work independently until final approval of the entire Task Force is required. Once we have reviewed all the high priority topics as part of this intensive short-term effort, we can then maintain the process at a more modest and sustainable level to address new topics and keep current on those topics that have already been reviewed.

The Guide also needs the resources to assure that we proactively disseminate the recommendations so they become standard practice for users in both the public and private sectors. This will require active dissemination, training, materials, and technical assistance developed and implemented in close conjunction with major partners, including health care organizations, governmental public

health agencies, the private sector, foundations, local organizations, and professional groups. Implementation will be greatly facilitated by systems to link local health objectives to high-value evidence-based services and assure their implementation and evaluation. Funding streams should be aligned with evidence-based practice and facilitate local implementation.

The ongoing work of the Task Force will require $15 million annually on a continuing basis. This very modest investment would produce evidence that would enable us to get much more health impact from the $2.4 trillion that we currently spend on health.

Fill the Evidence Gaps
Second, the Guide has identified major gaps in our evidence, particularly about the impact of interventions their economic value. Those gaps need to be filled with robust targeted research funding. CDC should be the lead the Agency to assure that those research gaps are filled.

Conduct Health Impact Assessments
Third, we need to use the best science we can to address intersectoral issues, such as global warming, and policy issues not amenable to traditional study designs. We need support particularly for health impact assessments to fill that void.

Evaluation
Fourth, the Guide and these initiatives need evaluation. What we are proposing represents a fundamental change to how decisions are made in the health and health care systems. We need to evaluate this process so we can understand how well it is being implemented, opportunities and challenges to implementation, assessment of the impact on processes and outcomes, and an assessment of the value. Evaluation needs to be built into these plans from an early stage so that impact can be prospectively assessed.

Link Healthy People 2020 and the Community Guide
Finally, as you know, Healthy People 2020 is currently under development and will provide health objectives for the nation. Those objectives need to be fully informed by the recommendations from the Guide so we can set realistic objectives, sub-objectives and targets based on our knowledge of the potential impact of evidence-based programs and policies. By the same token, Guide priorities need to be shaped by our health objectives. These two major initiatives need to be tightly linked to maximize the value of both efforts.

Both the health care and population health systems are critically important to the health of the United States. The demand for one-on-one health care will continue to increase. We must remember, though, that the common good can best be served by renewed emphasis on the health and wellness of the entire population with efficient and effective policies, systems, and programs.

Thank you again for providing me the opportunity to talk with you. If you should have any interest in discussing these issues further, I am available at your convenience.



Partnership
for Prevention

Shaping Policies • Improving Health

Real Health Reform Begins with Prevention

Model Legislative Language

A report by

Partnership for Prevention

in collaboration with

Helen Halpin, Sc.M., Ph.D.
University of California, Berkeley

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INTRODUCTION

Preventive services and programs offer Americans the possibility of longer, healthier, and more productive lives. Because full realization of these benefits requires inclusion of prevention programs, policies, and services in health reform legislation, this paper presents model language for use in crafting legislation that explicitly embraces the implied intent of any health reform bill: **to maintain and improve the health status of the American people.**

Until now, the debate about health reform has focused primarily on increasing access to medical care services and controlling rising health care costs. The following model legislative language is designed to bring to center stage two additional priorities that are central to successful health care and public health reform.

(1) Adopt "improving the health of the American people" as a primary goal of any health reform legislation.

(2) Define prevention broadly to include evidence-based:

- personal, clinical preventive services;
- community-based prevention and public health interventions; and
- social and economic policies central to health improvement.

How will we know whether sufficient prevention of the right types is incorporated into health reform proposals? One way to answer this question is to measure the bills against a "prevention standard."

Meeting a Prevention Standard

The following nine components represent key elements of a prevention standard:

- Provision of high-value, evidence-based personal, clinical preventive services, fully covered in the core benefit package based on the findings of the *US Preventive Services Task Force (USPSTF)* and the *Advisory Committee on Immunization Practices (ACIP).*

- Support for evidence-based community prevention and public health interventions at the national, state and local levels, based on the findings of the *Task Force on Community Preventive Services.*

- Identification of social and economic policy changes that are clearly tied to health improvement.

- Financial incentives to health organizations, employers, health insurers, and individuals to adopt effective prevention interventions, and rewards for the adoption of proven wellness programs.

- Commitment to strong and sustained support for stable public health funding to support the essential services of public health (defined below) at the national, state, and local levels and building the infrastructure needed to perform these functions.

- Assurance of the capacity for data collection and reporting for health status tracking, problem identification, and monitoring of implementation.

- Strategies for assuring the training and deployment of a public health workforce and a primary-care workforce, skilled in prevention and public health, adequate to meet the population's needs.

- Sustained public awareness interventions that contribute to an improved public understanding of the centrality of prevention to health and health care.

- Research to identify the most efficient and effective prevention services, programs, and policies.

We offer the following model legislative language with introductory comments and background for meeting the prevention standard in health reform legislation.

Prevention works. We believe that this report is unique in its specific, comprehensive approach to prevention and identification of the greatest opportunities to improve the health of the American people, overall and for specific vulnerable populations.

MODEL LEGISLATIVE LANGUAGE

1. PURPOSE

PREAMBLE:

The PREAMBLE to all health reform bills should explicitly state that the intent of the legislation is **to improve and maintain the public's health**.

- To ensure individual, family and community health, and health security through comprehensive, affordable, high quality health coverage for all Americans in a manner that improves and maintains the health of the American people, and ensures access to core public health and prevention services.

FINDINGS:

In the section on FINDINGS, the current status of the health care and public health systems necessitating reform should be addressed and shall include the following:

- Rates of preventable illness, disability, and premature mortality are high and significant disparities exist in the health status of population subgroups, including persons with low incomes, the elderly, children, and specific minority groups.
- The actual leading causes of death are tobacco use, poor diet, and lack of physical activity.
- The public health systems operating at the state and local levels are under-funded, in need of improved infrastructure to support the essential services of public health, and poorly linked to the medical care system.
- The public health system lacks adequate and stable funding to perform essential public health services at the national, state, and local level.
- Any reform of the health care and public health systems requires a broad approach to prevention that incorporates clinical preventive services, public health and community-based interventions, and social and economic policy to promote health.
- Most health insurance plans do not cover a comprehensive package of benefits that meet the full range of health needs, including primary, preventive, and specialized services — such as substance abuse, vision, dental, and hearing services.

PURPOSE:

A section on PURPOSES should describe broad-based health improvement goals of the legislation.

- To improve the health status of the population and attain the national health objectives as set forth in *Healthy People -- Objectives for the Nation.*
- To promote healthy behaviors of individuals and families and adopt policies that create and maintain healthy environments in institutions, worksites, and communities.
- To guarantee access to effective clinical and community-based preventive services.
- To guarantee the availability of the essential public health services in all States and communities with adequate and stable funding.
- To develop public policy with an understanding that the major determinants of health are environmental (physical, social, economic) and behavioral.

2. PUBLIC HEALTH ADVISORY COMMISSION

Health reform bills will create a Public Health Advisory Commission to make recommendations to the President, Congress, and any future federal health organization on the allocation of federal funds to maximize impact on the health of Americans, on coverage of clinical and community preventive services, and on the health impact of federal policies.

- This independent body reports to the President, Congress, and any future federal health organization created by health reform legislation. Membership would be appointed by the Government Accountability Office (GAO).
- With respect to **CLINICAL PREVENTIVE SERVICES**, the Public Health Advisory Commission:

  (1) shall review the findings of the U.S. Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP) for periodic, rigorous review of the most recent scientific evidence on the clinical effectiveness and relative cost-effectiveness of clinical preventive services for individuals and groups of varying age, gender, health status, and health risk.

  (2) shall report on recommended revisions for the coverage and periodicity of clinical preventive services as specified in the standard benefits package, and provided under Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP).

- With respect to **COMMUNITY-BASED PREVENTION**, the Public Health Advisory Commission:

  (1) shall review the findings of the Task Force on Community Preventive Services for the continuous and rigorous review of the most recent scientific evidence on the most effective and cost-effective community-based and public health approaches to health promotion and disease prevention for healthy individuals, families and communities; and

  (2) shall report on recommendations on the most effective community-based approaches to promote health. The recommendations made within each of the priority areas identified in the most recent version of the *Healthy People -- Objectives for the Nation* shall be listed in rank order based on their potential contribution to improving the population's health status.

- With respect to **SOCIAL AND ECONOMIC POLICY** for prevention, the Public Health Advisory Commission:

  (1) shall delegate responsibility to an independent Task Force for Health Impact Assessment to establish criteria to assess health impacts and for the continuous and rigorous review of the most recent evidence on the health impacts of current and proposed social and economic policy.

  (2) shall report on recommendations on the most effective social and economic prevention policies and recommend changes in public laws, regulations, and other public policies to improve the public's health.

MEMBERSHIP

The following expertise shall be represented in the membership of the Public Health Advisory Commission.

- Expertise in population-based health information systems, public health, health economics and health promotion and disease prevention.

BIENNIAL REPORT:

The Public Health Advisory Commission shall be responsible for monitoring and biennial reporting to the American public, the Congress, and the President on the health of the nation.

The Public Health Advisory Commission shall prepare an integrated report biennially to ensure that the priorities identified in each of the three essential areas of prevention - clinical preventive services, community-based prevention, and social and economic policy for prevention — are

coordinated and build on each other in such a way as to ensure the greatest improvements in the public's health. The report shall include:

(1) Recommendations or changes in the administration, regulation, and laws related to the public's health and the coordination of public health and medical services.

(2) Data needs related to health improvements in the population and high risk sub-population groups.

(3) An update on the specific services covered as clinical preventive services and the periodicity schedules, as specified in the standard benefit package, and an update on the clinical preventive services provided under Medicare and Medicaid.

(4) An update on the recommendations for public health funding allocation to be consistent with the evidence-based community interventions.

(5) An analysis on the progress towards implementation of the recommendations on the most effective social and economic prevention policies and recommend changes in public laws, regulations, and other public policies to improve the public's health.

3. PREVENTION BENEFITS UNDER HEALTH REFORM

CORE BENEFITS FOR CLINICAL PREVENTIVE SERVICES

Coverage of high-value, evidence-based clinical preventive services, based on the recommendations of the USPSTF and the ACIP, shall be included in any health reform bill:

- Full coverage for a core set of age-, gender-, and risk-appropriate, high-value, evidence-based clinical preventive services in the standard benefit package, including:

  (1) Immunizations

  (2) Screening tests

  (3) Periodic clinician visits

  (4) Preventive counseling and health education services

  (5) Chemoprophylaxis.

- Covers age-, gender-, and risk-appropriate evidence-based preventive counseling and health education services provided by health-care professionals or community-based providers to individuals or groups for risk factors identified in the risk assessment provided as part of the periodic clinician visit (described below). These services include activities such as preventive

counseling and health education for diet and nutrition, exercise, injury prevention, tobacco use, alcohol and drug use, sexual health, and dental health.

- Increases reimbursement in federally-sponsored health insurance programs to provide an incentive to deliver cost-effective clinical preventive services.

CLINICIAN VISIT:

A periodic health exam provided during a visit to a health-care professional shall be covered at age-, gender-, and risk-appropriate intervals.

- The clinician visit shall include the following health professional services:

  (1) Complete medical history.

  (2) Age-, gender-, and risk-appropriate appropriate physical examination.

  (3) Health risk assessment.

  (4) Targeted brief health advice and referral to comprehensive health education and preventive counseling, as needed.

  (5) The administration of age-, gender-, and risk-appropriate immunizations and screening tests.

COST SHARING:

- All preventive services recommended by the USPSTF and ACIP are covered services, but high-value, evidence-based preventive services that are cost-effective shall be exempt from all deductibles, co-payments and co-insurance, provided that their use is consistent with the recommended periodicity schedule.

PROVISION OF EFFECTIVE RISK REDUCTION AND HEALTH PROMOTION PROGRAMS:

Health reform shall require health plans to make available and refer patients, as indicated, to programs of established effectiveness in modifying health risks and promoting health.

- Health plans shall assess the availability of health education programs offered in the community, which have demonstrated their effectiveness in changing health behaviors, reducing health risks, and/or improving health status. Health plans shall offer and refer plan members to these health education programs based on an assessment of individual risks and learning styles.

- Health education programs may include health education classes and training classes, self-care modules, community-based programs, and computerized, web-based, and telecommunications venues.

MEDICAID COVERAGE FOR CLINICAL PREVENTIVE SERVICES:

Some bills incorporate Medicaid into a single national health insurance program and others leave it as a separate program. If Medicaid continues to be a separate program, Title XIX of the Social Security Act needs to be amended to require that all Medicaid recipients be fully covered for all of the clinical preventive services appropriate to their age, gender, and risk status, as recommended by the USPSTF.

- The Medicaid population shall receive the same age-, gender-, and risk-appropriate preventive services benefits as those included in any federally-defined standard benefit package.
- High-value, evidence-based preventive services that are cost-effective shall be exempt from all deductibles, co-payments and co-insurance, provided that their use is consistent with the recommended periodicity schedule.

4. COMMUNITY-BASED PREVENTION

SUPPORT FOR ESSENTIAL PUBLIC HEALTH SERVICES:

Health reform legislation should ensure strong and sustained support for public health through appropriated funds as may be necessary to assure adequate and stable funding for essential public health services.[1]

The capacity of federal public health programs and state and local public health agencies must be strengthened to carry out the essential public health services and to increase the capacity of community-based providers to meet the special needs and concerns of the most needy and

[1]The annual federal appropriation necessary to provide sufficient and stable funding for national, state and local core public health functions would be determined by the Public Health Advisory Commission and based on current scientific evidence. Until the time of the formation of the Commission, initial funding in the amount of $20 BILLION in additional funding would be used for immediate public health needs (e.g. infrastructure, workforce, reducing the major drivers of ill health) (from Trust for America's Health. *Blueprint for a Healthier America.* Washington, D.C.: Trust for America's Health, October 21, 2008). Funds available through this mechanism would be used for restoration, maintenance and expansion of essential public health services and programs. Funds would be allocated to the Centers for Disease Control and Prevention to make grants (including formula grants) to units of State and local government, and, in the case of research and training, institutions of higher education. The allocations of funds between the ten essential public health services would be determined by the CDC based upon demonstrated need and revised as necessary based upon the recommendations of the Public Health Advisory Commission.

vulnerable population groups. The public health system requires significant improvements in the infrastructure needed to effectively carry out the essential public health services.

- Congress shall provide adequate and stable funds for federal, state and local public health programs for the essential services of public health and the infrastructure to support it. The essential services of public health are to[2]:

  (1) Monitor health status to identify and solve community health problems (e.g. collecting vital health statistics; identifying community health resources; improving public health information systems).

  (2) Diagnose and investigate health problems and health hazards in the community (e.g. supporting infectious disease epidemiology programs; improving capacity and access to public health laboratories).

  (3) Inform, educate, and empower people about health issues (developing media campaigns and social marketing; building partnerships to implement and reinforce health promotion programs and messages).

  (4) Mobilize community partnerships and action to identify and solve health problems (e.g. collaborating with statewide partners to identify public health priorities and create effective solutions to solve state and local health problems; building coalitions to improve community health).

  (5) Develop policies and plans that support individual and community health efforts (e.g. aligning resources and strategies with a community health improvement plan; developing legislation, codes, rules, regulations, ordinances and other policies supporting health efforts).

  (6) Enforce laws and regulations that protect health and ensure safety (e.g. protecting drinking water; enforcing clean air standards; regulating care provided in health care facilities and programs; enforcing laws governing the sale of alcohol and tobacco to minors, seat belt and child safety seat usage, and childhood immunizations).

  (7) Link people to needed personal health services and assure the provision of health care when otherwise unavailable (e.g. assuring quality health care; coordinating provider services and clinical care; developing interventions that address barriers to care such as culturally and linguistically appropriate staff and materials and transportation services).

  (8) Assure competent public and personal health care workforce (e.g. educating and training of health professionals; maintaining public health workforce standards,

[2] National Public Health Performance Standards Program, Centers for Disease Prevention and Control. http://www.cdc.gov/od/ocphp/nphpsp/EssentialPublicHealthServices.htm.

including efficient processes for licensure/credentialing of public health professionals).

(9) Evaluate effectiveness, accessibility, and quality of personal and population-based health services (e.g. determining effectiveness of health programs through critical review based on analyses of health status and service utilization data; providing the necessary information for allocating resources and reshaping programs; critically reviewing).

(10) Research for new insights and innovative solutions to health problems (e.g. linking with institutions of higher learning and research; supporting research ranging from improvements in public health practice to formal scientific research; reporting results and implementing policy based on these results).

PUBLIC HEALTH REPORTING:

Health reform legislation should require States and Territories that receive federal public health funding to submit annual reports to the Secretary of Health and Human Services on the health status of the population and measurable objectives for improving the public's health. States and Territories must prepare the reports as a condition of receiving funding for essential public health services.

State reports shall address the following:

- A comparison of outcome measures of the health status of the State's population (at the state and local levels) compared to relevant objectives set forth in the *Healthy People -- Objectives for the Nation.*
- A description of health status measures to be improved within the State (at the state and local levels) through expanded public health functions and health promotion and disease prevention programs.
- A report on implementation of effective, evidence-based community interventions, as defined by the *Task Force on Community Preventive Services.*
- Information regarding how federal funding has been allocated and has improved population-based prevention activities and programs.
- A description of how the essential services of public health have been implemented at the state and local level.
- A description of the relationships between the State's public health system, community-based health promotion and disease prevention providers, health plans, and health care system.

5. HEALTH IMPACT OF SOCIAL AND ECONOMIC POLICY

Because many determinants of health are environmental (physical, social, economic), legislation should encourage greater use of health impact assessment in policymaking. Health impact assessment will provide policymakers with information on potential public health benefits and harms, differences of impacts, and alternatives for improving benefits and reducing harms of laws and regulations, including those outside the health sector. In order to examine the potential health effects of proposed policies, programs, and projects in a systematic way, we propose that legislation:

(1) create a National Center for Health Impact Assessment to examine the potential health effects of a wide range of multi-sectoral proposed policies and programs, especially those that are not viewed as primarily health policies and programs, such as housing and urban renewal, land use, and agriculture.

(2) require the Public Health Advisory Commission to report on recommendations on the most effective social and economic prevention policies and recommend changes in public laws, regulations, and other public policies to improve the public's health.

(3) support research and innovation by local and state agencies, research institutions, non-profit organization, and others to increase utilization of health impact assessment.

6. HEALTH RESEARCH

Legislation should provide additional funds to support health research initiatives that identify the most effective and cost-effective strategies to improve the public's health.

HEALTH RESEARCH INITIATIVES:

- In carrying out this initiative, the Secretary shall give priority to conducting and supporting research:

  (1) that reflects the full range of approaches identified in the priority areas of *Healthy People Objectives for the Nation*, including research to identify the most effective approaches to delivering clinical preventive services, community-based health promotion and disease prevention, public health systems, and social and economic prevention policy.

  (2) on the appropriateness and comparative effectiveness of alternative community-based and clinical strategies for preventive care; integrating preventive services into primary care; effectiveness of policy interventions; effectiveness of preventive counseling and health education; efficacy and cost-effectiveness of clinical and community preventive services; the effectiveness of employer incentives to offer and strengthen worksite health promotion programs; and the effectiveness of community health workers on the quality and outcomes of care.

(3) on the impact of health reform on health delivery systems; public health system, community-based injury and illness prevention; methods for risk assessment and risk adjustment; factors influencing access to primary care, preventive services, community-based health promotion and public health; individual health decision-making; and the feasibility of developing incentives for worksite health promotion programs.

(4) that translates the scientific evidence-base for clinical preventive care and public health interventions into national guidelines, the dissemination of such guidelines, and the assessment of the effectiveness of such guidelines.

7. HEALTH DATA SYSTEMS

NATIONAL QUALITY PERFORMANCE MEASURES:

The health reform bills should require the development of standard measures of system performance and evaluation and reporting of performance that address health status and prevention, funded as part of the stable and adequate funding for essential public health services. The availability of uniform health data is critical to assessing the performance of the health care and public health systems. Prior to the development of national measures of quality performance and operation of a national health information system, the Secretary shall assess current measures and data systems to establish a baseline report of the performance of the system.

- The Secretary shall develop a set of national measures of quality performance of the health care and public health systems to be used to assess the health and risk status of the population, the provision of health services, access to such services, and the health impacts of federal policy. These measures shall be based on a review of existing national quality performance measures (e.g., those developed by the National Quality Forum, the National Committee on Quality Assurance, and the Healthy People Objectives for the Nation).

- The Secretary shall develop a system of financial incentives to reward health organizations that deliver high rates of clinical preventive services. The metrics developed as part of the national measures of quality performance shall be the basis for these performance rewards.

- National measures of quality performance shall be selected in a manner that provides information on the following.

    (1) Health promotion, including population-based health status measures, prevalence of behavioral and environmental risk factors, incidence of preventable morbidity, injury, and mortality;

    (2) Prevention of disease, disorders, and other health conditions;

(3) Individual level health risk and health status, including behavioral health, and functional and mental status;

(4) The effect of policies intended to improve health at the national, state and local levels.

- The Secretary shall evaluate the impact of this Act on the health and risk status of the population, the quality of health-care services in the United States, and access of consumers to such services, and produce a biennial report to Congress and the President.

HEALTH INFORMATION SYSTEM:

Health reform bills should include the development and implementation, by the Secretary, of an electronic health information system for the routine collection, reporting, and regulation of health information for evaluating the health care and public health systems, and for the provision of clinical and community preventive services.

- The health information shall be collected and reported in a manner that facilitates its use for the following purposes.

(1) Improving the ability of health plans, health-care providers, public health organizations, employers, and consumers to promote the health of the population.

(2) Monitoring changes in the health status of the population.

(3) Supporting essential public health services and objectives.

(4) Developing and evaluating policy and undertaking research by the federal, state and local governments.

(5) Improving the ability of health plans, health-care providers, and consumers to coordinate, improve, and make informed choices about health-care.

(6) Assessing and improving the quality of care.

(7) Measuring and optimizing access to care.

ENROLLEE DATA:

- The bill shall include provisions for the collection of health and risk status data on all persons enrolled in the US health-care system by completing a consumer survey prior to enrolling in a health plan. These data will be used, per HIPAA regulations, for both personal health information systems for all eligible individuals, as well as for the collection of comprehensive population-based data on health risks and health status.

PUBLIC INFORMATION AND MARKETING:

The public needs to be provided clear, factual information that allows them to make informed health choices. This information shall be culturally and linguistically appropriate and at an appropriate grade level (5th grade or less). This information shall incorporate a broad perspective on preventive services and programs, designed to both educate and encourage their utilization, and will be funded as part of the stable and adequate funding for essential public health services.

- A summary of the annual national quality performance report, including population-based health and risk status, health outcomes, and preventive services utilization, shall be made available to the public.

- Information on the annual performance of individual health plans in a state and local area, addressing the quality measures of population-based health and risk status, health outcomes, and preventive services utilization shall be made available to the public.

- Information on the extent and availability of individual and societal impact of preventive services and programs shall be publicly available. Information shall be designed and targeted to promote healthy behaviors and lifestyles in both general and specific at-risk populations.

8. TECHNICAL ASSISTANCE:

Public health agencies at all levels are in need of infrastructure development and are poorly equipped and staffed in health information technology. Therefore, additional provisions need to be included in health reform legislation to provide information and technical assistance to States, health plans, and health-care providers to enable their full participation in and use of health information systems, funded as part of the stable and adequate funding for essential public health services. Specific attention needs to be given to the linkage of community-based information systems with patient care information systems.

- The Secretary shall provide information and technical assistance to the States, health plans, and health-care providers with respect to the establishment and operation of automated health information systems. Such assistance shall focus on:

    (1) The development and strengthening of community-based health information systems.

    (2) The linkage of community-based information systems with patient care information systems.

- The Secretary shall provide technical assistance to state and local public health agencies on how to most effectively and efficiently achieve the goals set forth in *Healthy People -- Objectives for the Nation.*

9. PROFESSIONAL TRAINING

FUNDING PROGRAMS:

Health reform bills shall provide adequate funding to train sufficient numbers of primary care and public health providers and to educate current health-care providers regarding preventive medicine, public health, and community-based health promotion, as part of the stable and adequate funding for essential public health services.

- The programs described in this section include programs to train sufficient numbers of health-care professionals in primary care, including programs to enhance training in clinical preventive services and health education, and training in community-based health promotion and disease prevention, addressing the relationships between the social, economic, and physical environments and the health of the population. These programs shall be available in accredited training programs of primary care providers, including physicians, physician assistants, nurse practitioners, certified nurse-midwives, nurses, and others.

- The programs described in this section shall include programs to educate current health-care and public health professionals, including community health workers, in community-based health promotion and disease prevention, including public health education, epidemiology, biostatistics, coalition-building, community development and participation, public policy, mediation, and advocacy.

Mr. PALLONE. Thank you, both of you. We will start with our questions, and we generally have 5 minutes from each member, and I will start with myself. I tend, and I guess most people, tend to look at prevention sort of from two perspectives. One is what we call clinical preventive services delivered by physicians and other practitioners during a patient's visit, and that is why we emphasize, you know, in health care reform we want everybody to be able to see a doctor on a regular basis, and whether it is a school-based clinic covered in your insurance that that is an important part of prevention, that you can see somebody who can review your situation and give you care without having to get sicker and go to a hospital or emergency room.

And the other thing is the community-based prevention like education campaigns, and these things are very important. I am going to use my kids as an example, and I hate to do that sometimes but it is the easiest thing for me. I do think that like education campaigns about, for example, not smoking are very effective. I mean I find that they see smoking as a very bad thing like almost socially unacceptable. And I think a lot of that has had to do with the campaigns. But I also question the limits of what we can do in these two categories because it just seems that so much of prevention is personal and individual. And, again, I will use my kids as an example. You know, they just want to watch TV. They want to play videos. In the old days, and I am really dating myself, you would be in the neighborhood and you would go out and play on the street or in the back yard. Today it is like watching the videos, watching TV, and, unfortunately, as members of Congress you are not with them every day so on the weekend I will try to get them out of the house but it is very tough.

And the same thing is true with foods, you know, They want to go to McDonald's and the fast food places. Even if we are going out to eat, it is hard to get them to go to any place but fast foods and so my point is there is no question that these community-based prevention things like education with no smoking are effective, but it just seem to me we are losing the battle. And, I don't know, can we spend enough money on these educational campaigns, for example, to really make a difference? I mean, obviously, the smoking is a good example of that if I can use my own children, but it just seems like we are doing—we are spending some money on things like anti-smoking initiatives and other things, but it is not anywhere near as effective as all the promotional and advertising activity that takes them in the other direction in terms of their lifestyle.

So I just wanted to comment. You just think we need to just spend a lot more money or is there actually something we can do about personal life style? My question is very general, gentlemen.

Dr. BESSER. Thanks very much for that comment and question, Mr. Chairman. And you raise a very challenging question, how do you change behavior. When we are talking about things like smoking, you are talking about things like obesity, how do you work to help support an individual to make those changes. And educational campaign is part of that, but when you are looking at behavior change, we try and look at it in a more comprehensive way. Educating and informing is part of that. But what can you do to sup-

port that individual? I volunteer in a clinic in Atlanta, and I have just been astounded by the increasing number of children I see who are obese, and I talk to that child about activity and why aren't you going outside and playing and engaging in sports programs.

Mr. PALLONE. Doctor, not to interrupt you, but I am very active with Native American issues.

Dr. BESSER. Yes.

Mr. PALLONE. And the more I go to the different reservations and meet the tribes, the more I see younger and younger kids with the adult onset diabetes. I mean 20 years ago you would find somebody who was maybe 21. Now you find kids that are 10 or 11 years old.

Dr. BESSER. There is an epidemic of diabetes taking place in this country, and we are seeing it younger and younger. American Indian populations, Latino populations, it is absolutely out of control, and if we are going to handle the problem of ever increasing health care costs prevention has to be part of that. But the children I am seeing, when they go to school they don't have access to physical education programs. When they come home, they are not in communities that encourage physical activity. When they go to a fast food restaurant, there is no posting of nutritional information to allow families to make healthy choices.

When we think about these problems, there are things that we can do on a policy level. There are things we can do on a community level. There are things we can do to help their clinician provide them with counseling, and there are things that we can do to help that individual make healthy choices. But it has to be a concerted effort not just focused on that individual. The public health solutions are the long-term solutions to many of these problems.

Mr. PALLONE. I just think we need to do so much more. I don't know if it is money or whatever it is to counteract the trend that we have no idea how much effort it is going to take and—go ahead.

Dr. BESSER. I think resources is part of it, evidence is part of it. As Dr. Fielding was saying, the more we know what works from various pilots in communities the more we can expand that to other communities. There is definitely a gap in research in many areas of the most effective ways to change behavior. We are very excited about the resources that are going into comparative effectiveness research on the clinical side, but we clearly feel that there needs to be more work done on comparing different interventions on the community level to see which ones give you the best bang for the buck.

Dr. FIELDING. Let me just mention a couple of things. With medicine, we are kind of taught that there is a single answer to a single problem. It is kind of one to one. When you take the issue as complex as obesity there isn't a magic bullet. You need to do a variety of things. Some of those are policies, as Dr. Besser said. Menu labeling, for example. I worked very hard with others in California to get menu labeling in the fast food restaurants right up on the order board. That is going to happen in the next 2 years. And so you and I as parents are going to look at that and say you want what? How many calories does that have? And, by the way, there is some confounding information. When you look at that, you wouldn't know that there is a yogurt shake that actually has over 1,000 calories. Oh, it is yogurt, you know, how bad can it be. So

part of it is changing consumer information. Part of it is changing the opportunities in the school.

We have worked with the school system in Los Angeles County to increase physical activity but again the funding is being cut so it is tough. Now we have changed the food in the vending machines there so there is not junk food available in the vending machines. But there is also an aggregation of fast food restaurants that are near high schools where kids go out from school and in fact buy that instead of eating the food that is available in school. So we have to take a variety of approaches. One thing is very clear that I as a physician talking to a patient is not the only answer. It is not going to be the whole problem solver for obesity. The same way with tobacco control. We know that physician very brief advice in a standardized way the research has shown that can be effective. That is not enough.

You reference the truth campaign, which has been very effective by the American Legacy Foundation. But that requires tens of millions of dollars a year. Now one of the opportunities would be the federal government to say as part of the recovery act, we are going to put substantial dollars, match that with what is already available from the American Legacy Foundation, and do not only the prevention through truth but become an X like program which is the cessation program tied to quit lines. So there have to be a variety of mechanisms. No one is going to do it, and that is why it is confusing because it is not the medical paradigm. We need a very strong public health infrastructure with states and local public health agencies taking the lead in convening and letting people know the evidence and in working across the aisle.

Mr. PALLONE. Thank you. I know I went too long here. Mr. Deal.

Mr. DEAL. Thank you. Thank you both for your testimony. You know, there are categories that we can look at. One category is whether we know enough to know to do the right thing. For adults, most of us probably know what we ought to do. We just don't do it. But for children, they are in the formative stages, and I am concerned about the things that the government can and can't do, things government should or shouldn't do. And for adults pretty much there is a freedom of choice there that government has very little ability to change other than maybe to educate, but in children I think it is a different area.

And I agree with what my colleague, Ms. Eshoo, brought up in her opening statement about the food stamp programs, and I want to enumerate a couple of things here and ask you if you all have looked at these things, and they primarily relate to children. Of course, I am a big proponent for recess. I have a theory that when recess went out obesity went up, but in Atlanta you mentioned, and my understanding is the school board in Atlanta has now made a decision to do away with the physical education classes because they had to use the time to meet the academic requirements that the state has imposed and maybe even we have imposed from the federal level down.

Things like school nurse programs, things like putting restraints on what products can be used with food stamp purchases, which I understand we do have some restraints in the WIC program already, things like the school lunch program. Now I know most

school lunch programs now have a salad bar. That is for the teachers primarily. It is not the students who are utilizing it. What are we doing, what can we do, what can we do in those environments because for children the majority of the time that anybody other than their parents have control over is in a school environment. Would you all address that as it relates to children and either what they eat in the school lunch program, what many of them eat as a result of food stamp purchases, et cetera?

Dr. BESSER. I think this relates to the concept of health in all policies, and how do we look to ensure that we are promoting health or not by implementing policies promoting un-health through what takes place. Your comments about requirements, education requirements, and their impact is a really telling one. The reason that classes were increased was to try and improve the academic qualifications of students coming out of school. But we do know that students learn better when they are physically active, and the untoward consequences of some of those policies was squeezing physical education out of schools. We need to be able to look at that, and as public health practitioners we need to ensure that we have linkages, not just within the Department of Health and Human Services, but across government so that we are looking at how do you promote health in these other areas.

The idea of a health impact assessment when policies are moving forward is very attractive because it would force us to say, OK, as we are looking to construction project, we are looking for new roads. Well, does that road project have sidewalks? Does it have bicycle lanes? Does it have things that actually could encourage people to be physically active or is that something that was not considered as part of that. The more creative we are and the more we are able to look at things that don't necessarily require new dollars the more effective we are going to be at building healthy communities that promote health for children and the entire population.

Dr. FIELDING. I think you are absolutely right. The WIC program has made important strides that can be emulated for the broader food stamp program, the SNAP program, but in the schools we changed the vending machines so they only have healthier snacks and taken out the soda, which has a lot of calories that kids——

Mr. DEAL. You have to be careful about that with Coca Cola in Atlanta as does Dr. Besser.

Dr. FIELDING. Well, my guess is Coca Cola probably makes more on the water they sell than on the Coke so maybe it helps——

Mr. DEAL. They have made a concerted effort as an organization to deal with that.

Dr. FIELDING. Exactly, so I think the large beverage manufacturers, they have a very broad range so whether it is A or B they certainly can do as well. But also the food that is served, a lot of that is bought through USDA so what percentage fat can that food be, what about portion size. You have people in the cafeteria who we have had to teach not to give huge amounts on a plate. There is also issues of plate waste. We can serve vegetables but what if kids don't eat them. So part of it is what we can do externally. Part of it is what has to be done in the family. In school, for example, physical activity needs to be real physical activity. As an example, playing softball or playing baseball, most people are sitting around.

They are standing. Well, what if everybody ran around the bases every time somebody got a hit? That is the way to change the game, if you will.

And the same way out of school. We have to make sure that kids have a safe environment in which to play. Are schools available after hours? What about those general after school programs? Is there lighting in neighborhoods? So you can't separate these. And then parents. For example, as Chairman Pallone said, you know, what about the kids watching television? Well, they are spending too much time in front of the screens. Well, some parents may say, you know, there is a limit on how much you can do or you can only do it after you have done some physical activity. Not easy for us as parents but we have to take charge of part of that ourselves.

Mr. DEAL. Thank you both.

Mr. PALLONE. Chairman Waxman.

Mr. WAXMAN. I want to ask a question for both of you. In a little while, we are going to hear from Dr. Satcher, and he notes in his written testimony that racial and ethnic health disparities result in at least 83,500 excess deaths among African Americans each year. That is simply unacceptable. We have to address it in health reform. My question is what contribution can public health make to reducing racial and ethnic health disparities? Are there specific clinical preventive services that will reduce disparities if we cover them in health reform? Are there specific community-based preventive services that will reduce disparities if we fund them in health reform? Dr. Besser, why don't we start with you?

Dr. BESSER. Thank you, Mr. Chairman, for that question. I think that your comment that this is unacceptable is right on target. It is absolutely unacceptable the degree of disparities we see in health. CDC has undertaken a number of initiatives to try and address racial and ethnic disparities, but not on the scale that they need to be done. There is a program at CDC called REACH, which is racial and ethnic approaches to community health that has been done in a number of communities to specifically address within those communities the racial and ethnic disparities that occur.

Where this program has been enacted, we have seen a removal of the disparity in rates of mammography among African American women. We have seen removal of disparity in the rates of blood pressure screening for African American men, an increase in the use of blood pressure medication. We have seen a decrease in smoking among Asian American men. We know how to address these disparities, and again it takes a community approach. It is not a one size fits all approach.

And with appropriate scale up of these programs, I think that we can see the removal of a lot of these disparities. We have seen it in immunization programs where you have seen universal immunization. You have seen elimination or at least a closing of many of those disparities, and it is time for us to ensure that those programs are available to all of our communities.

Dr. FIELDING. Thank you very much. As your constituent, I am happy to add a couple of thoughts. First of all, we are not going to get to parity in terms of health unless we address some of the underlying determinants. I was asked the other day at a RAND conference, what is the single thing you would do to improve the

health of the American people particularly focused on reducing disparities, and I said increase the graduation rate from high school for a number of minority groups. They are very poor in Los Angeles as in other parts of the country, and the differences in health that come along with that are substantial. The issues of transportation, the issues of access to nutritious foods, fruits and vegetables.

Mr. WAXMAN. Well, how would you address this, in a community-based way or would you do it in a clinical way? I know that you can solve all the world's problems and it would change the disparities but if we are doing health reform, what do you recommend we do in health reform? Should we provide money for community programs? Should we provide certain clinical practices for those who are going to now be insured if we get a health reform bill through?

Dr. FIELDING. Yes, I think that, as you suggest, Mr. Chairman, at all levels in a health care reform system, you want to make sure that there are not only the ability but the incentives so that the providers have incentives to make sure that there are not disparities in terms of the access to services, but we also know that we have to use a lot of efforts. It is not simply that one has to have services accessible. They have to use them. And so one of the things we do in the community guide is to develop interventions which basically help people to use the services. And with different groups that may be different so for one group it may be that recall reminders make a difference. For another group it may be that you need to call their cell phones.

For another group it may be that they have to have a case manager. It is trying to understand that that we are trying to do in the community guide working with the clinical guide, so I think the opportunity for all of those should be included in health system reform but we also, if we are going to reduce disparities, need to focus on the core of public health and the underlying problems. For example, in Los Angeles County African American men and women have a 25 percent smoking rate. The average rate in Los Angeles County is 14 percent. So we need programs, for example, social marketing programs that are particularly focused on the African American population there on tobacco.

We need programs on obesity for Latinos as well as African Americans, so I think it needs to be a combination of what can go in the health care reform and the other parts of health reform that are outside the strict health care system.

Dr. BESSER. Chairman Waxman, if I could add to that. I think that it also ties into comments that were made by many members about the importance of a strong state and local public health system. In a community you need to have a public health infrastructure, epidemiologists and public health specialists, who can look at what are the risk factors in that particular community and address those. It is not a one size fits all, and those in the community, as Dr. Fielding is saying, in a community that got higher rates of smoking in one particular population, they have to look at what is driving that, who the community leaders are, and how you build a public health program that targets the drivers in that particular community, and to do that you need a strong, local public health system.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. Our ranking member, Mr. Barton.

Mr. BARTON. Thank you, Mr. Chairman. One of the things that we can do to promote congressional health would be to stop scheduling simultaneous subcommittee hearings of this committee, which causes—but I guess it does promote de-obesity because it makes us run back and forth, up and down the stairs. I just have one question for this distinguished panel, and it is the idea of universal coverage. The President has said that every American should have health care insurance and you almost have to have—you don't have to but you almost have to have a mandate that every American has to have it, so my question is should that be an individual mandate or should it be some sort of a universal mandate that if you are not covered under a group plan there be a national kind of a backup fail safe plan for any individuals that don't have group coverage, so could you two gentlemen give us your ideas on how to get universal coverage for every American regardless of their employability and employment status?

Dr. BESSER. Thank you very much for that question. From a public health perspective, and that is the hat I wear and where my expertise lies, the critical factor is access to care and ensuring as a Nation that we move to a point where everyone has access to care and that care is not just being delivered in emergency rooms when people are sick. And I think there are many ways to get there. Which way we get there, I think is not one where CDC has the expertise. One thing that we hopefully over time will be able to bring more light to is the impact particular insurance or particular systems may have on an individual's health. We collect a lot of information on the health status of Americans through various surveys and one is the national health interview survey.

And through that survey, we are now starting to collect information about type of insurance, type of insurance plan, whether it is a health savings plan or such so that over time we should be able to look at does that particular type of system have an impact on health drivers.

Dr. FIELDING. Sir, I don't know which is the best way to get there. I think what is important is that there be however you get there a core of services which is going to contribute to health because health then allows us to be more competitive, more productive as a Nation by reducing preventable problems. I think if we focus on that aspect there are probably a number of ways to get there but providing the emphasis on what we can do within that system and then working together with public health is probably our best opportunity to improve the health of every American and to reduce disparities at a time when unfortunately our health is not as good as that of our trading partners in many cases.

Mr. BARTON. Thank you, Mr. Chairman.

Mr. PALLONE. Mr. Dingell.

Mr. DINGELL. Thank you, Mr. Chairman. This question is to Dr. Fielding and Dr. Besser. Question, public health has a cost benefit to the society, does it not, yes or no?

Dr. FIELDING. Yes, it has a very substantial benefit to society, sir.

Mr. DINGELL. Dr. Besser.

Dr. BESSER. Yes, sir, I would agree with that.

Mr. DINGELL. All right. Now the reason for that question is the dealings in this committee with national health insurance or getting a program which will cover every American, that cost benefit may get dropped out of the equation because of the Congressional Budget Office which has a rather stingy attitude of quantifying things which they view as being unquantifiable. How do we then see to it that we get this question resolved in a way which is quantifiable so that we can get some discernable, visible, and calculable benefits to the society from public health so that we can get CBO to give us a proper estimate of savings and benefits that could be achieved by public health service, by CDC and other entities which work towards this end? Starting first with Dr. Fielding and then Dr. Besser.

Dr. FIELDING. Thank you very much. A very important question, Chairman. I think several things. First of all, you will hear from Jeff Levi from Trust for America's Health the kind of studies that they have done suggest a very good return on investment for some of the things we could do in public health. It is clear to me that we are not going to get where we need to with the national system of strong local public health and state public health unless the federal government is a partner with the states and localities, unless there is a sustainable amount of money that goes to make sure that the spine of public health is strong.

With respect to the Congressional Budget Office with which I have had some discussions as well, I think that they tell me that the Congress is asking them to look very narrowly, and I don't think that looking narrowly answers the question. What they need to look at is the value. What is the relative value of different kinds of investments, and I think if you look at the relative value you get better.

Mr. DINGELL. That is an outfit, Doctor, that sometimes knows the cost of everything and the value of nothing and they have great difficulty in converting value to cost that is discernible and can then be included as justification in the legislation. I am asking your help about how do we get this quantification step done. And remember my time is running.

Dr. FIELDING. OK. What I am suggesting is that we look not only at the dollar savings in a very short period of time to the federal government, but we do two things——

Mr. DINGELL. Let me put it to you this way, Doctor. If we had Black Death there would be a—to spring back, we would all of a sudden have a very major cost to the society. AIDS has a very major cost to the society. If tuberculosis were to come back and break loose in the society, we would have a cost. How do we quantify these things and how do we request quantification from CBO so that they will give us something that will be useful in this discussion?

Dr. FIELDING. We can quantify the cost of epidemics in terms of health care costs, in terms of productivity loss, in terms of cost to the Social Security system and the like. That is easy. What is hard to know is what exactly it takes to prevent those because it comes from a number of different places. I think if we ask the CBO to look at what is the health benefit for a dollar invested in alternative ways, that is what I mean by value. Instead of just saying

what is the dollar back, what is the health value? We are spending right now $1 out of every $6 in this country on health care. We don't know in many cases what the value of those dollars is. We need to compare that with the value of public health.

Mr. DINGELL. If you give preventive care, you could shrink those numbers. Let me get to Dr. Besser.

Dr. BESSER. Thank you, Mr. Chairman. I think that you raise a critical question and a critical problem. When we look at many of the interventions and programs in public health the return on investment is long term. When we are talking about promoting physical activity and appropriate nutrition in children, that will have major payoffs to those individuals but also to our economy over the lifetime of that individual.

Mr. DINGELL. Or alcohol or smoking.

Dr. BESSER. Exactly. Alcohol or smoking. Those behaviors, if presented early, will have lifetime benefits and will have lifetime impacts on our economy.

Mr. DINGELL. How do we insist CBO assist us in quantifying those benefits?

Dr. BESSER. Well, I think that that is a real challenge. It is very promising, some of the data, Trust for America's Health, and Jeff Levi is going to be talking about short-term return on the investment. And that is promising, but I do think that for the broader consideration of public health that can't be the only part of the conversation because even if we were not seeing the return on investment that Trust for America's Health was seeing, we are seeing a very good value on the investment over the lifetime of individuals and over the lifetime of the economic return over the lifetime of those individuals. So the issue of time frame, cost to whom, who is paying the cost and who is the benefit being accrued by are very important parts of that discussion and one that we have to find a way around if we are going to see a long-term commitment to supporting public health.

Mr. DINGELL. Thank you, Mr. Chairman. My time has expired.

Mr. PALLONE. Thank you, Chairman Dingell. Mrs. Blackburn.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and thank you all for your testimony. Listening to you, it seems like we could—and listening to the questions, we are coming back to three things, which are lack of education, lack of physical activity, and then tobacco as three things that are really detrimental to health and good healthy lifestyles. Dr. Besser, you mentioned linkages with other resources and other agencies, and I just wanted to ask a couple of quick questions. Number one on the tobacco issue, we know that the Sinar amendment, the Sinar program, has been effective in helping states reduce their tobacco usage, their underage tobacco usage, but we also know that after the master settlement agreement that very little of that money is being used on tobacco.

I was in the state Senate in Tennessee when that was passed, and of course like so many states it went to fund a program, a health care delivery program, and the general fund and things of that nature that really weren't dealing with tobacco education. And some of us, myself included, who had been active with smoking cessation education, and as chairman of a former lung association, were disappointed in that. So would you all support a proposal that

would require states to use a certain percentage or an expanded percentage of that master settlement money for tobacco education? Just a quick yes or no from you all.

Dr. BESSER. Congresswoman, I have to confess that I am not familiar with the Sinar legislation and so I need some information around that. What I can say is that tobacco control is one of those areas where we have seen major public health successes both in terms of reduction in rates of smoking in adults, children who decide not to start smoking, decrease in second hand smoke, and I also know that if we don't keep up those efforts around tobacco control, we are going to see those benefits go away. It is not something where you do it and you are done.

Mrs. BLACKBURN. Dr. Fielding.

Dr. FIELDING. I don't know legally what can be done. It really is disappointing that the attorney general settlement did not specify that some of that money be used for tobacco control because a lot of states have not—tobacco control is an area we know a lot. We know a lot what can make a difference, and it is very disappointing that in many states unfortunately we are not putting the resources in that we need in order to reduce the rate. How that could be achieved, I am not sure legally, but it would be very important to have money consecrated to that problem because we know how to use it well.

Mrs. BLACKBURN. OK. On the linkages, coming back to that, I am one of those that believe that when you took physical education classes and consumer science or life skill classes out of the high schools that you started seeing lack of education with people, individuals, that did not understand, Dr. Fielding, as you were saying, what calories exist in food and what those choices should be. But along that line, have either of you worked with the U.S. Department of Agriculture and the Agricultural Extension Service, their FSC program or 4H club programs, anything like that on education because they have staff and they have materials that are developed to address that, either of you?

Dr. BESSER. I have not personally but let me get back to you about any collaboration CDC would have with USDA in that area.

Mrs. BLACKBURN. OK. That would be great. Dr. Fielding.

Dr. FIELDING. We have worked with WIC programs which we think are moving in the right direction and we have tried to change what is served in the schools and that works with USDA but we have not had direct contact.

Mrs. BLACKBURN. Well, and the WIC program for many of us that come from state governments when we did welfare reform, what we did was to require some of that education, and then in Tennessee one of the things we did was to move some of that education back out to our local county extension services because they do have the individuals there that not only can provide the education but can mentor, which is a critical component of changing the habits and the behavior. And I know when Dr. Satcher does his testimony, he is going to speak a little bit to the influence of lifestyle and behavior. Thank you. I yield back. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. Mr. Matheson.

Mr. MATHESON. Thank you, Mr. Chairman. Dr. Besser, I was going to mention to you, have a discussion with you about issues about MRSA, if I could. Last year, a study was reported that caught a lot of our eyes about the effect that MRSA is having. Specifically, the study estimates that in 2005 more than 94,000 invasive MRSA infections occurred in the United States and over 18,000 of these infections resulted in death which was many more than had previously been thought. But there are many infections and other resistant bugs that aren't receiving as much attention and certainly should be adequately monitored as we discuss prevention and public health.

You may be familiar with legislation I introduced last year and plan to reintroduce that is called the STAR Act. It would establish a network of 10 sites across the country which could be part of existing surveillance sites or health departments. These sites would provide an early warning system to monitor anti-microbial resistance. I look forward to working with you as we try to develop that legislation as a way to strengthen this country's ability to respond to what I see as an emerging public health problem. I wonder if you could just discuss with me any gaps you see in our current surveillance capabilities. Specifically, I would ask do we have an early warning surveillance system to monitor anti-microbial use and the emergence and spread of resistance?

I would also like to ask you if you think our current systems are reactionary or are they geared at preventing outbreaks. And, third, I would ask your sense of how we compare with other countries in this set of issues.

Dr. BESSER. Thank you, Mr. Matheson, for these questions about a very important public health problem. MRSA is one type of resistant infection and it is one that has gained a lot of national attention. One of my areas of focus early in my career at CDC was around appropriate antibiotic use, and I started CDC's program, Get Smart, Know When Antibiotics Work, so that is directed around trying to prevent the increasing rise or the academic of antibiotic resistant strains. We are absolutely thrilled that the ERA funds that have come down have $50 million in there to look at health care acquired infections because when you look at a site where resistance is likely to occur and develop health care settings are one of those places where you are seeing a lot of bad bacteria and a lot of antibiotics. You put those together and you are going to promote resistance.

There are major gaps in our ability to detect infectious diseases and detect resistant infections, and those ERA funds are going to help with that to some extent. Our ability to look at antibiotic use and behaviors around that, we have some surveys in the NCHS, National Center for Health Statistics, that allow us to get a window on how antibiotics are being used in clinical practice. As we move toward electronic health records, that is going to improve our ability to look at practices across providers and for providers to look at their own practice and see how are they complying with recommendations, how is their use of antibiotics.

When we look across different countries, there are some countries that we have higher rates of resistance in and some that we have lower rates of resistance, and it is important that we work

with other countries to see what strategies and solutions have been effective at reducing infections and resistance. We do know how to reduce infections in health care settings. We have programs that have been very effective that we have developed jointly with the Agency for Health Care Research and Quality. These demonstrated in southwestern Pennsylvania, implementation of these reduced bloodstream infections by 70 percent. And so for many states and localities, it is how do we help them go to scale and how do we provide the assistance and resources to make that happen.

Mr. MATHESON. Well, I appreciate that response, and again I look forward to continuing to work on this issue.

Dr. BESSER. Likewise.

Mr. MATHESON. I yield back, Mr. Chairman.

Mr. PALLONE. Thank you, Mr. Matheson. Next is Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. I got a number of things I want to get through. Of course, Mr. Pitts and Mr. Shimkus said before they left that they would yield me their time as well. Dr. Besser, let us stay on the subject of infection for just a moment, and you reference it in your written testimony but can you talk just a little bit about your approach to this or perhaps delineate what would be a preferred approach to controlling particularly central line infections and do so in a way that so that we don't inhibit reporting if we come at it. And I worry about this because we do this over and over and over again in Congress and CMS. We come at things punitively and then we tend to drive reporting underground so can you address that?

Dr. BESSER. Thank you, sir, for that question. It is a challenge. There is an inherent difficulty when reporting of an infectious disease could have negative consequences to the individual that is reporting that. The national health care safety network that CDC supports and is in place in many states allows for confidential reporting and provides to health care institutions an ability for them to look at their own rates of infection and develop strategies to reduce rates of infection.

Mr. BURGESS. Now under HIPA at CDC can you accept that data at CDC if someone wants to compile that data on a state level? Can they export it to you?

Dr. BESSER. CDC is able to receive anonymzed data from many sources and when we work with states around this area there are provisions that protect those data that come to CDC. What we found is that when hospitals start to do the surveillance around line infections and implement what have been shown to be effective control strategies that they see a dramatic decline in those infections. They are entirely preventable, and that is something that where we think there could be major improvements.

Mr. BURGESS. Sure. That is the epidemiologist mantra. To measure is to control. I guess I am concerned because our tendency is to be punitive on this and I know certainly from the physician community we are so goal directed. If you are not going to pay me if I diagnose a surgical site infection, I will never diagnose another surgical site infection through my professional career because after all I want to get paid. So we contend to obscure the data by how we focus on things. I want to touch on something else because you have got in your testimony about HIV prevention, and nowhere in

there do I see—I will just tell you the problem that I have in my community in southeast Fort Worth is that we have individuals who are arrested for one thing or another, incarcerated and returned to the community and now with an HIV infection and it then spreads outward from that exposure. Are we doing anything to look at our exposure to our prison population and then their subsequent re-integration into society?

Dr. BESSER. Mr. Burgess, I will need to get back to you on that in terms of specific programs in that setting. I think that when it comes to HIV prevention and control as with other infectious diseases understanding where transmission is occurring and ensuring that we have programs to address that route of transmission is absolutely essential. Earlier we heard someone mention the 3 percent HIV prevalence in African American males in the district. That is unacceptable. We need to understand what is driving transmission and put in place control efforts so that that will not be the case. But let me get back to you in terms of—I know we do a lot of work with health care—with infectious disease transmission in prison settings but I want to make sure I get back to you with accurate information.

Mr. BURGESS. OK. Very good. And I appreciate that, and of course we know that if we are seeing that high a rate in African American men it will just be a very short period of time before we see a similarly high rate in African American women, and part of our job is to prevent that from happening in the first place through educational activities. One last thing that I will just mention and I have heard access mentioned several points this morning. I have an area that I represent. Two or three of my zip codes have some of the highest infant mortality rates in the Nation, and it is in Tarrant County, which of course has a robust county hospital district, county tax supported facility and literally within the shadow of these facilities are some of these neighborhoods where infant mortality is so high and the problem therein is utilization and not access because access is clearly available but we don't have clinics where the people are, and trying to work through the cumbersome bureaucracy that exists in HERSA and HHS has made it all but impossible to get a community health center, a federally qualified health center, developed in those areas.

And one of the most meaningful things we can do as we go forward is to try to unravel some of that so that we don't put these barriers up to getting the care were it is actually needed. I hear testimony from other members on both sides of the dais where they talk about 10, 12, or 14 federally qualified health centers they have in their districts. I have zero in my district, and I have got infant mortality rates that are third world, and it is unconscionable that we will continue this program where—it is not just a racial disparity. It is a geographic disparity that is of startling proportions and I really hope that going forward this committee will spend some effort in looking at that, and certainly where CDC can give us some help, I hope they will do so. So I thank you, Mr. Chairman, and I will yield back.

Mr. PALLONE. Thank you. Next is Mrs. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman, and, boy, what an excellent panel. This could go all day. And I have a question for each

of you and I have tried to make it narrow but it is impossible. Dr. Besser, you discussed examples that make it clear that accurate information about key public health indicators such as infant maternal health is essential to improving the overall health of the public. Maybe this is what Chairman Dingell was kind of getting at as well. There are currently barriers to surveillance that make it difficult to gather public health data. We have to have the data in order to make the case for more access and better ways of implementing public health. Can you describe briefly some of those barriers, what we could do to help accomplish the positive health outcomes that comprehensive surveillance data could give us?

Dr. BESSER. Thank you very much for that question. There are a number of things that I can think about that would improve our ability to understand the health status of Americans. Right now there is so much discussion around electronic health records and what these are going to provide to improve clinical care by providing to that clinician information about screenings that need to take place. Well, this also is a potentially very powerful tool for population health and insuring that as this moves forward there are fields that are in there that represent the important components that we need to look at for public health, and that the clinics are not just connecting to each other but they are connecting to public health departments.

That is one thing that would be extremely effective. We at CDC have seen over time a decline in support for our National Center for Health Statistics. The National Center for Health Statistics is critically important to measuring health of people around this country. It is important for us in terms of measuring the impact of programs that we put in place and ensuring that we are spending our resources appropriately. It is important for identifying disparities and issues that need to be addressed in particular communities. And we have had to make tough choices over time in terms of decreasing the frequency of surveys or decreasing the size of a population under a survey, and it is very difficult when we are doing that to really get a measure of the health status of all Americans.

Mrs. CAPPS. Even though I know you could talk more about this topic, I just want to from that as we look for a comprehensive health legislation, we do need to be cognizant that data collection is an integral part of doing that. Dr. Fielding, you have done so much for the metropolitan Los Angeles area. Thank you. As we work to reform the health care system public hospitals and community health centers are essential to ensuring that rising numbers of uninsured and underinsured patients can access health care during a recession which we are seeing right before our eyes. In the future, safety net health systems must remain intact to provide the services that newly insured patients will need to effectively access care if we are really going to implement an increased number of people getting care.

We have got to find a place for that to happen, including language translation and social work services. Safety net providers will also continue to provide money losing services such as trauma and burn care that many other hospitals choose not to offer. So what kind of policy questions should we be addressing in our

health reform dialogue to insure that the safety net stays viable for the future and that kind of topic particularly now if we transition into a broader based health delivery system?

Dr. FIELDING. Thank you very much. You are absolutely right. We need to maintain a safety net. These are providers who are very sensitive to the population for whom language is not a barrier who understand the morays, the culture, the beliefs, and that has been lacking is sufficient funding to try and knit all the pieces together so that, for example, community health centers might have the same record as the hospital or primary care and secondary care might have the same ability and to transport things back and forth easily electronically. That is one need. Another need, of course, is simply to give people the tools so that they can maintain the infrastructure necessary.

In some cases, public systems have not done as well in trying to maintain themselves just physically as others have. But I also think that we have to look over time in the local situation to see what impacts a broader mandate will have and in some cases it may transform systems. In other cases, it may not change them very much. To what degree are there going to be competitive opportunities or not, so I think it is going to be a situation by situation issue. I would add one point to answer your last question. We do a local health survey. We have the LA health survey, and we do over 8,000 people every other year in Los Angeles County of over 10 million people. And we get a lot of interesting and important information on issues as diverse as breast feeding and what are the barriers to that, one of our most important opportunities, or emergency preparedness. What percentage of our population are prepared for emergencies and have a family communication plan, have the 10 essential items that they need?

We have more than our share of natural disasters and we worry, of course, about others so I think having local data collection is also important to supplement the very important role that NCHS plays. And I just want to echo that the National Center for Health Statistics has not had the funding they need, and if we are doing to coalesce our Nation around the 2020 objectives for the Nation, then we have to have the data on which to base that, and we have to know if we are tracking in the right direction or not and not just nationally but at the local level, so robust funding for that effort is going to be essential.

Mrs. CAPPS. Thank you both.

Mr. PALLONE. Thank you. Mr. Gingrey.

Mr. GINGREY. Mr. Chairman, thank you. And I wanted to ask both Dr. Besser and Dr. Fielding, all Americans of course should have quality health care regardless of income, race or age. Dr. Besser, let me start with you. I believe, of course, that any disparity should be a major part of health care reform, and I know we have talked about this this morning and several of my colleagues on both sides of the aisle touched on that issue. And, Dr. Fielding, I think in your testimony you talked about a lot of things, situations, education, but I guess really what I want to find out is if either one of you think that there are other reasons for racial disparity in regard to receiving the kind of high quality health care.

An example, in the Medicaid program, there might be a tendency, might, I would hope not but I think likely there is for health care providers to be a little bit prejudice towards people who come in the door who obviously are not taking care of themselves. Maybe they are obese, maybe they are unkempt, maybe they are smoking cigarettes, whatever. But I really am concerned there could also be that same sort of attitude towards different minority groups. And so this is a little touchy subject but I think it is hugely important that we talk about it, so I would like for you to address that.

Dr. BESSER. Thank you, Mr. Gingrey. Dr. Fielding, in his discussion earlier was talking on issues around social determinants of health, and I do think those are critically important. Where you live, whether your parents graduated from school, what type of occupation they may have and what type of occupation you have are things that do impact on your health. We know that children who live in the inner city have rates of asthma that are far greater than individuals who don't live in an urban environment. We know that children who are born to a single parent have a lower likelihood of graduating from school, and if you don't graduate from high school then your health future is more bleak.

And so there are a lot of factors that go into issues of health, some having to do with access to care. In the clinic I work in in Atlanta, I would say that it is a fraction of the children I see there have any health insurance at all. Those who do, the state pays Medicaid, and whenever I have one of those children it is like a blessing because I know that I can refer them to the dentist down the hall to get their teeth taken care of, and I can refer them to other services. So I think access to care is part of the issue when we look at promoting health, but it is important to look in each community to see what are the barriers for the entire population to get the health services and the health that they deserve.

Mr. GINGREY. Dr. Fielding.

Dr. FIELDING. Yes. I think one of the needs is to develop a work force which is reflective of the population and I think there are a lot of efforts, and Dr. Satcher has been a real leader and can talk about both his leadership training and other efforts. I think that is a very important initiative. I think it is also important to realize that a lot of the health disparities are really inequities. They arise from social and economic disadvantage, and we have some responsibility to try and overcome those. We are not always entirely successful but we need to do that and sometimes it will take some extra effort.

The third point though is that we have a very heterogeneous population. In Los Angeles County, for example, there are no minorities because there is no majority currently. Now there will be a majority within 10 years and that will be Latino in this largest county in the country, so the whole issue of minorities is an interesting one in terms of definition. But I think there is real opportunities, and we have to marry what we do at the individual level with what we do at the community level. That is why having core public health is so essential to helping to reduce disparities, and we need a lot more research on that.

When we in the community guide look at each of these policies and programs we find often times that there isn't data on which

programs have reduced disparities, and we need a very focused research effort to do that, realizing of course that not all disparities are ones that come from social or economic disadvantage, sickle cell among African Americans, Tay-Sach's among Jews and northern Europe origin, et cetera, et cetera, so there are some differences that are not real disparities in the same sense.

Mr. GINGREY. And thank you, Dr. Fielding, as well. As I read my book and material, and I think I noticed the figure of 58,000 or so deaths per year in a minority population, all these things considered, which both you and Dr. Besser discussed, over and above that there are still this many deaths over what it should be for minority groups, and I look forward to the second panel. I will bring up this same issue with Dr. Satcher because I think it is very important. I would like to know is there any evidence that providers of health care whether they are in Los Angeles County or in Atlanta, Georgia that for reasons of maybe unrecognized prejudice within themselves are not ordering the necessary tests or not taking the necessary amount of time with certain populations, and if that is the case obviously that is something that we need to stop whether it is through educating our young people in medical school or what, but I thank you for your response. I know my time has expired. And, as I say, I look forward to the next panel as well. I appreciate that. I yield back, Mr. Chairman.

Mr. PALLONE. Thank you, Mr. Gingrey. Mrs. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. I am tempted to answer Dr. Gingrey's question, but I am going to leave it to Dr. Satcher in the interest of time. But I am glad that just about every one of the panelists speak to the importance of the social determinants, and I am particularly interested in the health impact assessment, something that I have been advocating for as well. I have two questions. I am going to try to get two questions in. Dr. Besser, all of us are very pleased with the $1 billion for prevention and you have outlined broadly how CDC plans to use that money, but in the $650 million for prevention and wellness, how much of that is going to be used to target health disparities, maybe expand on reach programs, for example, and we also within the three minority caucuses are working on a bill to create health empowerment zones, which would allow health communities to have the resources and develop the plans, address the health disparities, and then give them priority for funding from any one of the agencies in the federal government to not only address the disease entities but also the social determinants. What do you think about that program? How are you using the money?

Dr. BESSER. Thank you, Mrs. Christensen. In terms of the prevention and wellness funds, we are absolutely thrilled to have $650 million to work on that. Those funds were appropriate to the department, and I chair the group, the subgroup within the department that is looking at how best to utilize those funds. We have put together a working group from across the department and it has been an incredible process because when we look at the areas that CDC has control over, we see what we know, but when we sit down in the same room with people from the Agency on Aging, folks from SAMSA, folks from HERSA, we get additional ideas, and so we are in the process of formulating this signature initiative.

Disparities is going to be one of those factors that is looked at here because in everything we do in public health, we need to ensure that we are addressing disparities. At this point, I can't tell you what the entire program will look like but disparities will be part of that.

Mrs. CHRISTENSEN. Thank you. And I am going to ask the other question about the health empowerment zones on the next panel as well. So, Dr. Fielding, I am interested to know how the task force over 200 proven methods relates to communities of color and if they go far enough to help eliminate health disparities. A lot of people have made reference to diabetes so let me just focus on that. ADA recommends, for example, screening for pre-diabetes if one is a racial or ethnic minority or over 45. The task force really as best as I understand it doesn't recommend pre-diabetic screening. And in terms of diabetes screening, Medicare covers screening for if one has two out of seven risk factors the task force recommends if there is hypertension present, but do you think that CMS recommendations or the task force recommendations are adequate to address the issues of people of color when, as we have heard, Mexican Americans have twice as much—twice as more likely to have diabetes, African Americans and Native Americans as well.

And you, yourself, have said in your testimony that there is this major gap in information on health disparities that needs to be closed. What can be done to close that gap and to make sure that the solutions that we recommend address all Americans?

Dr. FIELDING. Well, thank you. A very well crafted and complicated set of questions that I hope I can answer easily, but it is not so easy because, first of all, we have to make sure that if we screen for something that we have the ability to change the course of the disease based on screening. Fortunately, for diabetes the evidence growing for Type II diabetes that we can, that there are programs that can help people, particularly through nutrition and physical activity can, in fact, reduce the likelihood that they are going to get frank diabetes, so that is very important.

There are huge differences with Latinos and African Americans having much higher rates associated with higher rates of overweight and obesity. There has not been enough research on what the differences are, and are there any specific ways that we should be treating people based on genetic differences, cultural differences, and the like. One of the opportunities, I think, is to take some of the money that is being allocated for comparative effectiveness and to look at not only comparative effect of different methods but look at them with respect to different populations.

Mrs. CHRISTENSEN. We had a big major battle in trying to make that happen, but I think we were successful.

Mr. PALLONE. Thank you. Mr. Murphy.

Mr. MURPHY of Connecticut. Thank you, Mr. Chairman. I think one of the most exciting things about the more broader comprehensive health care debate that is happening right now is that we are focusing not just on the financing piece of the equation but also trying to challenge Congress to step up and look at the way we deliver health care. And one of the, I think, emerging consensus points is the role of primary care providers in that equation, and our lack

of focus on trying to give those primary care doctors the space with which to really engage in good preventive medicine.

One concept that has been talked a lot about is the medical home model which would give primary care doctors a much greater role in coordinating care. And it strikes me that to the extent that we are going to return to a much more primary care based model it is an opportunity for public health as well. And so my question to both of you is simply this. What is the space in which a greater focus on primary care intersects with public health and what are the things that we need to do as a Congress to try to create a greater role for primary care physicians to be able to do real coordination with public health systems that surround them? I will ask Dr. Besser first and then Dr. Fielding.

Dr. BESSER. Thank you, Mr. Murphy. I spent 5 years as a pediatric residency director in California and served on a commission that was trying to see what we could do to encourage more people to go into primary care. Clearly, there are major gaps in the number of primary care physicians in this country and in particular in isolated areas that contribute to disparities. I think to make primary care more attractive in addition to the balance on reimbursement being different than what it currently is, we need to have community services available that primary care physicians can tie into, so that when they see an adult with pre-diabetes they can connect to something in the community that will help address that issue.

I visited Vermont a couple weeks ago and was exposed to the Vermont blueprint for health, and what they are experimenting with is just that, how do they—they have a system where if they have a patient who has a medical condition that has partially a community solution, they can connect to a team in the community to address that. And it is profound what that does in terms of your ability as a primary care physician to impact on the health of your patients.

Mr. MURPHY of Connecticut. Dr. Fielding.

Dr. FIELDING. Yes, I would agree entirely. We need to have ways of interfacing between those in primary care and those in public health who are doing community services. When I say public health, it is not just governmental public health, it is all the voluntary agencies and the other supporting and social agencies that are equally important and that aren't always well coordinated. There is a real problem in getting those in training to go into primary care. And I think the reimbursement issue is probably going to have to be addressed if we are going to redress some of that balance between those who want to go into specialty care and those who want to do primary care.

But I also feel it is important to point out that even if we have good primary care and good linkages unless we are addressing the other determinants of health, we are not going to become the healthiest Nation. We are going to be still pretty low on that list despite spending $1 out of $6 on health care. So the question is, and one of the things that would be helpful would be to have the physicians who are more understanding and knowledgeable about public health, I think the amount of training that a physician has, for example, in public health as part of their residency, as part of

their medical school, varies tremendously, and in some cases not very much, so they don't have an understanding of how there can be a better fit between what goes on in the office and what goes on in the community.

Mr. MURPHY of Connecticut. Thank you for those responses. Dr. Fielding, I want to take a right turn and just move to a different subject and ask your quick thoughts. About the structure of health care delivery through the public sector, in Connecticut we have a very disjointed system where we have some municipal offices of health, we have some regional offices of health, and in more rural areas we have part-time offices of health where there is just a doctor, a physician in the community, who is that local health director. And it is of great worry to me that if something big and terrible was to happen that we might not have the sort of aligned and consistent infrastructure to respond. I would ask very quickly if that is a concern of yours and to Dr. Besser as well.

Dr. FIELDING. It is a real concern. There is great diversity in the capacities. One of the things that I think has to happen is there has to be some coalesce. There need to be networks. Whether you want to do that structurally or simply through memos of agreement and joint training or whatever, but we have too many. In some cases we have departments with very, very limited. The accreditation process will help that that will coalesce, will push people to try and come together but there needs to be statewide and even regional systems around metropolitan areas where people can respond as one.

Mr. MURPHY of Connecticut. Thank you very much. I yield back, Mr. Chairman.

Mr. PALLONE. Thank you. Ms. Eshoo.

Ms. ESHOO. Thank you, Mr. Chairman. I guess the benefit of staying for a long time in a hearing is that you get to hear a lot, and I appreciate what you have said, both in terms of your testimony, and I respect the work that you do. It seems to me that we already know a lot. It doesn't mean that we shouldn't continue to comply to do the research that is necessary, to drill down, to understand better the composition of a community, what the various factors are that contribute to the bad outcomes that we know that we have, and so I support all of that. I am looking forward to a really great surgeon general of the United States because I think we need someone that is going to really market public health and what we can do.

Now I think that we have a lot of structure. I am not saying that we shouldn't add to it and make sure that we target our investments very well, but we also know what the tremendous contributors are to very poor public health. I mean is there any community in the country, rich or poor, black, white, green, purple, yellow that benefits from smoking? I mean we just know that it is bad. It is worse in some communities because they are targeted. They are targeted because they may be uneducated, because they are poorer, because they are that much more vulnerable. What community is it terrific to be overweight? I mean we know what obesity does. We know what it does in children. We know what it does in adults. Everything from heart attacks to juvenile onset of diabetes and on and on. I think that the public health system in the country really

needs to concentrate or take a fresh look at how you can do better marketing.

Don't you think it would be powerful to do even ads that show maybe a bag of sugar, a 10-pound bag of sugar? I mean where is it—children are sweet by nature but they don't need to consume 40 to 60 pounds of sugar, refined sugar, a year, in order to be sweeter or better or healthier. So I think that there are some things that we may be overlooking that are very, very powerful messages, and I don't know, there must be a national association of public health directors in the country. Why not look at some of this outreach money from the stimulus package that will really target those communities that are being mauled by these terrible things.

It is more of a statement than a question. I was very taken with the public health service did in Japan. They required adults, men and women, to come in and have their waist measurements taken, and if they were over a certain number of inches for males, over a certain number of inches for females, they had to go back in 3 months to have that taken again. Why? They made a pointed effort to bring it to every person that if they are overweight that they are subject to that we may not be able to do that in our country that way. But the whole issue of food stamps. Why don't you all come out with a great campaign and come here and advocate the hell out of the Congress and say let us link obesity and food stamps and do something about that together?

So while my colleagues have come up with a hundred good items today, I think that we need to look at just marketing the heck out of the country on some of these things that we know are bad, awful, that are killers, that are contributors to the heavy, heavy costs in our system and to the agony and tragedy that takes place in families and also to give kids a chance, give kids a break. So, I don't know, you may not want to respond to that. I got 20 seconds left. I think that you have some power that you may be overlooking to tell you the truth, and I want you to have the maximum amount of dollars to do what needs to be done. I am not going to go into that. But do you have anything to say about this? Do you have anything that you can tell us that you are going to be marketing as kind of the marketing directors for public health across the country?

Dr. BESSER. Two comments. Thank you for that statement. One is that I think you are on target that for many things we know what works, and we need to implement it. And what we are working on with the stimulus dollars is implementing evidence-based programs.

Ms. ESHOO. Yes, I don't want any wild marketing that can't keep a promise or isn't based in sound science, but it seems to me we got a pile of science about some of these things already.

Dr. BESSER. The other comment I want to make is that there is a $20 million pilot in the Farm Bill to look at what you can do to promote healthy food in food stamps. And we have seen improvements in WIC and hopefully there will be evidence that doing that with food stamps will also be effective.

Ms. ESHOO. Well, you know, see, I kind of disagree with that. I think that that has got to be the slow man's approach in order not to go anywhere. We know that food stamps purchase junk in plain

English and it seems to me that the public health directors in the country would be a great antidote to the lobbyists that come here and say really this junk is OK, but let us do a study in a slow walk. So you can tell where I am headed. I have a legislative impatience, but I think outside of legislation but advocacy in some of these areas here that we could really make some headway. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. Mr. Gonzalez.

Mr. GONZALEZ. Thank you very much, Mr. Chairman. And to the witnesses, thank you for your testimony. We are having hearings, multiple hearings, just about every week in preparation for what will be landmark legislation, health care reform, so in the context of that, first, a general proposition is what is the role of public health, but specifically and in the context of what we are contemplating doing here in Congress, which I know that you have been following because there is impact to you, but I guess not everyone agrees that we should have this reform and surely not everyone—we will have witnesses that will follow you that don't agree even about your particular role. There are some that believe that for contagious diseases public health has an appropriate role but when it comes to treatment and prevention of chronic diseases that public health does not.

And I believe that one of the witnesses will testify specifically to that. I could be incorrect about that, but that is the first question. What is the role when it comes to contagious versus chronic? It really kind of sets the stage for what is the appropriate role for public health. And, secondly, there are those that are saying, well, if we do revolutionize the availability of access to health insurance with a public option that has tremendous impact, and so I want to know what you bring to the table. What does public health bring to the table in this greater equation when it comes to expanding where we were talking about accessibility, affordability, and quality health care as we attempt to fashion legislation?

Dr. BESSER. Thank you very much for that question, and I think it is a fundamental question that we are dealing with today, and that is what is the relative roles between access to care and providing health care services and public health which focuses on prevention and health promotion. I think that if we solely look at access to care, and don't get me wrong, access to care is critically important, but if we only look at access to care, we are not going to see an improvement in the health status of our Nation in the long run. We need programs that are looking at what is driving the diabetes epidemic, what is driving the rise in heart disease, what is driving these issues. And that is where public health comes in.

If our entire country has access to care, we still have a critical role for public health setting aside the health protection issues of emerging infectious diseases and responding to public health emergencies. Public health is responsible for ensuring that the environment we live in is healthy and looking to ensure that there aren't toxins in the environment that are putting people at risk. Public health looks at addressing disparities. Even with access to care, there will be disparities that need to be addressed by the public health community. Public health is critical for occupational safety

and health and ensuring that the work environments in our community are safe.

And we know through so many programs that public health can have a dramatic impact by promoting health, by addressing those issues of physical exercise, nutrition, and smoking. We keep hearing those three. Those are the big three. There are also additional ones, alcohol use, substance abuse, but public health and what public health does within the community setting is fundamental to ensuring that in the long run we are spending less on health care and that our population is healthy.

Mr. GONZALEZ. Thank you.

Dr. FIELDING. I think Dr. Besser said it extremely well. Our job is to provide conditions in which people can be healthy, and we are going to get there just by increasing access as important as that is. We also need to be clear what we are talking about when we talk about public health. I think we have been using it here in different ways. One way is governmental public health, very important. The state and local public health agencies, that is the core infrastructure. But public health also means working with non-profits, working with businesses, working with voluntary organizations at the community and state and national level.

And we need that broader conception of public health to be effective, but we are not going to solve a tobacco problem or unintentional injuries or substance abuse problems just by providing more medical care. We have to focus on the prevention side. We have to focus on the community support side and that can't all be done through the health care system. We have already medicalized perhaps too much and it is time perhaps to redress that balance.

Mr. GONZALEZ. Thank you. Mr. Chairman, I have a minute left, and I just really want to make a statement in appreciation for some of the things that you have said. You have eluded though to health information technology or electronic medical records. I can think of no greater beneficiary than public health in making sure that we have wide acceptance and adoption of HIT. It is called information gathering, analysis and dissemination which is basically the essentials in what you all do, so I commend you, thank you for your comments, and I hope that you will be pushing hard every initiative that we have regarding the adoption of HIT. I yield back.

Mr. PALLONE. Thank you. The gentlewoman from Florida, Ms. Castor.

Ms. CASTOR. Thank you very much. Yesterday morning I visited a community health center in my district in Tampa and we were announcing additional recovery funds, grants, under President Obama's recovery plan. The Tampa Bay area community health center has received a little more than $3½ million. The center I visited, they are going to hire doctors and physician assistants and nurses, and they are very appreciative, and they will be able to see more patients. And they took me on a tour afterwards, and I was not aware that all of the community health centers in most of the urban areas in Florida have already converted to electronic medical records. And they raved about it. They said we really are able to provide better patient care.

They also said we are able to cut down on fraud because there is a picture of each patient. If they have someone come in and ask

for certain pharmaceuticals and the picture doesn't match that they call security. But following up on some of the discussions there are requirements in place right now for health centers and other providers to collect data and to transmit it, whether it is a community level, a state health level or to the National Center for Health Statistics that you mentioned, are there requirements in place now?

Dr. BESSER. No. Within particular states and localities, there may be individual requirements but at a federal level there is not a requirement for reporting of that information. When I was talking earlier about the National Health Safety Network that is looking at infections in health care settings, that is a voluntary system of collaboration between states or health care facilities and the CDC. I look forward to a day when all of our health care settings are connected electronically and that information is flowing to public health at all levels because that can really have a dramatic impact on improving health.

Dr. FIELDING. There is one exception though and that is reportable diseases through the states and to the Centers for Disease Control, and one of the real advantages of having electronic systems that work through laboratories is that we get much faster reporting and much more complete reporting because it is one thing if you have to ask a busy doctor to fill out this report and send it in, and maybe it comes in and maybe it doesn't and maybe it is timely and maybe it isn't. When you are getting direct feeds from the laboratory as we are in Los Angeles County from a lot of the large laboratories, we know about identification of problems of reportable diseases much more quickly and are able to get a jump on them. And from the standpoint of controlling outbreaks and potential epidemics, that is a crucial advantage.

Ms. CASTOR. So as we build this infrastructure, there needs to be data collection points. What is the logical location? Is it community based, state based? Is it reporting to this National Center for Health Statistics? How do we build that infrastructure? What is your recommendation?

Dr. BESSER. There are a number of different models that look at this and there are several critical pieces. As Dr. Fielding was saying, being able to transmit laboratory data that way is essential to early detection and control of outbreaks. But creating a health information community so that the data can be viewed at different levels. It can be viewed within a health system. It can be viewed at the local or state public health level. It can be viewed at the federal level. Clearly, there have to be protections within those systems that protect the identity of individuals but having that kind of common space for looking at data would have enormous benefits.

Ms. CASTOR. OK. In my 1 minute that I have left, Dr. Besser, you have experienced environmental justice issues. Can you provide your priority recommendations for health care reform and public health relating to environmental justice in 1 minute or less?

Dr. BESSER. Thank you. Clearly, health is not something that takes place in a doctor's office. It takes place in all settings, and we have to ensure that our population is living in healthy environments. So looking at schools, work places, where you reside is critically important, and that is an essential protective value of public health. Public health is there to look to ensure that our commu-

nities are safe. From an environmental perspective, we need to make sure that we are not being exposed to chemicals and toxins that could impact on our health, and the resources need to be there for public health at all levels to fulfill that function.

Ms. CASTOR. Thank you very much.

Mr. PALLONE. Thank you. Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman. Thanks for your testimony today. I am fighting the same battle you are, Mr. Chairman, with my kids and getting them outside, and so I wanted to pick up on that theme and develop it a little bit more because there is such huge benefits to getting our kids outdoors. I have authored something called the No Child Left Inside Act, which I invite you to learn more about. It began with a coalition of 12 organizations in Maryland. We now have 1,200 organizations across the country that represent 40 million members among them, and this coalition is comprised of educators who understand that when you get kids outdoors and have a chance to apply what they are learning outside, thy learn better. It consists of environmentalists, of course, who want the next generation to have a heightened awareness of the environment typically when we are facing issues of climate change.

But it is also comprised of many, many public health advocates who recognize that getting kids outdoors and engaging them, not just saying go outside, but giving them a reason to be there and excited about being outside is fundamental to improving their health, health of the next generation. And so I would for starters invite you to join the coalition and be a supporter of that. But the information that underpins the effort is showing, for example, that the average child today spends 4 to 5 hours indoors on television, the Internet, the video games, and notwithstanding the arrival of Wii and its contribution to physical exercise in a virtual world, there are still reasons to get kids outdoors.

The data also shows that kid spend an average of about 4 minutes a day outdoors in unstructured play and recreation. We have predictable consequences for their health, both in terms of attention span and their physical health and so forth. So I am very excited about the potential to link our efforts with No Child Left Inside, which is to try to create a federal source of funding, grant funding, to promote environmental education to really integrate it in the instructional program across our public school system to get kids outdoors to link that effort to the public health effort.

And what I would love to hear you speak about for just a few moments is the extent to which you think environment education efforts of that kind can represent kind of a leading edge of public health effort with respect to the next generation in particular although I will add that when you talk to these kids who have gotten so jazzed and engaged by being outdoors, they are telling you that they are going back to their families insisting that their parents and their siblings go for hikes on the weekends and get outdoors. So they are dragging the rest of their family into the light at a time when we need that for so many reasons.

So I wonder if you have brought this lens in thinking about public health and maybe a revolution of public health, this lens on edu-

cation and environmental education in particular to the effort. And I invite either one to address it.

Dr. BESSER. Thank you, Mr. Sarbanes. First, I love the title No Child Left Inside and look forward to reading more about that particular legislation. I think that this fits in very well with our view of how public health can contribute to health and the idea that health occurs in all settings. Schools that foster a culture that values the environment, that values getting out into the environment will create adults who do the same and that will be a more active society and a healthier society. The Academy of Pediatrics has standard recommendations on how much time should be allowed in front of a television or a computer screen but your point is very well taken that there have to be alternatives to that.

When I talk to a parent about getting their child outside to play either on structured play or on team play if those options aren't available there is not a lot of value in my spending that time with that parent going through that counseling, so I look forward to reading about your legislation. I think the intent of it is right on target in terms of promoting health in all areas.

Mr. SARBANES. We will make sure it is on your desk when you get back to your office. Mr. Chairman, I won't name the particular video game that does this, but it is not atypical, and there is one game in particular where I think after about an hour of playing on it, it invites the child to blink their eyes, close their eyes and open them 10 times before they embark on the next level of the game and so this is meant to represent the compensation for the fact that they are not getting exercise or need a break from that virtual engagement, so we have got a lot—and I just want to say obviously the next generation has to be well versed in technology. That is not what I am talking about. We are trying to achieve a balance at a time when things are way out of whack. I yield back my time.

Mr. PALLONE. Thank you. You are right. Ms. Baldwin.

Mrs. BALDWIN. Thank you, Mr. Chairman. As you have heard, our committee has had a lot of focus on addressing health care disparities especially based on race and ethnicity, and you have already been questioned a lot about those issues. I believe that there are serious health disparities that exist based on sexual orientation and gender identity and that belief is based on much input from and discussion with leaders of community-based organizations that provide direct services to lesbian, gay, bisexual, and transgender youth and adults, and also based on some of the few local survey tools that actually ask questions. But it is really quite frustrating to get a clear understanding of the scope of these disparities because most of the data collection tools at the national level don't ask questions about sexual orientation or gender identity.

Dr. Besser, you have noted that you have learned about the importance of tracking health data and monitoring changes in health. I am wondering if you are aware that the national health interview survey, the federal government's most comprehensive and influential survey, does not include a question on either sexual orientation or gender identity.

Dr. BESSER. That is not something that I was aware of but something that I think I need to learn more about. Clearly, if we are

going to address a particular health issue, we need data to be able to look at that clearly.

Mrs. BALDWIN. Would you support adding such a question to that survey tool if you find that it indeed doesn't exist?

Dr. BESSER. What I would like to do is understand first whether it is there and, if not, why it is here, whether there are any legal restrictions to collecting any particular data. I think that in order to make informed health decisions, we have to know. In addition, I think we need to do work on the health care delivery side to improve the core competencies of health care providers to address issues of gender and sexual orientation. My experience coming through medical school and even as a residency director, it is not something where there is a lot of education in how to address those issues.

Mrs. BALDWIN. I think that is a very important companion inquiry. I want to share that it is my understanding that none of the surveys that are conducted through the National Center for Health Statistics inquire about issues of sexual orientation or gender identity, and it is my understanding that the only mention of such issues in the 2020 objectives is that there is a statement basically that we need more data on LGBT populations because we cannot currently understand the depth of the problem. So I think we have a very serious issue that it is really hard to make evidence-based recommendations when you are not collecting any evidence. Can you tell me in any way right now how does the CDC currently track and monitor the health of the LGBT population?

Dr. BESSER. I can't answer that question, but I will get back to you on that. I think that is an important area for us to be pursuing.

Mrs. BALDWIN. I have some time left, and I want to ask some really broad questions about the public health infrastructure. I wonder if you could each give me an assessment of the current local, state, and federal public health surveillance system, what you think the infrastructure status is right now. As I noted in my opening statement, I author a bill with my colleague, Congressman Terry, to make some infrastructure investments there. And the second quick comment I would like you to make is whether epidemiology struggles with the same work force shortage issues that we are seeing in the medical system generally.

Dr. BESSER. Addressing your second question first, since it is an easy one, there are major gaps in our public health work force and a number of organizations have developed estimates of how great those gaps are. Of great concern is with the current state of our governments at all levels, we are seeing a loss of the work force at the state and local level, tens of thousands of state and local public health employees who will be let go and so that is a gap. Your question about surveillance, I will answer briefly and would be happy to follow up in more detail but there is great variability in our ability to detect laboratory capacity is extremely variable. Some states have wonderful systems. Others are much more rudimentary, and we need a system that protects our entire country.

Dr. FIELDING. Let me just add a couple of things to that. We also have pipeline issues, not just those that are being laid off because of the economic climate but in epidemiology, laboratorians and

those that can do the analysis work as those techniques become more and more sophisticated there is serious gaps in that. With respect to surveillance, I think that we need to be very broad in what we look at. Increasingly, we need to look at the environment and a lot of aspects of the environment. Some of that is the physical environment, some of that is the social environment, and we need to have good core indicators to look at those. With respect to the LGBT community, we have done some—we have, in fact, in Los Angeles asked those questions in our survey and find that there are serious gaps in the delivery system, found, for example, that the highest rate of tobacco use was among the LGBT community, and have, in fact, devoted specific programs to some of the problems that we found.

Certainly, with respect to HIV, you know, in Los Angeles County a very disproportionate burden is on men who have sex with men. So I think that information is very important information and we can't develop effective programming without that.

Mr. PALLONE. Thank you. I think that concludes our questions and thanks for bearing with us. I know we have a lot of members of the subcommittee now. When they all show up it goes on a for a while. But this is very helpful, and I don't think that we stress public health enough but it is also difficult to get a handle on what exactly we should do. But I think you gave us some very good ideas so thank you very much.

Dr. FIELDING. Thank you very much. Mr. Chairman, if you can indulge me just 30 seconds. I just want to make the point that if we do the things that we already know work in terms of things from the community guide and the clinical guide, we can save very many lives today with what we know, not that we don't have to know more, but we need to make sure we put in place what we know. And that has not been fully done and I think we need more work to get that out to everybody who can work on it. Secondly, I would like to suggest that the Partnership for Prevention, which is a good non-profit here has suggested some model legislative language for health reform in the areas of public health and prevention. If you don't mind, I would submit that for the record so that others can——

Mr. PALLONE. We would certainly appreciate that. Without objection, so ordered.

Dr. FIELDING. Thank you so much.

Mr. PALLONE. And thank you both.

Dr. BESSER. Thank you, Mr. Chairman.

Mr. PALLONE. I appreciate it. Let me welcome all of you, and I will just basically introduce each of you. From my left certainly no stranger to this process is Commissioner Heather Howard, who is the Commissioner of the New Jersey Department of Health and Senior Services. Thanks for being here today, Heather. And then we have Dr. David Satcher, who is the former U.S. Surgeon General, and now Director of the Satcher Health Leadership Institute at Morehouse School of Medicine. And then we have Dr. Barbara Spivak, who is President of Mount Auburn Cambridge Independent Physician's Association, and Dr. Devon Herrick, who is Senior Fellow at the National Center for Policy Analysis, and, finally, Dr. Jef-

frey Levi, who is Executive Director of the Trust for America's Health.

And, as I said before to the previous panel, we ask you to basically make a presentation for about 5 minutes and then we will have questions from the panel. And I will start with my New Jersey Commissioner Heather Howard.

STATEMENTS OF HEATHER HOWARD, J.D., COMMISSIONER, NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES; DAVID SATCHER, M.D., PH.D., FORMER U.S. SURGEON GENERAL, DIRECTOR, SATCHER HEALTH LEADERSHIP INSTITUTE, MOREHOUSE SCHOOL OF MEDICINE; BARBARA SPIVAK, M.D., PRESIDENT, MOUNT AUBURN CAMBRIDGE INDEPENDENT PHYSICIANS ASSOCIATION, INC.; DEVON HERRICK, PH.D., SENIOR FELLOW, NATIONAL CENTER FOR POLICY ANALYSIS; AND JEFFREY LEVI, PH.D., EXECUTIVE DIRECTOR, TRUST FOR AMERICA'S HEALTH

STATEMENT OF HEATHER HOWARD

Ms. HOWARD. Good afternoon. Thank you, Chairman Pallone, Ranking Member Deal. New Jersey is very, I have said it before but it bears repeating, we are very lucky to have your leadership, Chairman Pallone. I am pleased to be here today as the Commissioner of the New Jersey Department of Health and Senior Services, and also as a representative of the Association of State and Territorial Health Officers. I represent more than 50 public health officers today. We know that public health has been the cornerstone for most of the health achievements of the 20th Century. Advances in maternal and child health, sanitation and clean water, immunizations, infectious disease control, food safety, declines in death from heart disease and stroke and environmental health protection, these were all spearheaded through public health initiatives.

During the 20th Century, the health and life expectancy of people living in the U.S. improved dramatically. According to the CDC, 85 percent of that increase, fully 25 of the 30 years gained in life expectancy is attributable to public health. So I am optimistic today that we are talking about the importance of public health, and I am optimistic that significant health reform is going to happen this year and it is long overdue. Part of that health reform package together with universal health insurance coverage and health systems reforms must be a strengthening of our capacity to protect public health, to encourage wellness and to prevent illness.

Too often when we talk about health policy in the United States, we talk primarily about the financing of health care and we don't focus as much on improving health and preventing disease. That is why today's hearing is so important. We know that nearly 80 percent of our health care dollars are spent on chronic illness, and until we do what we need to do to improve the health of all Americans, we will never be able to get those costs under control. We need to take a system approach to prevention. Everyone should have access to essential preventive services and screenings, and we need a public health work force to deliver that basic package.

These investments in public health and prevention are essential elements in transformation of health reform.

In fact, a focus on public health is what will make health care reform sustainable, both as finances and improving people's well being. As we enhance prevention by preventing and managing chronic diseases better and reducing obesity rates, we will reduce skyrocketing health costs and achieve significant cost savings over the long run. Simply put, public health both improves lives and saves money, and health care reform cannot be successful without a strong public health foundation. It is clear that President Obama and the Congress understand this critical link because of the $1 billion investment in the Recovery Act and the creation of a prevention and wellness trust. I want to thank the members here for that achievement.

As the President has said, investing in prevention will lower health care costs, improve care, and lower the incidents of heart disease, cancer, asthma, and diabetes, which are among New Jersey's leading killers just as they are around the Nation. Public health is the responsibility of all levels of government starting at local and county level through the state and to the federal government, but the role of a state public health agency is distinct. We must work to ensure a clean and healthy environment for the entire community. The state public health system ensures that the water along the Jersey shore is safe to swim in and that the beaches are clean, something I know is very important to the chairman. The state public health system ensures that the water we drink is safe and that our children play in day care centers that are free of hazardous contaminants.

One of the ways that state public health agencies work to reduce health disparities is by promoting healthy lifestyles, providing services like services like tobacco quit lines for those who want to kick the habit and obesity prevention programs. Recently, I visited several WIC clinics, that is the Women, Infant and Children program, as part of a public education campaign to promote healthy mothers and healthy babies, and I saw first hand the valuable work that peer counselors do to promote breastfeeding and provide new mothers with the support and education they need to successfully breast feed their babies.

In addition, thousands of women at these clinics learn the importance of feeding their family nutritious meals. Just this year, WIC will soon be introducing fruits and vegetables as part of the basic food package. That is a reform that is long overdue, and I am sorry Congresswoman Eshoo is not here. She was talking about the importance of improving what we do with food stamp dollars, but we are doing that already with our WIC dollars. This healthy mothers equals healthy babies campaign was a key recommendation of a prenatal care task force I created to improve access to early prenatal care for women across New Jersey.

We know that public health has been responsible for a 90 percent reduction in infant mortality over the last 100 years but as a public health leader, I recognize there is more to be done until all children are born with a healthy start in life, and when we know that in New Jersey a black infant is more than 3 times as likely to die in its first year of life than a white infant, we have more work to be

done. In addition to educating the public about public health the New Jersey Department of Health is responsible for testing chemical and biological agents in its lab and coordinating the state's response to a flu pandemic that would immobilize business, cripple the food supply, and sicken millions.

The state public health agency is also responsible for licensing, regulating, and inspecting nursing homes and hospitals, insuring access to quality health care for everyone, reducing the incidents of adverse medical events and supporting our safety net providers. In short, the state public health agency is where the rubber hits the road in terms of protecting and promoting the health status of New Jersians and all across the country. Let me give you a few key examples. Mr. Chairman, I know that food safety is one of your top priorities and you have worked with your colleagues to introduce a comprehensive bill to reform the FDA. We need to look no further than the recent salmonella outbreak to know how important our work is in this area.

When New Jersey was at the center of the anthrax attacks in the fall of 2002 the state's health department lab functioned as New Jersey's only CDC approved facility in the quest to identify anthrax. During this national crisis, the state lab rotated teams of trained scientists working 15-hour shifts for 2 months processing more than 3,000 specimens and positively identifying 106 samples for the presence of anthrax. Since then, New Jersey has developed a national reputation as a leader in emergency preparedness. We are developing and implementing a statewide response to public health emergencies and with critical federal financial support we built a health command center, the first and only facility of its kind in the Nation which coordinates situational updates, medical assets, and resources to provide a timely and efficient response to an emergency.

Coordination among federal, state, and local agencies is also key in addressing environmental conditions that can threaten the public health of our residents. New Jersey is the most densely populated state in the Nation and many of our residents live in an urban environment where the potential for exposures to hazardous chemicals and contaminants is a very real threat. We have an estimated 20,000 contaminated sites and more superfund sites than any state in the Nation. Because of this, the work of the department is so important to coordinate with the federal, county, and local partners to protect the public health by preventing potential exposures to harmful environmental substances. Just 2 years ago after high levels of mercury were discovered in a day care center on the site of a former thermometer factory the public health system responded by closing the center.

Then Governor Corzine quickly enacted legislation requiring the department to establish evaluation and assessment procedures for the interior buildings used as day care centers——

Mr. PALLONE. I am going to have to ask you to summarize a little bit.

Ms. HOWARD. Wrap it up?

Mr. PALLONE. Yes.

Ms. HOWARD. Well, thank you. There are many other examples of how we are working together, many other great examples of New

Jersey, but in sum, as I said earlier, I am extremely hopeful that transformation of health reform will happen this year and that will include a strengthening of our capacity to protect the public health, to encourage wellness, and prevent illness. I look forward to working with you.

[The prepared statement of Ms. Howard follows:]

New Jersey Health and Senior Services
Commissioner Heather Howard
Making Health Care Work for America's Families:
Protecting the Public Health
House Energy and Commerce Health Subcommittee
Tuesday, March 31, 2009
Washington, DC
10 am

Good morning Chairman Pallone and Distinguished members of the House Energy and Commerce Health Subcommittee.

I am pleased to be here today not only as the Commissioner of the New Jersey Department of Health and Senior Services, but also as a representative of the Association of State and Territorial Health Officers.

I am honored to have this opportunity to discuss the unique role that state public health agencies play in protecting our nation's health. Public Health has been the cornerstone for most of the health achievements of the 20th Century. For example -- advances in maternal and child health, sanitation and clean water, immunizations, infectious disease control, food safety, declines in deaths from heart disease and stroke and environmental health protections -- these were all spearheaded through public-health initiatives.

During the 20th century, the health and life expectancy of people living in the United States improved dramatically. According to the CDC, 85 percent of that increase in Americans' life expectancy since 1900 – 25 of the 30 years gained -- is attributable to public health.

I am optimistic that significant health reform is going to happen this year, and it is long overdue. Part of that health reform package—together with universal health insurance coverage and health system reforms—must be a strengthening of our capacity to protect public health, to encourage wellness and to prevent illness.

Too often, when we talk about health policy in the United States, we talk primarily about the financing of health care. We don't focus as much on improving health and preventing disease. And that is why today's hearing is so important.

Nearly 80 percent of our health care dollars are spent on chronic illness. Until we do what we need to do to improve the health of all Americans, we will never be able to get those costs under control.

We have to take a system approach to prevention. Everyone should have access to essential preventive services and screenings. And we need a public health workforce to deliver that basic package. These investments in public health and prevention are essential elements in transformational health reform.

In fact, a focus on public health is what will make health care reform sustainable—both as far as finances and improving people's well-being. As we enhance prevention—by preventing and managing chronic diseases better and reducing obesity rates—we will reduce skyrocketing health care costs and achieve significant cost savings over the long run.

Simply put, public health both improves lives and saves money.

And healthcare reform cannot be successful without a strong public health foundation.

It is clear that President Barack Obama and the Congress understand the critical link between public health and health reform because of the $1 billion investment the American Recovery and Reinvestment Act makes in the creation of a prevention and wellness trust. As the President has said, investing in prevention will lower health care costs, improve care and lower the incidence of heart disease, cancer, asthma and diabetes, which are among New Jersey's leading killers, just as they are around the nation.

Mr. Chairman, I know that your committee has held three previous hearings on health insurance access, disparities and other health reform issues, and I want to commend you and the members of this committee for your leadership and commitment in continuing that discussion with a focus today on the role of public health in health reform.

Public Health is the responsibility of all levels of government—starting at the local and county level, through the state, to the federal government. But, the role of the state public health agency is distinct.

States ensure a clean and healthy environment for the entire community. The state public health system ensures that the water along the Jersey Shore is safe to swim in and that the beaches are clean. The state public health system ensures that the water we drink is safe and that our children play in day care centers that are free of hazardous contaminants.

States play an important coordinating role to bring partners and coalitions together and that leads to sustainability of initiatives. The state public health agency is responsible for health equity. Reducing the unacceptable gaps in disease prevalence and death rates among minority and multicultural populations is a core mission of state public health agencies.

One of the ways that state public health agencies work to reduce health disparities is by promoting healthy lifestyles, providing services like tobacco quitlines for those who want to kick the habit and obesity prevention programs.

This fall I visited several Women, Infant and Children (WIC) clinics as part of a public education campaign to promote healthy mothers and healthy babies and I saw first hand the valuable work that peer counselors do to promote breastfeeding and provide new

mothers with the support and education they need to successfully breastfeed their babies.

In addition, thousands of women learn the importance of feeding their families nutritious meals. And, WIC will soon be including fruits and vegetables as part of the basic food package—a reform long overdue.

The *"Healthy Mothers Equals Healthy Babies"* campaign I undertook was a key recommendation of a Prenatal Care Task Force that I created last year to improve access to early prenatal care for women across New Jersey. Public health has been responsible for a 90% reduction in infant mortality over the last 100 years, but as a public health leader I recognize there is more to be done until all children are born with a healthy start in life.

In addition to the task of health education, New Jersey's public health agency is responsible for testing for chemical and biological agents in its lab and coordinating the state's response to a flu pandemic that would immobilize business, cripple the food supply and sicken millions.

The state public health agency is also responsible for licensing, regulating and inspecting nursing homes and hospitals, ensuring access to quality health care for everyone, reducing the incidence of adverse medical events and supporting our safety net providers.

In short, the state public health agency is where the rubber meets the road in terms of the health status of all Americans.

Let me turn to a few key areas that illustrate this notion.

Mr. Chairman, I know that food safety is one of your top priorities and that you have worked with your colleagues and introduced a comprehensive bill that would reform the Food and Drug Administration.

I am pleased also that the President has formed a Food Safety Working Group to upgrade our food safety laws for the 21st Century, and his proposal to consolidate the responsibilities of multiple agencies into one will sharpen the focus on food safety and likely mean additional resources.

The outbreak of e-coli in spinach a few years ago and the recent salmonella outbreak—the largest in U.S. history—with nearly 700 cases in 46 states—are dramatic examples of what happens when the public health system breaks down

When public health laws are not enforced and the system is overwhelmed—with 60 food safety workers responsible for inspecting more than 10,000 sites—the result is a nationwide outbreak where hundreds of people get sick and some die, often the young, the weak and the elderly.

When New Jersey was at the epicenter of the anthrax attacks in the fall of 2001, the state health department's lab functioned as New Jersey's only CDC-approved facility in the quest to identify anthrax. During this national crisis, the state lab rotated teams of trained scientists working 15 hour shifts for two months, processing more than 3,000 specimens and positively identifying 106 samples for the presence of anthrax.

Since then, New Jersey has developed a national reputation as a leader in emergency preparedness. Its division of Health Infrastructure Preparedness and Emergency Response is responsible for developing and implementing the statewide response to public health emergencies. With critical federal financial support, the Department built a Health Command Center—the first and only facility of its kind in the nation—which coordinates situational updates, medical assets and resources to provide a timely and efficient response.

Coordination among various federal, state and local agencies is also key in addressing environmental conditions that can threaten the public safety of our residents.

New Jersey is the most densely populated state in the nation. Most New Jersey residents live in an urban environment where the potential for exposures to hazardous chemicals and contaminants is a very real threat. We have an estimated 20,000 contaminated sites and more Superfund sites then any state in the nation.

Because of New Jersey's industrial past, the work that the Department does to evaluate and monitor contaminated sites—in coordination with our federal, county and local partners— protects the public's health by preventing potential exposures to harmful environmental substances.

Let me give you an example of our work in this area.

After high levels of mercury were discovered in a day care center on the site of a former thermometer factory, the public health system responded by closing the center. Legislation—considered the first of its kind in the nation—was quickly enacted by Governor Jon Corzine requiring the Department to establish evaluation and assessment procedures for the interior of buildings used as day care centers and educational facilities.

Mr. Chairman, I know that environmental health has been a special area of concern for you. Our advances in protecting the people in New Jersey have been many, and most have been recognized as state-of-the-art and state-of-the-science.

The state public health system is also responsible for protecting children at the beginning of life.

A critical component of giving our children a healthy start is newborn screening.

Every state faces the challenge of expanding its newborn screening program to test for additional metabolic and genetic disorders.

New Jersey is among the top states in expanding its program. The state will soon mandate testing for 54 diseases or conditions, up from 20.

We know that early detection and treatment of these disorders can prevent life-long disabilities, including mental retardation, developmental disabilities, and life threatening infections. Without treatment, permanent disability—or even death—can occur. This expansion is a critical tool to ensure that newborns receive timely and appropriate services so that they have the best chances to survive and thrive, and to avert much more costly interventions later in life.

Through public health surveillance of birth defects and developmental disabilities including autism, the state public health agency works to ensure timely linkage with services for children with special health needs and their families.

New Jersey has the nation's highest prevalence of children with autism spectrum disorder. Through screening, the public health system is increasing the number of children who are identified early and enter appropriate developmental intervention services.

Each year in New Jersey, approximately 9,000 children are referred by the Department to specialized care including case management and development of individual plans that address each child's health, medical and social needs.

We know that when we intervene early in the life of an infant or toddler with a disability, we improve the ability of a family to meet the long-term developmental and health-related needs of their special child. We also save our health and education systems significant costs over the long run – yet another example of how public health both improves lives and saves money.

Mr. Chairman, we cannot talk about the important role of public health without talking about lead poisoning. Lead poisoning, despite incredible advancements in the 1970's and 1980's following the removal of lead from gasoline, is still a significant environmental threat to children, especially those who live in older housing stock in urban areas. New Jersey has a renewed focus on this critical threat and the Department's public health branch is working closely with our partners in other agencies—including housing—to implement the state's plan to eliminate lead poisoning.

For example, the Department is in the process of reducing our action level for environmental investigation and case management down to 10 micrograms per deciliter, recognizing that studies show that any elevated lead level in children can be damaging.

With support from the Administration on Aging, we are working with local agencies across New Jersey to implement an innovative model developed at Stanford University to help senior citizens to better manage chronic conditions. Our medical system has struggled to provide chronic secondary prevention services, and this program is an example of a public health intervention that complements the doctor-patient relationship by improving patients' ability to manage their own chronic disease.

Another important responsibility that is unique to public health is health education for the entire community.

When the Rapid HIV Test was first introduced in New Jersey, the Department began a health promotion campaign in 2004 to communicate the value of early and consistent testing and to increase the number of people who were tested—thus reducing the transmission of AIDS in New Jersey.

In the first year of the campaign, calls to the HIV/AIDS hotline increased 139 percent and 65 percent of those callers requested testing.

The Department's swift and successful implementation of Rapid HIV testing was honored by the Association of State and Territorial Health Officials (ASTHO) with its "Vision Award" in 2006.

Today, New Jersey has 158 test sites and 21 mobile vans. As of November 2008, more than 228,000 people have taken the Rapid HIV test.

As the salmonella outbreak illustrated so dramatically, much of the progress we have made in public health in the past century is now jeopardized by this unprecedented economic crisis.

While we provide cradle to grave public health protection to citizens, our state budgets are in crises. Budget cuts and vacancies in specialized areas like food safety are resulting in a public health infrastructure that is crumbling.

As I said earlier, I am extremely hopeful that transformational health reform will happen this year. That health reform package—together with universal health insurance and health system reforms—must include a strengthening of our capacity to protect public health, to encourage wellness and to prevent illness.

Thank you again Mr. Chairman and members of this committee for this opportunity to make the case that public health prevention is a critical component in transformational health care reform.

And now I would be happy to answer your questions.

Mr. PALLONE. Thanks a lot. Dr. Satcher.

STATEMENT OF DAVID SATCHER

Dr. SATCHER. Thank you, Chairman Pallone, Ranking Member Deal, and members of the committee for this opportunity. I appreciate the discussion that has taken place this morning around the public health approach to health system reform. I want to just say a word about my background because I think it may be the basis for some of the discussion. I had the opportunity to direct the Centers for Disease Control and Prevention from 1993 to 1998, served as Surgeon General from 1998 to 2002. Three of those years, I also served as assistant secretary for health which made me responsible for leading the development of health to 2010. As Surgeon General, I had the opportunity to release the first ever report from a Surgeon General on mental health but also to release the first report on sexual health, and finally in 2001 the report on overweight and obesity.

Since leaving government, I have had the opportunity to serve as founding chair of Action for Healthy Kids which focuses on programs in the schools to create the kind of environment that help children develop habits of healthy living. I have also served on WHO's Commission on Social Determinants of Health, and more recently on the Alzheimer's study group, co-chaired by Speaker Newt Gingrich and Senator Bob Kerrey.

I want to make four quick points. Today, I think based on our discussion the health care system is the patient, and the patient is clearly sick. You have talked about the problems of runaway cost, restricted access, questionable quality of care, and disparities in health, not just among racial and ethnic groups but different socio-economic groups, rural versus urban, and certainly disparities in the way we approach mental health when compared to physical health. I think in order to respond to these health systems problems we must revisit the major determinants of health. And again I think the four major determinants, access to quality health care, which according to our data, accounts for about 10 to 15 percent of the variation in health outcome, biological/genetics, which accounts for 15 to 20 percent, environment, both physical and social, accounting for 25 to 30 percent, and then human behavior or lifestyle, which accounts for 40 to 50 percent of the variation.

I point this out because any health system that is going to be effective must respond to all of these determinants, not just access to health care. Public health is the only approach that will allow us to respond to all of these determinants of health. Only a health system that is balanced at the community level that balances health promotion, disease prevention, early detection, and universal access to care including mental health parity. Finally, in order to implement such a system, I would make points of the following recommendation.

Clearly, we need the appropriate incentives in place. As you have heard, most of the incentives today are for the provision of medical care. That is very costly. We pay for procedures. We do not encourage students to go into primary care because primary care does not pay the way specialty care does if we are going to encourage people to go into primary care. We need to really reimburse appropriately.

I heard a recent example which is very interesting, and that is if we had a building that we were trying to improve, and it had, say, 12 to 15 stories, and we focus all of our attention on the 10th floor and not on the foundation, then that building would be very weak. Primary care, which coordinates public health and medicine, is in fact the foundation. A population database is critical and I strongly support the electronic health records system.

After Hurricane Katrina, one of the major problems we had was that most of the people who left New Orleans not only didn't know their diagnosis, not only did not know what medications they were taking, they didn't know the diagnosis, so we need an electronic health record, but it will also significantly improve data management for improving our system. We need a community-based collaboration for health care, and we need a work force that is balanced, balanced in terms of the different levels of health care and not just physicians but nurse practitioners, physician assistants, community health workers, a balanced work force. And that work force needs to represent a diversity of cultures and language, race and ethnicity. So, Mr. Chairman, I strongly recommend that we pay much more attention to public health as we move forward in this system, that we incentivize prevention and health promotion, as many businesses, by the way, are doing right now, and they are answering some of those questions about the cost benefits. So I again appreciate the opportunity. I look forward to the question and answer period.

[The prepared statement of Dr. Satcher follows:]

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Making Healthcare Work for America's Families: Protecting the Public Health

The Public Health Approach to Health Reform

Testimony to the House Energy and Commerce Committee

Subcommittee on Health

Chairman Frank Pallone Jr.

David Satcher, M.D., Ph.D

16th United States Surgeon General

Director, Satcher Health Leadership Institute at Morehouse School of Medicine

March 31, 2009

Introductory Remarks

To Chairman Frank Pallone Jr. and members of the Subcommittee on Health of the House Energy and Commerce Committee, I appreciate this opportunity to join you as you discuss Making Healthcare Work for America's Families: Protecting the Public Health. My remarks will focus on the specific topic of "The Public Health Approach to Health Reform."

I am David Satcher and currently serve as director of the Satcher Health Leadership Institute at Morehouse School of Medicine in Atlanta, Georgia. Before joining Morehouse School of Medicine in September 2002, I served in government for almost nine years. From 1993-1998, I served as director of the Center for Disease Control and Prevention and then from February 1998 to February 2002, I served as Surgeon General of the United States, three years of which I also served as Assistant Secretary for Health. Prior to entering government, I was president of Meharry Medical College for eleven years from 1982-1993. Since leaving government, I have directed a Center of Excellence on Health Disparities at Morehouse School of Medicine and as I mentioned earlier, I am currently the director of the Satcher Health Leadership Institute at Morehouse School of Medicine. I served as the interim president of the Morehouse School of Medicine for two years.

Immediately upon leaving government, with the help of Mrs. Laura Bush, I became the founding chair of a program called *Action for Healthy Kids*, which works with schools to improve the lifestyle of children. More recently, I have served as a member of the Alzheimer's Study Group, which released its report last week. I was a member of the World Health Organization's Commission on Social Determinants of Health and we released our report in November 2008. My testimony will reflect not only my experience in government, but also the work that I have been involved in since leaving government.

The Four-Fold Imperative to Reform our Health System

As you have heard from other presenters, our health system is in dire need of reform. The major imperatives are the high and uncontrollable cost of healthcare, major access problems resulting in over 46 million people being uninsured and at least half that number underinsured. By the same token, several studies have pointed out major quality problems in our health system. Finally, we have focused in this decade on the goal of eliminating disparities in health – a problem which results in at least 83,500 excess deaths among African Americans in this country each year, when compared to the majority of the population. So, the imperatives are cost, access, quality, and major disparities in health.

What is the Goal of our Health System?

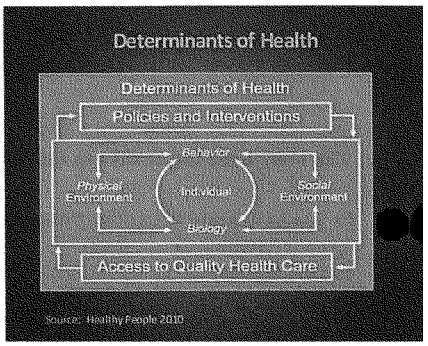
Succinctly stated, the goal of our health system is to promote health and enhance health outcomes even in the face of disease or injuries. This definition leads us to examine the major determinants of health which were outlined in Volume 1 of *Healthy People 2010*. In this report, we pointed out that there were four major determinants of health. They include:

1) Access to quality healthcare

2) A person's biological/genetic background

3) Environment (physical and social)

4) Lifestyle/ Human Behavior



It is important to remember, as pointed out by Foege and McGuinness in an article in the New England Journal of Medicine in 1993, that of these determinants, access to quality healthcare accounts for 10-15 percent of variation in health outcomes, while biology/genetics accounts for 15-20 percent, environment 25-30 percent, and human behavior 40-50 percent. Yet we have to keep in mind that overriding these determinants are major social issues such as poverty, income, and working conditions. These issues

can influence human behaviors; they can influence the environmental exposures; and they can influence access to quality healthcare or even the distribution of quality healthcare in our communities. Given these determinants of health, it is clear that only a Public Health Approach can serve to reach our goals in terms of promoting health and enhancing health outcomes.

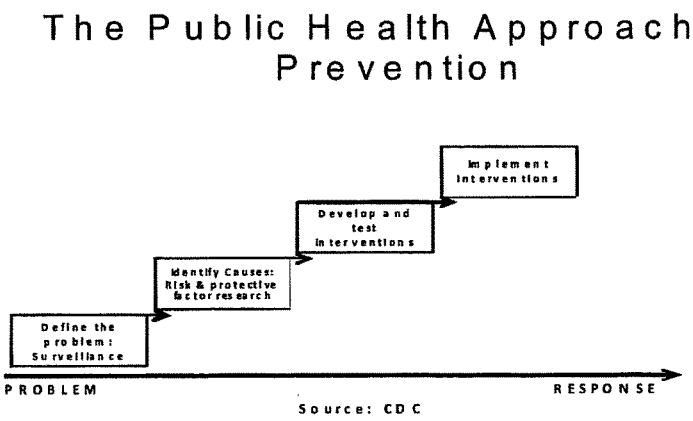
If the goal of our health system is to promote health and improve health outcomes, we cannot ignore the major determinants of health. This is why the" Public Health Approach to Health Reform" is in the long-run, the only viable approach.

What is The Public Health Approach?

Public Health is defined as "the collective efforts of a society to create the conditions in which people can be healthy." This definition by the Institute of Medicine in 1988 perhaps best defines public health. However, The Public Health Approach consists of the four very important steps listed below:

1. Define the problem, including its magnitude, nature, and distribution.
2. Determine the cause of the problem and the risk factor(s) associated with it.
3. Determine what prevents or ameliorates the problem.

4. Translate solutions to the population more broadly.



Using this approach, we can define what must be "The Public Health Approach to Healthcare Reform." First, if we begin by asking the question –What is the problem with our health system? –then we are taken back to the areas of cost, access, quality, and disparities in health. To a great extent, they define our health system problem. The fact that we are spending 2.5 trillion dollars per year or $8,000 per capita, or 18 percent of our gross national product is a major part of our health system problem. And as stated earlier, it is a fact that so many people lack access to our health system including the uninsured, the underinsured, and the underserved. Several studies have pointed to quality

problems with our health system and we have made eliminating disparities in health a goal of *Healthy People 2010.*

What is Causing the Problems in our Health System?

Perhaps the most unifying cause of our health system problems is the lack of balance in our health system. A balanced health system balances health promotion, disease prevention, early detection, and universal access to care. But presently, we spend over 95 percent of our health budget on treating diseases and their complications, and very little investment is made in promoting health and preventing diseases. In fact, only three percent of our health budget is currently spent on population-based prevention today. We invest too little in improving the social determinants of health or the conditions in which people are born, grow, learn, develop, and age. Since we invest little in improving the social determinants, we pay for the consequences of poverty, poor working conditions, and unsafe streets that discourage physical activity. We provide limited access to fresh fruits and vegetables in many communities.

What Works to Prevent or Ameliorate the Problem in our Health System?

We must commit more of our resources to promoting health in the home, workplace, school, and in the community. We must better target the major social determinants of health.

We must better educate the population about healthy behaviors and about the risk to health that can and must be avoided. For example, even when children have ideologies that are different from our own, they deserve to know how to protect themselves from risky behaviors and environmental hazards.

We must provide incentives and rewards for healthy lifestyles that can both prevent unnecessary pain and suffering and reduce costs in our health system. Some businesses have implemented such programs and are now realizing the benefits of these programs.

How Do We Implement These Interventions More Broadly?

Access to programs that promote health and prevent diseases is as important as access to quality healthcare. Access to these programs is critical to the viability of our health system. Therefore, access to these programs must be a major part of healthcare reform.

Whether we use tax incentives to encourage wellness programs in the workplace or better support for school activities and physical education; good nutrition that helps to habituate children to healthy lifestyles; or even faith-based programs to reach communities that would otherwise fall through the cracks, we must invest in a balanced health system.

Now I would like to use two cases to illustrate how such a reformed health system, using The Public Health Approach, could impact some of our major health challenges today.

Case 1- Obesity

Overweight and obesity now impacts two out of three Americans. It is a major risk factor for diabetes, cardiovascular disease, cancer, and other health problems. Obesity is a disease that usually begins in childhood, with 40 percent of our children today now classified as being overweight or obese. According to The Institute of Medicine (IOM) report of 2003 entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, the epidemic of overweight and obesity, and its disproportionate impact on African Americans and other minorities, is an increasing and troublesome problem in this country.

In addition to the long-term risk of obesity, children who are obese are at increased risk for depression, do not perform as well academically, and have a higher rate of absenteeism from school.

The implications for cost in our health system as well as unnecessary pain and suffering are astounding. We need a healthcare model that targets the major determinants of this obesity epidemic, including the social determinants. We need to invest in programs to support an environment of good nutrition and physical activity that will habituate children to healthy lifestyles. Such programs are documented to reduce the onset of Type 2 diabetes by up to 60 percent and reduce hypertension and other forms of cardiovascular disease.

This reformed health system sees education policy, workplace policy, and environmental policy, as forms as health policy, and invests accordingly in improving the school and community environment. In short, we need a health system that targets the social determinants of health while promoting healthy lifestyles and healthy environments. Such a health system is most cost effective and is most likely to prevent unnecessary pain and suffering.

The Community Care Model utilizes expanded health teams including physical education teachers, school nurses, and community health workers to promote healthy lifestyles. We know that obesity is at epidemic proportions in our nation and is a major challenge to our health system. In fact, in some ways, it threatens to overwhelm our health system in the future because of increased risk for diabetes, hypertension and other forms of cardiovascular disease, as well as cancer.

According to the Centers for Disease Control and Prevention (CDC), the estimated total cost of obesity was nearly $117 billion in 2000. Today, chronic diseases account for 75 percent of the cost in our health system, and that figure will continue to grow unless we implement programs to prevent our chronic diseases.

Case 2- Alzheimer's Disease

Last week we (the members of the Alzheimer's Study Group, co-chaired by former Speaker of the House Newt Gingrich and former Senator Bob Kerry) presented the results of our deliberations over the past year. We pointed out the magnitude of the problem of Alzheimer's disease in America today. Alzheimer's is a debilitating disease resulting from a deterioration of brain function and brain cells leading to progressive memory loss. Today there are approximately 5.3 million Americans suffering from

Alzheimer's disease. But Alzheimer's is a disease of families and not just individuals because of the amount and nature of the care involved and the impact on relationships. The risk for Alzheimer's is approximately one in eight after the age of 65 and almost one in two after the age of 85. This is in fact the fastest growing group of people in America according to the CDC data. The toll of pain and suffering on individuals and families is beyond accounting.

We need a health system that can provide for the research and intervention needed to prevent and delay the onset of Alzheimer's disease. In the meantime, we need a coordinated community-based system of care that engages and supports family and community in dealing with this disease. An average delay of five years in the onset of Alzheimer's disease would save trillions of dollars over the next 30-40 years, when Alzheimer's disease is projected to increase to over 16 million Americans. We believe that an investment in prevention research could prevent most cases of Alzheimer's by the year 2020. Our present healthcare model is unable to meet the needs of families and communities dealing with Alzheimer's disease. Thus, we can project that if we continue at the rate we are going, by the year 2050 the cost of treating Alzheimer's disease will increase by 20 trillion dollars and will be at least a trillion dollars per year by the year

2050. Such an approach is unsustainable; such a health system is unsustainable; and we are all threatened by it.

Why The Public Health Approach?

The Public Health Approach would invest in a Home and Community Care Model with a redefined healthcare team that includes family and community care-givers that are trained and coordinated. Reimbursement would no longer be based on a Fee-for-Service Model, which rewards procedures, but instead a Continuing Care Community-Based Model. Not only would persons with Alzheimer's disease and their families and communities benefit, but such a system could impact other chronic diseases and developmental disorders in the future. Only a public health approach that integrates the social determinants of health into our strategy can begin to deal with the health needs and the health challenges which are ahead of us.

Once again, thank you for this opportunity to provide my testimony on "The Public Health Approach to Health Reform."

Mr. PALLONE. Thank you, Dr. Satcher. Dr. Spivak.

STATEMENT OF BARBARA SPIVAK

Dr. SPIVAK. Thank you. My name is Barbara Spivak. I am a practicing physician in Watertown, Massachusetts, and President of the Mount Auburn Cambridge Independent Physician Association, which is a member organization of approximately 500 physicians affiliated with Mount Auburn Hospital and Cambridge Health Alliance, the public hospital in Cambridge. I appreciate this opportunity to testify about the important role coordinated care plans play in helping us both align as incentives and give us the resources to create a comprehensive program to deliver higher quality care at a reasonable cost. I would like to share with you today the—give you some flavor of the infrastructure that we have in our organization that provides care coordination, case management, pharmacy management, referral management, utilization management, and does quality programs that encourages prevention strategies as well as improvement in chronic disease outcomes.

Our arrangement with our hospital and Tufts Health Plan through the Tufts Medicare Preferred HMO product allows us to provide different levels of care for patients depending on their health status, their social status, and their frailty. For example, in patients who are severely ill who are at home, we have programs that send nurse practitioners into the home. When people are in rehab facilities, we have nurse practitioners and physicians who go in not once a month like in traditional fee for service but go in up to four or five times a week to keep them in the facility.

Our lowest level of care was where a case manager may just call the patient on a monthly basis, make sure they are taking their medicines properly and help them arrange rides for their doctor's appointments. In some cases, nurse practitioners actually go with patients to physician's appointments because the patients themselves may not be able to hear everything that the physician says and organize all the med changes that happen. We use case managers who follow patients through the continuum of care so that when a patient is in the hospital in a rehab and then goes home that case manager knows their family and social situation and can help set them up with the most appropriate services to keep them at the lowest level of care possible.

We have a pharmacist who works with us full time who works with patients who are on eight or more medicines to simplify their regime, encourage the use of generics, and when patients with chronic diseases are out of control in terms of cholesterol management, for example, or diabetic control, they work with specialists to make recommendations to the primary care doctor for better medical management. We have utilization management programs that do not deny care but work with physicians to make sure that they are ordering the right test for the right patient for the right disease or referring to the right doctor the first time. This avoids both duplication of testing and unnecessary testing.

We work with a health plan in doing disease management programs in CHF and COPD, and the help plan provides us with a care alert program that takes claims data and runs it against 1,500 rules based on evidence-based medicine that provides us with gaps

in care that our physicians can then address. Our hospital works aggressively on decreasing med errors, improving quality so that we have not had a ventilation assisted pneumonia in over a year. Many of these programs are not funded in traditional fee for service medicine. Traditional fee for service medicine leaves the doctor alone in the room with the patient and when the patient walks out, they are on their own.

In our system, we have multiple levels of support for the physician, the patient, and their families. We use education as a prime method of improving care. We just try to help physicians do a better job. We help to keep patients at the lowest level of care possible, mainly trying to keep them at home when we can. Traditional medicine really does not allow for the infrastructure that we have had to do that, and I would encourage the committee as they look forward to funding plans that continue to allow us to have the networks and the support and the infrastructure. I also would like in my testimony, I made reference to some quality data because I think it is important for people to see that we actually do what we say we do.

So if you look at our mammogram rates, they are 14-percent higher than in fee for service medicine. Diabetic eye exams are 21-percent higher. Colon cancer screening rates are 18-percent higher. Diabetic patients go to the hospital 35-percent less often. Our readmission rates are 58-percent fee for service Medicare, and our ER utilization is over 20-percent lower. Our diabetic patients have heart disease that is 23-percent lower than Medicare patients and have strokes that are 46-percent less often. So I think the statistics show that what we are doing actually works. Part of what this does is it really aligns the incentives so that the health plans, the hospitals, and the physicians all work together in a collaborative way to do the right thing.

[The prepared statement of Dr. Spivak follows:]

Testimony by Barbara Spivak, M.D.
House Energy and Commerce Committee, Subcommittee on Health
"Making Health Care Work for American Families:
The Role of Public Health"
March 31, 2009

I. Introduction

Mr. Chairman and members of the subcommittee, I am Barbara Spivak, M.D., a practicing physician and president of the Mount Auburn Cambridge Independent Physician Association (MACIPA), which is a physician organization in Massachusetts including approximately 500 physicians who are affiliated with Mount Auburn Hospital and the Cambridge Health Alliance.

At MACIPA, which was formed more than 20 years ago, we place a strong emphasis on innovation and leading our physician members in new ventures for improving health care quality and patient care. The investments we have made in creating an infrastructure for care coordination, wellness programs, and prevention strategies offer valuable lessons for strengthening public programs. Our organization includes a dedicated Quality Improvement Department that works with our members in a variety of quality improvement activities for specialists and primary care physicians.

I appreciate this opportunity to testify about the important role coordinated care plans can play in delivering high quality, affordable coverage with an emphasis on keeping beneficiaries healthy, avoiding preventable illnesses, detecting diseases at an early stage, and pro-actively managing care for patients with chronic conditions. In my testimony, I will discuss how MACIPA's 500 physicians work together collaboratively at the local level with nurse practitioners and case managers to improve health care quality through integrated systems of care.

II. Using Integrated Systems of Care to Improve Quality

Our arrangement with Tufts Health Plan Medicare Preferred (TMP) has created an environment in which physicians and other health care providers can work together with a network-based

health plan to promote high quality care for Medicare beneficiaries. MACIPA works closely with TMP in Massachusetts to meet the health care needs of Medicare beneficiaries, particularly those with chronic conditions. My testimony provides a glimpse at how my practice treats patients under this model and how this approach is different from the traditional Medicare fee-for-service (FFS) paradigm.

Our arrangements with TMP allow us to coordinate care for patients by providing different levels of care based on the severity of their illness and their social situation. Under the HMO model, each enrollee chooses a primary care physician who, after being alerted that the enrollee is on his patient roster, brings the patient into his office to evaluate the individual's health care needs. Patients are then stratified based on their needs.

Those with chronic conditions are placed in more intensive case management programs under which a nurse practitioner conducts weekly visits to ensure that the patient is taking all prescribed medications and following their physician's recommendations with respect to nutrition and other factors affecting their health status. Over time, as the patient's health status improves, the nurse practitioner may reduce the frequency of in-home visits to a monthly basis. In cases where patients demonstrate significant improvement, they may be moved into a different strata in which a nurse case manager reaches out to them through regular phone calls.

We also establish a role for case managers in monitoring the health and well-being of patients who are admitted to the hospital or rehabilitation facilities. By following patients throughout the continuum of services they receive, case managers get to know them on a personal level so they can ensure they are receiving the appropriate level of care and follow-up assistance even after returning home. We also have pharmacists who review each patient's medications continuously to ensure that they are receiving the right dosage and that they are not taking medications that would result in dangerous interactions when taken together.

Unfortunately, this approach does not exist under the traditional Medicare FFS program as it exists today.

I also want to emphasize that all health care is delivered at the local level, and that greater coordination and teamwork can be achieved through initiatives that are organized locally. MACIPA's team members approach patients in a collegial fashion – offering education and support – so they view us as neighbors and colleagues. Likewise, we have developed a strong and collaborative relationship with our local health plan, Tufts Health Plan. We believe the local nature of these partnerships is the key that enables us to achieve results, as I will discuss later, that significantly exceed the performance of the federally administered Medicare FFS program.

The integrated system of care used by MACIPA represents a paradigm shift in the delivery of health care services to Medicare beneficiaries. This approach requires significant investments, in both time and resources, that are possible only because the Medicare Advantage program, unlike the traditional Medicare FFS program, enables network-based health plans to work with MACIPA and other physician groups to commit resources to these pro-active initiatives.

The success of this approach indicates the importance of maintaining a strong, adequately funded Medicare Advantage program to serve as a foundation for strengthening Medicare. We believe that innovative strategies in the private sector have a spillover effect in influencing the way physicians treat patients who are covered under the FFS system. By continuing to support the Medicare Advantage program, Congress can help promote the delivery of high quality care across the entire Medicare population.

III. Real-Life Example of How Coordinated Care Works for Seniors

To illustrate on a personal level how integrated systems of care make a difference in the lives of Medicare beneficiaries, I would like to share the story of a senior who has benefited in a very meaningful way from her experience in receiving coordinated care.

This woman, who I will call "Mary" (not her real name), was living independently with no family when she was diagnosed with a heart condition, bladder cancer, and breast cancer within a short period of time. Over the course of 18 months, Mary was in and out of the hospital constantly, largely because she was not taking her medications and was receiving fragmented

care without any meaningful coordination among the multiple physicians who were caring for her.

A little more than two years ago, as Mary was battling these serious medical conditions, she enrolled in the Tufts Medicare Preferred (TMP) plan, an HMO offered through the Medicare Advantage program. She immediately was placed in a high risk case management program, where she received coordinated care from physicians working together in MACIPA's integrated system. Mary also received one-on-one assistance from a nurse practitioner who contacted her on a regular basis to ensure that she was taking her medications and was keeping her appointments with her physicians. In addition, to address her social situation, a case manager made arrangements for Mary to receive transportation to and from her doctors' offices and other support services offered by community organizations. The end result for Mary is that today she is enjoying greatly improved health and a higher quality of life than before she enrolled in her Medicare Advantage plan and, additionally, she has now gone two full years without being hospitalized, despite her chronic conditions.

It is personally gratifying to me to see patients like Mary benefit from the integrated systems of care we are able to offer in collaboration with Tufts HP. I would be thrilled if I could offer the same level of care management to all of my Medicare patients, including those who are covered under the Medicare FFS program.

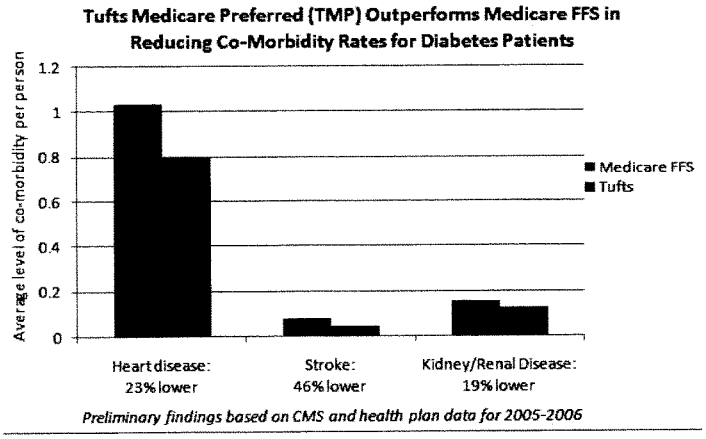
IV. Measuring the Impact of Our Quality-Focused Approach to Patient Care

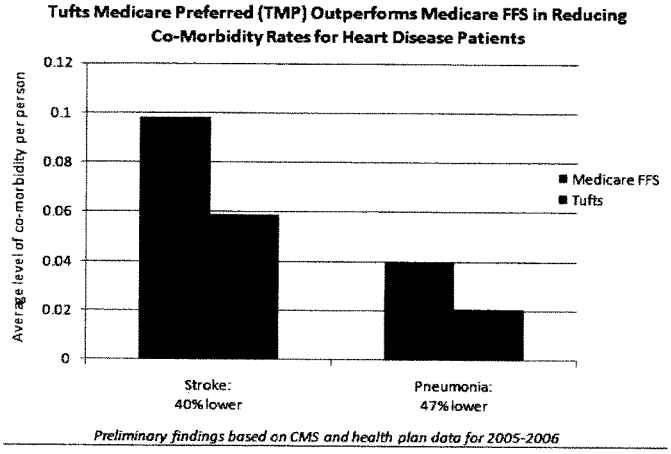
A recent study by Massachusetts Health Quality Partners (MHQP) evaluated the quality of care delivered to all Massachusetts Medicare Advantage enrollees based on six quality of care measures, and concluded that the care delivered by Medicare Advantage plans exceeds the care delivered by the Medicare FFS program. As shown in the table below, this study found that Medicare Advantage enrollees were more likely to receive recommended medical tests – for breast cancer screening, diabetes care, and colorectal cancer screening – that are important to the early identification and early treatment of serious medical conditions.

Percent of patients receiving recommended medical tests by health insurance coverage:

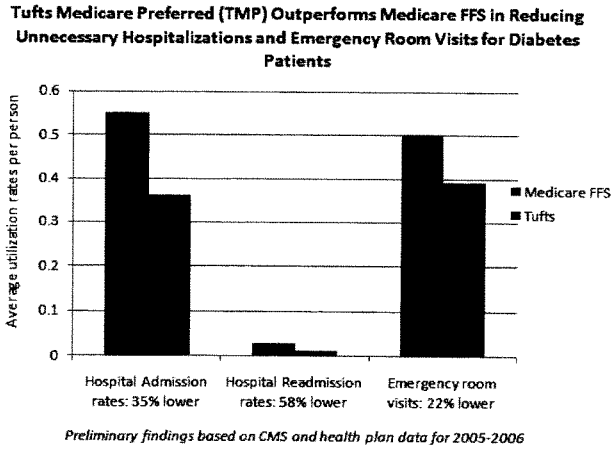
Measure	FFS Medicare Members	Medicare Advantage Members	Difference
Breast Cancer Screen (BCS)	70.6	84.9	+14.3
Comp. Diabetes Care – Cholesterol Testing (CDC-CT)	80.5	94.5	+14.0
Comp. Diabetes Care – Eye Exam (CDC-EY)	61.6	83.4	+21.8
Comp. Diabetes Care – HbA1c Testing (CDC-HT)	85.5	95.4	+9.9
Comp. Diabetes Care – Nephropathy Monitoring (CDC-NM)	74.8	89.8	+15.0
Colorectal Cancer Screening (COL)	50.2	68.7	+18.5

Additional research, based on an analysis of CMS and health plan data, shows that Tufts Health Plan, our health plan partner, with its local network of providers, has been highly successful in working with physicians and other providers to reduce complications for Medicare Advantage enrollees with diabetes and heart disease. The charts below, based on preliminary findings, show the extent to which the Tufts Medicare Preferred (TMP) Medicare Advantage plan, working with MACIPA and other physician groups, has reduced the onset of heart disease, stroke, and kidney/renal disease for patients with diabetes, compared to the Medicare FFS system, while also significantly reducing the rate of stroke and pneumonia for Medicare Advantage enrollees with heart disease.





The preliminary findings of this research also show that the Tufts Medicare Preferred (TMP) Medicare Advantage plan and its local network of providers have been highly successful in reducing hospital admissions, readmissions, and emergency room visits for diabetes patients, through its collaborative efforts with MACIPA and other provider groups. By reducing the need for hospitalizations and emergency room care, we are not only improving the health and well-being of Medicare beneficiaries – but also achieving greater efficiencies and cost savings.



V. Enhancing Quality Through Payment Reforms, Wellness Programs, and Electronic Health Records

Looking forward, MACIPA is working in other areas to take steps toward bringing health care costs under control. In January 2009, we entered into a new five-year arrangement with Blue Cross Blue Shield of Massachusetts for their commercial members (non-Medicare members). This initiative will pay physicians and hospitals based on health outcomes and the quality of care they deliver to patients. This effort builds upon a one-year program we initiated in 2008. We were willing to do this because of our experience and track record in treating Medicare Advantage patients under a similar arrangement. This is a good example of how what we are doing with TMP in Medicare has inspired alternative delivery system approaches for other populations and products.

Under this two-pronged arrangement, physicians will receive a capitation payment throughout the five-year period, plus they will qualify for performance payments linked to measures of quality, effectiveness, and patient satisfaction. This payment structure provides strong incentives for physicians to improve health care quality and help patients avoid unnecessary hospitalizations. It also removes any incentives physician might otherwise face to increase the volume of services they deliver, and reorients them to focus on health outcomes, quality, and efficiency. We anticipate that implementation of this payment structure will significantly reduce the growth rate of health care spending for the populations we serve, while improving patient care. As this initiative progresses, we look forward to updating the subcommittee on its impact on both the quality and efficiency of care we deliver.

MACIPA also works with Tufts Health Plan to implement wellness programs on behalf of the patients we serve. One important example is the "Care Alerts" program, recently implemented by Tufts HP, which compares claims data to treatment guidelines to identify potential gaps in care, medication interactions, and quality and patient safety issues. Under this initiative, Tufts HP uses 1,500 evidence-based clinical rules to flag actionable opportunities for optimizing patient care, ensuring compliance with recommended treatments, and delivering preventive services. Mammograms for breast cancer screening, ace inhibitors for patients with congestive

heart failure, and the prevention of dangerous drug interactions -- to name just a few -- are the types of areas targeted by this initiative.

After gaps in care are identified, depending on the severity of the issue, Tufts HP takes action on one of the following three levels: (1) immediately calling the physician to initiate corrective action for issues such as a potential drug interaction; (2) sending a letter to the physician to make him/her aware of a gap in care, followed by a letter to the patient; or (3) sending a letter directly to the patient. The "Care Alerts" program was implemented for enrollees in Tufts' commercial plans in February 2009, and was expanded to the Medicare population in March. After six months, Tufts HP will begin tracking the results of this initiative to evaluate its impact in improving patient care and health outcomes.

Finally, I want to briefly highlight our involvement in implementing electronic health records (EHR) for all of the physician members of MACIPA. In addition to supporting the funding of this new technology and providing training for our physicians, we are emphasizing the importance of using electronic health records to improve patient care and health care quality. Going to a paperless system only improves quality if a provider uses it differently and sets up processes to improve care. Our organization is essentially performing the functions of "population management" for our providers with the EHR as the basis for information.

VI. Conclusion

Thank you for this opportunity to testify on these important issues. I wish you success in passing health care reforms that facilitate the expansion of innovative private sector strategies – based on locally-established integrated systems of care – to all health care consumers.

Mr. PALLONE. Thank you, Dr. Spivak. Dr. Herrick.

STATEMENT OF DEVON HERRICK

Mr. HERRICK. Mr. Chairman and members of the committee, I am Devon Herrick, a Senior Fellow at the National Center for Policy Analysis, a nonprofit, nonpartisan research institute. We strive to solve problems by relying on the strength of the competitive entrepreneurial private sector. I welcome the opportunity to share my views, and I look forward to your questions. Community-based public health has a very important role in our society in our health care system, and it has achieved some very significant results over the past century. I mean, for example, like I mentioned before, vaccination, safe foods, fluoridation. The London cholera epidemics in the late 1800's are a classic example of a public health initiative that was very successful as are controlling contagious diseases.

Yet, over the past few decades public health has struggled to tackle many of the problems through community-based initiatives that don't particularly lend themselves to community-based solutions. Most Americans who suffer from chronic ailments don't really consider their problems to be public health problems. Rather, people who suffer from diabetes, from asthma, from hypertension, to them their problems are very real and very personal. That is to improve public health. We also need to free the doctors and free the patients to find innovative solutions that meet their individual needs. America is unlikely to mitigate the increasing problem of chronic diseases unless patients themselves become more involved, and moreover patients are not likely to become more involved unless they have a financial incentive for doing so and control more of their own health care dollars.

For example, approximately 125 million Americans have a chronic ailment and many of these are not receiving the appropriate care from their physicians. One reason for this poor compliance is because the physicians often lack the integrated systems to care for their patients but a bigger reason is they often lack the financial incentives to provide appropriate care. For example, consider diabetes. Nearly 24 million Americans have diabetes, about a third of which don't even know they have it. This constitutes around 8 percent of the population arising to nearly one in four seniors the leading cause of death. We spend several billion dollars a year for diabetes complications that could have been averted through appropriate care.

But, yet, numerous studies have shown that considerable benefit from self management training for Type II diabetes, patients can be trained to inject insulin, monitor and maintain a log of blood glucose levels, and use the results to appropriately adjust dietary intake, activity levels, and medical doses. I recently came across a firm that helps patients manage diabetes remotely using tele-medicine. For example, an enrollee is given a wireless blood glucose monitor. They are instructed to test their blood glucose or blood sugar at selected times a day. They can send the results wirelessly to their physician's office. If they fail to test on schedule, they are given an e-mail or a phone call to prompt them to repeat the test or take the test. A particularly high reading might prompt a phone

call from a diabetes nurse inspecting them, inquiring what have I just eaten, and don't do it again.

This all becomes part of their electronic medical record, the result of which can be used and shared with their health coach to help them maintain better compliance. A great example of what is often times considered a community-based approach was the Ashville project in North Carolina, which helped enrollees and self-insured health plans better control their diabetes, but yet on closer inspection what it really was, was individual pharmacists being compensated and being paid to help individual patients manage their diabetes. Another area I want to talk about is asthma self management. Nearly 20 million Americans suffer from asthma, around 2.5 million school kids miss around 15 million school days per year because of asthma.

A Dutch study comparing self management to usual care found that those that were trying to monitor their own conditions received a savings of about 28 percent in their second year compared to additional physician care alone. They can also use software packages just to track and monitor their conditions and their readings. These become part of their electronic medical records, the data which can be shared with their physicians. A recent study of asthma patients trained to perform in-home asthma self-monitoring found that their readings were consistent to establish guidelines. Another study of bleeding and clotting disorders by the VA and the home self-monitoring of clotting of those taking Warfarin therapy was superior to standard monitoring alone. Tele-medicine holds significant promise to allow patients with chronic ailments who are motivated to better manage their conditions and interact with physicians in ways not possible just a few years ago. I think this is critical to better self-management of chronic conditions.

In conclusion, community-based health care has a place in our health care system. However, disease is very personal. The solution to the public health problems associated with increasing chronic disease is to allow patients to control more of their own health care dollars and to allow patients and providers to benefit from new arrangements that produce higher quality and lower cost. For example, government insurers, Medicare and Medicaid should also allow doctors and hospitals to repackage and re-price their services under government health care payment systems allowing them to gain financially from providing better care. The most important lesson is entrepreneurs can solve many of the problems that plague our health care system. Public policy should encourage these efforts, not discourage these efforts. Thank you.

[The prepared statement of Mr. Herrick follows:]



Statement of

Devon M. Herrick, Ph.D.

Senior Fellow

National Center for Policy Analysis

on

Empowering Patients and Improving Public Health

Energy and Commerce Subcommittee on Health

United States House of Representatives

March 31, 2009

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Mr. Chairman and members of the Subcommittee, I am Devon Herrick, Senior Fellow at the National Center for Policy Analysis, a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector. I welcome the opportunity to share my views and look forward to your questions.

Traditional Role of Public Health

Public health plays an important role in our overall health care system. Several significant achievements are directly attributable to public health. For instance, the response to the London cholera epidemics of the late 1800s is a well-known, classic example of public health. In that case, no single individual had an incentive to bear the full cost of repairing sewer lines that were leaking into the water supply because all the costs would be borne by the repairer, while the benefits would accrue to community at large. Thus, keeping community water supplies free from sewage contamination became a *public* health matter, as opposed to a *private* health matter.

Controlling the spread of infectious diseases is another typical example of public health. Because we know that the actions of individuals (if left to act independently) would likely fail to control the spread of a particular contagious disease, public health services intervene as a matter of *public* health, as opposed to *private* health.

In that context, consider CDC's list of the greatest public health achievements of the past century:[1]

- Vaccination
- Motor-vehicle safety
- Safer workplaces
- Control of infectious diseases
- Decline in deaths from coronary heart disease and stroke
- Safer and healthier foods
- Healthier mothers and babies
- Family planning
- Fluoridation of drinking water
- Recognition of tobacco use as a health hazard

Indeed, over the past 60 years, the role of public health has changed over time to include services that don't particularly meet the criteria for *public* goods. For instance, government funds 45.2% of health care spending – yet only 3% to 4% of federal health care spending is on *public* health. The rest is used to subsidize care that is probably best described as *personal* or *private* health care.

Many modern public health efforts are aimed at treating or preventing chronic diseases, such as diabetes, heart disease, cancer and so forth. Yet, most of these chronic ailments that afflict Americans are very personal and individual – not public problems like treating sewage or

[1] "Ten Great Public Health Achievements--United States, 1900-1999," *Morbidity and Mortality Weekly Report*, Vol. 48, No.12, April 21999, pp. 241-243.

preventing the spread of infectious diseases. Thus, community-based programs to treat and prevent personal chronic illness may not be as effective as creating an environment where individuals can gain access to quality care. In a sense, the best way to improve the public's health (in the modern sense of treating and preventing chronic disease) is to empower individuals with purchasing power, information and access to affordable health care – including preventive health care.

A Market for Health Care

Unfortunately, the modern health care market does not work like other markets.[2] Long before we enter a doctor's office, third-party bureaucracies have determined which services they will pay for, which ones they will not and how much they will pay. Providers typically do not disclose prices prior to treatment because they do not compete for patients based on price. If they do not compete for patients on price, they don't compete on quality either. This is because patients pay only one-eighth of their medical bills directly.[3] The rest is paid by third-parties – insurers, employers and government. This lack of competition for patients has a profound effect on the quality and cost of health care – and may be a reason for the perceived need to expand public health to treat and prevent chronic disease. The result is a highly artificial market plagued by fragmented care, uncoordinated care, failure to use simple technology (including the telephone, e-mail and the Internet), inadequate use of chronic disease management, a lack of electronic medical records (EMRs) and the absence of safety-enhancing software.

However, in health markets where patients control some of their own dollars, providers are creating innovative services that please patients and solve the very problems this Subcommittee is examining. In addition, recent advances in information technology — the hardware and software systems used to record, store, process and transmit data — have created new opportunities for patients and doctors to interact in ways that were impractical only a few years ago. Health care entrepreneurs are using these opportunities to make health care more accessible and convenient to patients, to raise quality and to reduce costs. Allowed to flourish, these types of developments and innovations can have a profound effect on public health.

Chronic Diseases

Treatment of chronic diseases is one of the factors driving up health care costs and a major focus of public health programs. Nearly half (45 percent) of all Americans have a chronic condition, and half of those (60 million) have multiple chronic conditions.[4] A Yale University study found that one-quarter of Americans have one or more of five chronic conditions: mood disorders,

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[2] This section taken from Devon M. Herrick, "Health Care Entrepreneurs: The Changing Nature of Providers," National Center for Policy Analysis, NCPA Policy Report No. 318, December 2008.

[3] Centers for Medicare and Medicaid Services, "National Health Expenditures by Type of Service and Source of Funds: Calendar Years 2006-1960," U.S. Department of Health and Human Services, 2008.

[4] Gerard Anderson et al., "Chronic Conditions: Making the Case for Ongoing Care," Partnership for Solutions (The Robert Wood Johnson Foundation and Johns Hopkins University), September 2004. Available at: http://www.rwjf.org/pr/product.jsp?id=14197. Accessed March 27, 2009.

diabetes, heart disease, high blood pressure and asthma. Moreover, patients with these conditions account for almost half of all health care spending.[5]

The estimated cost of chronic diseases in the United States, including treatment and lost productivity, is $1.3 trillion per year.[6] Unless this trend is reversed, by 2023 the cost will swell to $4.2 trillion.

Of the 125 million or so Americans have chronic medical conditions, most are not receiving appropriate care from their physicians.[7] For instance, less than one-quarter of patients with high blood pressure control it adequately. Twenty percent of Type-1 diabetic patients do not see a doctor annually. Twice that number do not test their blood sugar level regularly, and 40 percent do not receive recommended yearly retinal examinations.[8] One reason for this poor compliance with recommended care is that physicians often lack an integrated system to monitor their patients' chronic conditions.[9] They also often lack an incentive.

Helping patients properly manage a chronic condition — especially diabetes, which often results in complications such as heart disease — is often complex and time-consuming.[10] When multiple physicians are treating a patient for multiple conditions, a case manager must ensure that they are coordinating their efforts. However, such close monitoring and interaction is labor-intensive and costly. Insurers rarely reimburse these management tasks, or reimburse them at rates lower than the cost of providing the services. It should be easy for doctors to get paid a different way by Medicaid if they propose to repackage and reprice their services in ways that raise quality and lower taxpayer costs.

Take diabetes, for example. Care tends to be delivered in discrete bundles, each with its own price. No one provider is responsible for the end result (fewer ER visits, lower blood sugar level, etc). This is because no one has bundled "diabetic care" as such — taking responsibility for final outcomes over a period of time — in return for a fee.[11]

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[5] Benjamin Druss et al., "Comparing the National Economic Burden of Five Chronic Conditions," *Health Affairs*, Vol. 20, No. 6, November/December 2001, pages 233-241.

[6] Ross DeVol and Armen Bedroussian, "An Unhealthy America: The Economic Burden of Chronic Disease — Charting a New Course to Save Lives and Increase Productivity and Economic Growth," Milken Institute, October 2007.

[7] "Disease Management: The New Tool for Cost Containment and Quality Care," Health Policy Studies Division, National Governors Association, Issue Brief, February 2003; Thomas Bodenheimer, "Disease Management — Promises and Pitfalls," *New England Journal of Medicine*, Vol. 340, No. 15, April 15, 1999, pages 1,202-05.

[8] Ibid.

[9] "Disease Management: The New Tool for Cost Containment and Quality Care."

[10] For instance, see Gina Kolata, "Looking Past Blood Sugar to Survive with Diabetes," *New York Times*, August 20, 2007.

[11] Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* (Boston, Mass.: Harvard Business School Publishing, 2006).

To appreciate how different diabetes care could be, imagine a conversation in which a doctor says to a diabetic patient: "You do not need to come to my office as often as you do. Most of our communication can be by telephone or e-mail. For these consultations you will pay less. I need to put your records on a computer so that I can take advantage of safety protocols and order your prescriptions electronically. For these quality improvements, you will pay a bit more. I'm also going to teach you how to manage your own care and I'm going charge for the instruction. But you'll get your money back through fewer consultations. Also, I'm going to show you how to cut your drug costs by shopping in a national online marketplace and I'm going to charge you for that advice as well. But you'll get that money back too through lower drug prices."

This conversation cannot take place in the current system. Why? Because each of the bundles of care mentioned above are services Blue Cross does not pay for (no e-mail, no telephone, no electronic records). Medicare doesn't pay for these bundles either. Nor do most employer plans. But this conversation, and thousands of others just like it, would take place if doctors were free to repackage and rebundle their services and get paid.

So how do we get from here to there? A reasonable reform might work like this:[12] A state Medicaid office announces that it welcomes offers from doctors, hospitals and other providers to repackage and reprice their services. The parameters are: (1) the repriced, repackaged services must not increase total spending by the state, (2) the quality of care received by patients must not decline and (3) the provider/entrepreneur must propose a way to measure cost and quality to make sure that requirements (1) and (2) are satisfied.

For the reform to be workable, the transactions must be easy to negotiate and consummate. Paperwork and time delays are the enemy of entrepreneurship. However, given a willing state administrator, the process of reform should not take long. There are already low-cost, high-quality pockets of excellence just waiting to be replicated. A similar arrangements could work in Medicare.

Economic Incentives. Because chronic disease is so costly, insurers and many public health advocates hope that chronic disease management (CDM) will reduce costs and improve quality of life in chronically ill patients.[13] The goal is to identify expensive-to-treat patients and reduce costs through better management of their disease before costly complications occur.

Patients may not be able to rely on their health insurers for disease management.[14] The reason is that, for the most part, insurers and providers don't benefit from the results. The efforts of health insurers to use disease management generally don't pay off because patients do not stay enrolled in their plans long enough to recoup the investment. Furthermore, a recent study in *Health Affairs* found that when disease management was provided to broad populations of patients with

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[12] John C. Goodman et al., *Handbook on State Health Care Reform* (Dallas, TX: National Center for Policy Analysis, 2007).

[13] See Ben Wheatley, "Medicaid Disease Management: Seeking to Reduce Spending by Promoting Health," Academy for Health Service Research and Health Policy, State Coverage Initiatives, Issue Brief, August 2001 and Robert E. Mechanic, "Disease Management: A Promising Approach for Health Care Purchasers," National Health Care Purchasing Institute, May 2002.

[14] For a good discussion of this issue, see Roger Lowenstein, "The Quality Cure," *New York Times*, March 13, 2005.

chronic disease, overall costs generally rose rather than fell. The only group who benefited from disease management was the small subset of patients not following treatment protocols.[15] For patients already adhering to protocols, additional expenditures to better manage their conditions generally result in higher marginal costs with little marginal benefit. But when patients control their own expenditures, and benefit from any savings they realize, they have an economic incentive to adhere to treatment protocols.

Patients also may not be able to rely on their doctors to manage their conditions. Physicians' compensation is based on the services they render, rather than evaluations of their performance based on patient outcomes.[16] Consequently, physicians have little incentive to counsel patients on disease management and follow up to see if recommendations were followed. Patients benefit the most from disease management in terms of better health. If patients tend to reap most of the benefits, they should control the funds necessary to manage their chronic conditions. Since chronic conditions increase patients' out-of-pocket costs, controlling the funds to manage their conditions is a step towards motivating them.[17] Patients with health savings accounts would reap financial rewards (beside the reward of good health) since they would be at liberty to use fund for prevention rather than acute care.

America is unlikely to mitigate the problem of chronic disease unless patients themselves become more involved. Moreover, patients are unlikely to get involved unless they have a financial incentive to do so and control some of their own health care dollars.

In addition, patients with chronic illnesses can use the Internet to obtain information on specific medical conditions, clinical trials and the latest drugs. They can also share their experiences with and learn from others suffering from the same conditions. Once patients inform themselves, they can manage their conditions and control their health care in ways unheard of only a few decades ago. Following are some examples of how patients with some common chronic conditions can take a more active role in their own care.

Diabetes. Nearly 24 million Americans have diabetes, comprising just nearly 8 percent of the population.[18] Diabetes is the sixth-leading cause of death by disease in the United States.[19] The mortality rate for people with diabetes is 11 times the rate for those without the disease.[20] In

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[15] Ben Fireman, Joan Bartlett, and Joe Selby, "Can Disease Management Reduce Health Care Costs by Improving Quality?" *Health Affairs*, Vol. 23, No. 6, November/December 2004. For a commentary see Francis J. Crosson and Philip Madvig, "Does Population Management of Chronic Disease Lead To Lower Costs Of Care? *Health Affairs*, Vol. 23, No. 6, November/December 2004.

[16] Roger Lowenstein, "The Quality Cure," *New York Times*, March 13, 2005.

[17] Gerard Anderson, "Chronic Conditions: The Cost and Prevalence of Chronic Conditions are Increasing. A Response is Overdue," National Institute for Health Care Management, Expert Voices, Issue 4, January 2002.

[18] American Diabetes Association, "All about Diabetes." Available at: http://www.diabetes.org/about-diabetes.jsp. Accessed March 27, 2009.

[19] American Diabetes Association, "Improved Diabetes Control Yields 'Zest for Life'," PRNewswire, June 14, 2000.

[20] "Diabetes Statistics," U.S. Dept. of Health and Human Services, Public Health Service, National Institutes of Health, NIH Pub. No. 96-3926, 1995.

addition, diabetics spend four times more money on health care than nondiabetics.[21] There is much to be gained from better disease management. By one estimate, nearly $2.5 billion in annual hospital costs for diabetes complications could be averted with appropriate care.[22] Numerous studies have shown considerable benefit from self-management training for Type 2 diabetes.[23] Patients can be trained to inject insulin, monitor and maintain a log of blood glucose levels, and use the results to adjust their dietary intake, activity levels and medicine doses.[24]

There are approximately 20 different monitors to test blood glucose available in a variety of shapes and sizes.[25] Occasionally monitors are given away free — but some only work with a proprietary brand of glucose test strips and therefore are more costly in the long run.[26] Costs for test strips vary considerably. A diabetic patient could pay $59.99 for 100 Ascensia Microfill Blood Glucose Test Strips at the Web site OTC Wholesale.com to $88.74 at ZuckermanPharmacy.com.[27] If patients who check their blood sugar four times a day could save 29 cents per test strip, the savings would add up to $420 for the year. In the past few years several new oral medications for diabetes became available.[28] Savvy consumers will also find the price of diabetic medications vary considerably.[29] Some are available in generic form while some are not.[30] In addition, many diabetics can reduce reliance on medications and control their diabetes completely by adhering to a meal plan, losing weight and exercising.[31]

Innovative Providers of Diabetes Management. HealthPoints is a firm that provides chronic disease management for health plans and third-party payers willing to pay for their services. However, this is an example of the type of service that patients may choose if they control the funds. HealthPoints takes advantage of the latest information technology to monitor diabetics

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[21] Patti Bazel Beil and Laura Hieronymus, "Money-Saving Tips: Supplies, Nutrition, and Exercise," *Diabetes Self-Management*, March/April 1999.

[22] "Economic and Health Costs of Diabetes," Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, Healthcare Cost and Utilization Project Highlights, No. 1, AHRQ Pub. No. 05-0034, January 2005.

[23] Susan L. Norris, Michael M. Engelgau and K. M. Venkat Narayan, "Effectiveness of Self-Management Training in Type 2 Diabetes," *Diabetes Care*, March, 2001.

[24] Teresa Pearson, "Getting the Most From Health-Care Visits," *Diabetes Self-Management*, March/April 2001.

[25] "Self-Monitoring of Blood Glucose," *Clinical Diabetes*, Winter 2002.

[26] Patti Bazel Beil and Laura Hieronymus, "Money-Saving Tips: Supplies, Nutrition, and Exercise," *Diabetes Self-Management*, March/April 1999.

[27] Prices found at www.otcwholesale.com and ZuckermanPharmcy.com. Accessed March 27, 2009.

[28] Joe A. Florence and Bryan F. Yeager, "Treatment of Type 2 Diabetes Mellitus," *American Family Physician*, Vol. 59, No. 10, May 15, 1999.

[29] For techniques to lower one's drug bill, see Devon M. Herrick, "Shopping for Drugs: 2007," National Center for Policy Analysis, NCPA Policy Report No. 293, November 16, 2006.

[30] For instance, some oral medications for diabetes mellitus include, Sulfonylureas, Biguanides, Thiazolidinediones, Alpha-glucosidase inhibitors, Meglitinides and Dipeptidyl peptidase IV inhibitors. See "Oral Diabetes Medications (Diabetes Pills)," WebMD.com, undated. Accessed March 27, 2009.

[31] Patti Bazel Beil and Laura Hieronymus, "Money-Saving Tips: Supplies, Nutrition, and Exercise," *Diabetes Self-Management*, March/April 1999.

remotely. Enrollees use a small, high-tech blood glucose-testing monitor with a wireless Bluetooth connection. A Web-based computer or Personal Digital Assistant (PDA) sends the blood glucose readings electronically to HealthPoint's office. A patient who forgets to take a reading at the appointed time receives a reminder by e-mail or phone. An extremely high reading will notify a health coach or diabetes nurse at HealthPoints to call the patient and inquire about foods recently eaten. The (multiple) daily blood glucose readings become part of a medical record that can be used to establish health metrics and a baseline of a patient's progress. A health coach can also counsel patients on ways to improve compliance.[32]

Asthma Self-Management. From 4 percent to 6 percent of the population of Western countries have been diagnosed with asthma, which imposes huge economic costs on society.[33] The Asthma and Allergy Foundations of America estimates nearly 20 million Americans suffer from asthma — resulting in 500,000 hospital stays each year.[34] More than 2.5 million school-age children suffer from asthma, missing nearly 15 million school days per year, averaging out to nearly $800 per child per year.[35] A Dutch study comparing self-management to usual care found that those monitoring their own asthma achieved a savings of about 7 percent the first year and a 28 percent savings the second year compared to those in standard care with a primary physician.[36]

Patients should develop a self-management plan with their physician or asthma nurse. An asthma plan is essentially a list of established guidelines indicating which actions to take in response to various symptoms.[37]

Asthmatics can use a software package called Asthma Assistant to monitor their condition.[38] This computer program helps patients measure their condition on a daily basis, including peak air flow, medication and events that may trigger symptoms. Such biometric data can be transmitted over the Internet from a patient's computer to a physician's office computer for evaluation by a doctor or technician (a process called telemonitoring). The software program analyzes airway obstruction data gathered by the patient using a spirometer, which measures the speed and volume of exhalations. A recent study of asthma patients trained to perform in-home

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[32] Author's conversation with HealthPoints CEO, J. Mark Lambright, and HealthPoints Web site.

[33] Tjard R. Schermer, et al., "Randomized Controlled Economic Evaluation of Asthma Self-Management in Primary Health Care," *American Journal of Respiratory and Critical Care Medicine* Vol. 166, No. 8, August 2002, pages 1062-1072. For an evaluation of direct medical treatment costs for asthma, see Michael T. Halpern, et al., "Asthma: Resource Use and Costs for Inhaled Corticosteroid vs Leukotriene Modifier Treatment—a Meta-Analysis," *Journal of Family Practice*, May 23, 2005.

[34] "Asthma Overview," Asthma and Allergy Foundations of America, Internet. Available online at http://www.aafa.org/display.cfm?id=8&cont=5.

[35] Li Yan Wang, Yuna Zhong and Lani Wheeler, "Direct and Indirect Costs of Asthma in School-age Children," *Preventing Chronic Disease*, Vol. 2, No. 1, January 2005.

[36] Ibid. Implementation costs were mostly incurred in year one and amounted to about $200.

[37] See "Take Control - Q&A to Having a Self Management Plan," AsthmaAssistant.com. For instance, an asthma self-management plan could stipulate that if a patient's "peak airflow" falls to 80 percent of their personal best peak airflow, they should increase medications at a pre-established rate and schedule a physician appointment. Patients should go to the emergency room if their peak airflow falls below 50 percent.

[38] For information see http://www.asthmaassistant.com.

asthma telemonitoring found that the results of self-testing were consistent and met established guidelines.

Moreover, participation in telemonitoring did not require that patients have extensive computer knowledge.[39] Some 87 percent of patients in the study were "strongly interested" in continuing to use this method. CorScience Cardiovascular Innovations has a peak airflow meter that is equipped with Bluetooth connectivity to a telemedicine transmission device.[40]

Bleeding and Clotting Disorders. A variety of conditions cause patients to bleed too freely or their blood to clot too readily. A study of Veteran's Administration patients found that home self-monitoring of prothrombin time (clotting) while taking Coumadin (Warfarin) to reduce the formation of blood clots is superior to standard monitoring by physicians. The "bleeding rate" was 11 percent for patients monitored monthly at a clinic, but only 4.5 percent for patients who monitored their own prothrombin time at home on a weekly basis. The rate of blockages caused by blood clots, known as thromboembolism, was four times higher with standard follow-up therapy than with self-monitoring (3.6 percent each year versus 0.9 percent). Serious cases of bleeding (and/or thromboembolic events) occurred in 2.7 percent of cases per year in the standard-monitoring group but there were none in the home-monitoring group.[41]

Innovative Services that Increase Access to Care[42]

Entrepreneurial health care providers are creating many new services to better serve patients by offering greater convenience and lower prices. These services are often unavailable in traditional clinical settings, while in other cases, convenience and access have improved. Many of these services initially began outside the third-party payment system. In virtually all cases, adopting quality-enhancing or patient-pleasing amenities is an integral part of their business model.

Laboratory and Diagnostic Testing. When diagnostic tests are needed, patients can order their own blood tests without a doctor's appointment and compare prices at different testing facilities. Patients can also avoid a second doctor's appointment to receive the test results. In many cases, the results and an analysis are available online within 24 to 48 hours. Another option is cash-based storefront locations or mobile coaches, which are beginning to offer affordable lab tests in a convenient setting. These provide results quickly and without a visit to a physician's office. Results are stored in a personal health record and accessible to patients. For example, MyMedLab.com offers full range of laboratory tests and sells bundled packages designed to meet the needs of different groups of patients — by age, sex and family medical history. Prices are 50 percent to 80 percent lower than identical tests ordered by a physician. A general health screen of 30 blood metrics costs about $54, and patients who order online save an additional 10

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[39] Joseph Finkelstein and Manuel R. Cabrera, "Internet-Based Home Asthma Telemonitoring," *Chest* (American College of Chest Physicians), Vol. 117, No. 1, January 2000, pages 148-155.

[40] CorScience Web site: http://www.corscience.de/en/medical-engineering/products-systems/telemedicine/sensors/peakflow-meter.html. Accessed March 27, 2009.

[41] Bruce Jancin, "Warfarin Home Self-Monitoring," *Family Practice News*, April 1, 2000.

[42] Much of this is taken from Devon M. Herrick, "Health Care Entrepreneurs: The Changing Nature of Providers," National Center for Policy Analysis, Policy Report No. 318, December 2008.

percent. Patients can access the service by visiting more than 2,000 collection centers nationwide. The firm also stores customers' lab tests results electronically for later comparison.[43] HealthFair, a health care screening company based in Winter Park, Fla., operates a fleet of mobile screening "Health Coaches." The firm is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and it claims to have performed over 1 million preventive screening tests since 1999. Its big sellers are preventive screens to assess the risk of heart attack, stroke and aneurism. The seven-test package consists of an echocardiogram, electrocardiogram, an Adrenal Stress Index test, carotid artery ultrasound, ultrasound to detect abdominal aortic aneurysms, an ankle-brachial blood pressure index test and bone density ultrasound. In some locations, patients are offered a full lipid panel, glucose test, and a choice of one thyroid, prostate, C-reactive protein or ALT/AST (liver function) test for an additional fee. HealthFair claims its popular 7-test pack would cost around $2,300 if performed in a hospital setting. But it offers a promotional package deal (with interpretation) for only $195 — an 85 percent discount off the price of having the same tests performed piecemeal at a local hospital. Why so cheap? For one thing, HealthFair streamlines the scanning process, keeping overhead low and offering package deals. Results are automatically sent to the patient and his primary care physician. But the primary reason the price is so dramatically lower is that patients pay cash at the time of services. When patients pay with their own dollars, firms must offer value and convenience.[44] These firms are competing on price in order to attract cash-paying customers.

Entrepreneurs have created a number of innovative medical practices in the past few years.

Retail Clinics.[45] Walk-in clinics are small health care centers located inside big-box retailers, or storefront operations in strip shopping centers. They are staffed by nurse practitioners and offer a limited scope of services but added convenience.[46] Originally, patients were expected to pay the cost out-of-pocket. However, as the service has proven to be convenient and efficient, insurers are beginning to reimburse for the service. MinuteClinic is the pioneer of clinics operating within larger retailers — allowing shoppers in Cub Foods, CVS pharmacies and Target stores to get routine medical services such as immunizations and strep tests. No appointment is necessary and most office visits take only 15 minutes. MinuteClinics clearly list prices, which are often only half as much as a traditional medical practice — most treatments cost $59.[47] MinuteClinics use proprietary software to guide practitioners through diagnosis and treatment protocols based on evidence-based medicine. In contrast to standard physician practice, medical records are stored electronically and prescriptions can also be ordered that way. There is also evidence that the quality of routine care in walk-in clinics is comparable to treatment in traditional physicians' practices. MinuteClinics received high marks for quality of care in the recent Minnesota

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[43] Author's conversations with CEO David Clymer and Web site MyMedLab.com. Accessed November 15, 2008.

[44] HealthFair promotional advertisement, *Dallas Morning News*, August 2008, and HealthFair.com Web site. Accessed October 2008.

[45] Devon M. Herrick and John C. Goodman, "The Market for Medical Care: Why You Don't Know the Price; Why You Don't Know about Quality; And What Can Be Done about It," National Center for Policy Analysis, Policy Report No. 296, March 12, 2007.

[46] Milt Freudenheim, "Attention Shoppers: Low Prices on Shots in Clinic," *New York Times*, May 14, 2006.

[47] Information taken from MinuteClinic.com Web site. Accessed November 16, 2008.

Community Measurement Health Care Quality Report.[48] The report measured appropriateness and quality of care for two common ailments among children: colds and sore throats. For example, in treating sore throats, each medical practice was evaluated on the basis of whether they administered a strep test and only prescribed antibiotics when test results were positive. For appropriate care:[49]

- MinuteClinics scored around 99 percent.
- The Mayo Clinics scored 77 percent.
- The average provider rating was 81 percent.
- The lowest provider score reported was 26 percent.

On care of children with colds:

- The Mayo Clinics scored 95 percent.
- MinuteClinics scored 87 percent.
- The average provider rating was 84 percent.
- The lowest provider score reported was 37 percent.

MinuteClinics scored at least as well as the average and there was far less variation.

To be successful, retail clinics must provide consistent, high-quality service and a way to share patient information with customers' primary care physicians. These require the use of technology, including computerized protocols, decision-support tools and EMRs. When patient records are stored electronically, it is more efficient and accurate to prescribe electronically than to handwrite a paper prescription that is then transcribed into an electronic record. Furthermore, the use of EMRs and electronic prescribing allows for error-reducing software to check for drug errors, patient allergies, contraindications and drug interactions. These are systems that health care reformers believe all doctors should adopt, but few actually do. However, in these cash-pay markets, providers have adopted quality-enhancing information technology because their business model virtually requires them to do so. Without it, retail clinics would find it difficult to compete. Many other entrepreneurs are launching similar limited-service clinics. Walmart leases space for walk-in clinics to MinuteClinic and RediClinic (among others) and has begun to expand these operations nationwide.[50] RediClinic also allows patients to order numerous lab tests for fees that are nearly 50 percent less than tests ordered by physician offices.[51] Competition from these new clinics may lead traditional physician practices to adopt new technology and offer more convenient weekend and extended hours.[52]

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[48] Minnesota Community Measurement, "2007 Health Care Quality Report," available at http://www.mnhealthcare.org/Resources/2006/FinalReport/2007 Full Report.pdf. Accessed November 16, 2008.

[49] For sore throat scores, see http://www.mnhealthcare.org/Resources/2006/FinalReport/2007 Full Report.pdf. Accessed November 17, 2008.

[50] Rik Kirkland, "Walmart's RX for Health Care," *Fortune*, April 17, 2006. RediClinic is a venture of AOL founder Steve Case's Revolution Health Group and the company Interfit.

[51] Information taken from RediClinic Web site.

[52] Maureen Glabman, "What Doctors Don't Know About the New Plan Designs," *Managed Care Magazine*, January 2006.

Telephone-Based Practices.[53] Many medical conditions do not require the physical presence of a physician or the time and expense of an office visit. Some of these could be easily diagnosed, and treatment recommended, over the phone. However, many patients report having a hard time reaching their physician on the phone — especially after hours. To meet this demand, entrepreneurs are creating nontraditional medical services in which clinical care is available at more convenient locations, by telephone or through virtual offices on the Internet. They are staffed by physicians who will order tests, initiate therapies or treatments and prescribe drugs. These services are not designed to replace primary care physicians. Rather, they are for patients who urgently need a consultation but are unable to contact their regular physician.

TelaDoc Medical Services, located in Dallas, is a phone-based medical consultation service that works with physicians across the country. Consultations are available around the clock, but patients must sign up in advance so their medical histories can be placed online. When a patient calls TelaDoc, several participating physicians near the caller are paged. The first physician to respond is paid for the consultation. TelaDoc guarantees a return call within three hours, or the ($35) consultation is free — but most calls are usually returned within 30 to 40 minutes.[54] Further, unlike most primary care practices, TelaDoc retrieves and stores patient records electronically so that participating physicians can access the patient's medical history. Because patients are not in the physician's office (and the physician can vary from one consultation to the next), patient records must be stored and retrieved electrically. Drug therapies also must be prescribed electronically — facilitating safety-enhancing software that checks for harmful interactions. Due to the nature of telemedicine, firms like TelaDoc must have EMRs to perform tasks. Some telemedicine firms also have computerized protocols to assist the physician in diagnosing ailments. Thus, competition to reduce waiting or enhance convenience using telemedicine leads to personal and portable electronic medical records.

Concierge Medical Practices. Some innovative physicians are creating practices designed to be convenient and accessible to patients. These so-called concierge physicians compete on two different facets of cost: time and mone. Time costs refers to the waiting and inconvenience often entailed in traditional physician office visits. Thus, some of these physicians provide after-hours office visits, patient education and house calls. Physicians in concierge practices relate to their patients in much the same way lawyers and accountants interact with their clients — including phone calls, e-mail consultations and convenient Web-based services. These practices are essentially rebundling and repricing medical services in ways that are not possible under third-party insurance. Thus, a necessary part of their business model is to find patient-pleasing services that solve the problem of excessive time costs and poor quality. *Doctokr Family Medicine* is the Virginia medical practice of Dr. Alan Dappen, who practices medicine mostly by telephone and e-mail contact. Patients can schedule an appointment or e-mail the doctor, all from the Doctokr.com Web site. In fact, Dappen's waiting room is a Web page. Patients can also make appointments to be examined in his office, and though he will even make house calls for some patients, he encourages most patients to consult with him by e-mail or telephone. Like attorneys,

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[53] Devon M. Herrick, "Convenient Care and Telemedicine," National Center for Policy Analysis, Policy Report No. 305, November 28, 2007.

[54] Ibid. Also, information obtained from conversations with TelaDoc executives and the TelaDoc Web site.

Dappen bases his consultation fees on the amount of time required. Charges are billed in five-minute increments and range from $67.50 for in-office visits (first 10 minutes; $22.50 each additional 5 minutes) to $22.50 for phone consultations with patients who have set up membership accounts. A simple call to renew a prescription or ask questions generally costs less than $20. Although the office does not bill insurance companies for services, most patients can easily turn in a claim themselves. Patient records are kept electronically.[55] Concierge medicine is normally associated with personalized services for the wealthy. Depending on the practice, these services can be expensive — in some cases more than $2,500 a year per person. However, in the Dallas suburb of Collin County, Texas, physician Nelson Simmons offers a version of that service for less than $500 a year.[56] About 70 small business owners pay $40 per employee per month for Simmons' plan. In return, employees get same-day primary care services and steep discounts on diagnostic tests and specialist care. Enrollees must pay out-of-pocket for specialist care, surgeries and diagnostic tests. But Simmons negotiates the rates, which are typically much lower than what others pay. For example, a tonsillectomy for a child costs less than half of the normal fee ($2,100 versus $4,800) and an MRI scan can be less than one-fourth of the standard charge ($350 versus $1,600).[57]

Conclusion

Community-based public health is valuable and cost-effective, when focused on public problems. However, most chronic diseases are very personal and individual. The most cost-effective way to treat and prevent chronic disease – and achieve many modern public health goals – is to allow patients to control more of their own health care dollars, and to allow patients and providers to benefit from new arrangements that produce lower cost, higher-quality care. Government insurers should also allow doctors and hospitals to repackage and reprice their services under government health care payment systems — allowing them to gain financially from providing better care.

Today, competitive markets are emerging outside the third-party payment system covering services ranging from primary care to major surgery. The reason: Patients are paying for more services out of pocket. What lesson can we learn from these examples of entrepreneurship in health care? The most important is that entrepreneurs can solve many of the health care problems that critics condemn. Public policy should encourage, not discourage, these efforts.

Consumers now have numerous avenues to become smart shoppers of health services – particularly those services that public health professionals agree will help treat and prevent chronic diseases. Research has shown that employees are more satisfied when they have a greater choice of plans and consumer-driven health care offers them the ultimate choice. With these new plans comes the opportunity to manage our own care. An important byproduct is that the quality of health care and service improves when patients control the checkbook, rather than third-party insurers.

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[55] Doctokr.com Web site. Accessed November 18, 2008.

[56] Jason Roberson, "Doctor Taking Care of Small Business," *Dallas Morning News*, April 30, 2007.

[57] Ibid.

Mr. PALLONE. Thank you, Dr. Herrick. Dr. Levi.

STATEMENT OF JEFFREY LEVI

Mr. LEVI. Thank you, Mr. Chairman. Good afternoon. My name is Jeffrey Levi and I am the Executive Director of Trust for America's Health, a nonpartisan, nonprofit organization dedicated to saving lives by protecting the health of every community, and working to make disease prevention a national priority. I would like to thank the members of the subcommittee for the opportunity to testify on the role of prevention and public health as a component of the health reform debate. This afternoon I would like to make 2 major points. First, the critical importance of public health programs, in particular, population and community-based prevention in improving the health of Americans and making a reformed health care system more effective.

Second, the need to create a reliable, stable funding stream for public health programs and services as part of health reform. Otherwise, the potential benefits of public health to the health care system will be lost. My written testimony also addresses the need to build the evidenced-based prevention programs and invest in public health systems and services research, to improve the quality of public health that is delivered in the U.S. Much of what is said there has been covered in Dr. Fielding's testimony. Health care in the United States has become an expensive burden on our economy. High rates of chronic disease are among the biggest drivers of the American health care costs. What this means in real terms is that Americans are not as healthy as they could be or should be and that is translating into huge growth in our health care costs.

The country will never be able to contain health care costs until we do a better job of preventing people from getting sick in the first place. That is where public health comes in. The Nation's public health system is responsible for keeping Americans healthy and safe by preventing disease and promoting healthy lifestyles including those that prevent or mitigate chronic disease, diseases that are driving up health care costs. The goal is to prevent disease, prevent people from having to enter the clinic and need disease management, which is really what Dr. Herrick was talking about. He was talking about disease management rather than primary prevention. Yet, there are proven community-based programs that actually prevent disease that promote healthy environments and behavior making it easier for people to make healthy choices.

Shifting community norms about tobacco use, the social marketing campaigns, changing the physical and social environment in which people live by making communities more walkable through better street lighting and sidewalks, creating group walking or exercise programs to encourage physical activity or improving access to healthy foods are all examples of community interventions that work to prevent or mitigate chronic diseases; and we know that investing in prevention, especially community-based programs, can have a big payoff. A study, Trust for America's Health, issued last summer found that an investment of $10 per person per year in improving community-based programs to increase physical activity, improve nutrition and prevent smoking and other tobacco use, with

that the country could save more than $16 billion annually within 5 years.

This is a return of investment of $5.60 for every dollar spent, based on an economic model developed by Urban Institute and an extensive review of evidence-based studies by the New York Academy of Medicine. Out of that $16 billion in savings Medicare could save more than $5 billion, Medicaid $1.9 billion, and private payers could save more than $9 billion. That is the good news. We have proven community-based public health interventions work; but to fully realize this potential return on investment and keeping Americans healthy requires a larger and sustained investment in public health. The bad news is right now the public health system is structurally weak in nearly every area and that is the system which ranges from federal agencies such as the CDC from whom you heard earlier to the nearly 3,000 state and local public health agencies to countless non-governmental organizations.

That system does not have enough resources to adequately carry out core disease prevention functions. In collaboration with the New York Academy of Medicine, Trust for America's Health convened a panel of experts to analyze how much is currently spent on public health in the United States and how much more would be needed to support core public health services at a sufficient level. The panel's professional judgment was that there is currently a shortfall of $20 billion per year in spending on public health. Therefore, we believe that a reformed health care financing system must include stable and dedicated funding for core public health functions and community-based prevention. We recommend the establishment of a public health and wellness trust fund through a mandatory appropriation or set aside of a portion of new revenues generated from the financing of health reform. Resources from the trust fund would be allocated to specific public health programs or activities as directed by the relevant appropriations committees those public health functions and services that surround, support, and strengthen the health.

The trust fund would fund core governmental public health functions. It would also fund population level non-clinical prevention and wellness programs which can be delivered both through governmental and non-governmental agencies. It would support clinical preventive services such as screening and immunizations that are not covered by third party payers, and it would also support work force training and development, as well as public health research. The trust fund could help make up for the country's current $20 billion annual shortfall in public health spending. Based on the current distribution of responsibility along with federal, state, and local governments, $10 to $12 billion of that amount should be a federal responsibility. In short, Trust for America's Health believes that prevention and public health must be at the center of any effort to reform our health system. Public health programs are a critical and underfunded component of the Nation's health system. We encourage Congress to establish a public health and wellness trust fund to make our country healthier, our health system more cost effective and our economy more competitive. Thank you, Mr. Chairman.

[The prepared statement of Mr. Levi follows:]



Written Testimony of
Jeffrey Levi, PhD
Executive Director
Trust for America's Health

Before the House Energy and Commerce Committee
Subcommittee on Health

March 31, 2009

Good morning. My name is Jeffrey Levi and I am the Executive Director of Trust for America's Health (TFAH), a nonpartisan, nonprofit organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority. I would like to thank the members of the Committee for the opportunity to testify on the role of prevention and public health as a component of the health reform debate.

This morning I would like to emphasize three major points:

1. The critical importance of public health programs, in particular population and community-based prevention, in improving the health of Americans and making a reformed health care system more effective.

2. The need to create a reliable, stable funding stream for public health programs and services as part of health reform. Otherwise, the potential benefits of public health to the health care system will be lost.

3. The need to build the evidence base for prevention programs and invest in public health systems and services research to improve the quality of public health that is delivered in the U.S.

Escalating Health Care Costs and Consequences

Health care in the U.S. has become an expensive burden on our economy. For over 30 years, health care costs have increased two percentage points faster than the rest of the Gross Domestic Product (GDP).[1] Businesses and families were struggling to cover health care costs before the recent economic crisis, and as we all know, times have gotten even harder when it comes to paying these bills. And, the Federal and state governments are also struggling with how to cover the impact of rising costs on Medicare and Medicaid.

Clearly, the country is working hard to address the current broader financial problems we face. However, if we are going to get the economy back on the track for the long term, we also need to get health care costs under control. The country is searching for effective ways to restrain these staggering costs. Office of Management and Budget (OMB) Director Peter Orszag has stated that reducing the growth in health care to one percent higher than the rest of the GDP per year rather than the projected two percent is a realistic goal to help get costs under control. Disease prevention is a critical, but often neglected, strategy for meeting this goal.

High rates of chronic disease are among the biggest drivers of U.S. health care costs. What this means in real terms is that Americans are not as healthy as they could be or should be, and that is translating into huge growth in our health care costs. And our workforce is less productive than it could be or should be to compete with the rest of the world.

America's future economic well-being is inextricably tied to our health. The country will never be able to contain health care costs until we do a better job of preventing people from getting sick in the first place, and giving people the opportunity and support they need to be as healthy as they can be.

We spend more than any other country in the world on health care -- more than $6,000 per person per year.[2] But we have some of the worst health outcomes of industrialized countries -- and tens of millions of Americans suffer every day from preventable illnesses and chronic diseases like cancer, diabetes, and heart disease that rob them of health and quality of life.

More than half of all Americans live with one or more chronic disease, including heart disease, stroke, diabetes, and cancer.[3] Experts estimate that 75 percent of U.S. health care costs are attributable to chronic diseases. The U.S. Centers for Disease Control and Prevention (CDC) estimates that a large percentage of these diseases could be prevented through lifestyle and environmental changes -- such as improving nutrition and physical activity and preventing smoking.

Keeping people healthier is one of the most important, but often overlooked, ways to reduce health care costs. Health reform efforts often focus on health care coverage, which is clearly essential. But, coverage alone -- even affordable, quality coverage -- is not enough.

The Value of Public Health and Community Disease Prevention

That's where public health comes in. The nation's public health system is responsible for keeping Americans healthy and safe. Public health is devoted to preventing disease and injury. Public health officials help protect our food and water supplies, prevent infectious disease outbreaks like pandemic flu or tuberculosis, respond to natural disasters and bioterrorism threats, and control chronic diseases like diabetes and cancer in communities.

There are proven community-based programs that promote healthy environments and behaviors, making it easier for people to make healthy choices. Shifting community norms about tobacco use through social marketing campaigns, changing the physical and social environment in which people live by making communities more walkable through better lighting and sidewalks, creating group walking or exercise programs to encourage physical activity, or improving access to healthy foods, are examples of community interventions that work to prevent or mitigate certain chronic diseases.

Community prevention programs can also magnify the effectiveness of prevention efforts initiated in the clinical setting by supporting the ability of individuals to follow medical advice and make healthier lifestyle choices. For example, a doctor can encourage a person to be more physically active, including writing a prescription for that individual to get more exercise. However, unless the patient has access to a safe, nearby place to engage in physical activity, he or she will not be able to "fill" this prescription.

And, the good news is we know that investing in prevention, especially community-based programs, can have a big payoff. A study we at the Trust for America's Health issued last summer, entitled *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities,* found that for an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use, the country could save more than $16 billion annually within five years.[4] This is a return of $5.60 for every $1 spent.

Out of the $16 billion in savings, Medicare could save more than $5 billion, Medicaid could save more than $1.9 billion, and private payers could save more than $9 billion.

These findings, which are based on a economic model developed by the Urban Institute and an extensive review of evidence-based studies by The New York Academy of Medicine, show that this investment could result in reducing rates of type 2 diabetes and high blood pressure by five percent within just one to two years, and rates of heart disease, stroke, and kidney disease by five percent within five years, and rates of some types of cancer, arthritis, and chronic obstructive pulmonary disease by 2.5 percent within 10 to 20 years.

There are a number of examples of evidence-based programs that work. *The Community Guide to Preventive Services,* published by the CDC, includes more than 200 interventions reviewed by the Task Force on Preventive Services. And numerous programs that the CDC supports with funds to state and local health departments are seeing strong results. For instance, Fulton County, Georgia officials implemented a campaign to promote cardiovascular disease education called REACH OUT, which has led to results within just two years. The percentage of adult participants who regularly engage in moderate-to-vigorous physical activity increased from 25 percent to 29 percent. During this period, the percentage of adults who reported checking total blood cholesterol

levels increased from 69 percent to 80 percent, and the percentage of adults who smoked decreased from 26 percent to 21 percent.[5]

In Broome County, New York, more than three of every five adults are either overweight or obese. Utilizing a CDC grant from the Steps to a Healthier US (now Healthier Communities) program to help rural families has, within one year, led to an increase in the percentage of people who walk for 30 minutes or more five days a week -- from 51 percent to 61 percent. The program also supported a consolidated bid for 15 school districts to purchase healthy foods at lower costs, which resulted in a 14 percent increase in fruit and vegetable consumption; and expanded a diabetes prevention program in conjunction with the local YMCA and Office of Aging, where participants in the program lost more than five pounds on average.[6]

Public Health Does Not Currently Have Sufficient or Steady Funding

The bad news is, right now, the public health system is structurally weak in nearly every area. A range of studies from leading authorities including the Institute of Medicine (IOM) and the Government Accountability Office (GAO) have found the public health system is chronically underfunded and in need of major modernization. The public health system is comprised of federal agencies, ranging from the CDC to nearly 3,000 state and local public health agencies to countless non-governmental organizations.

Federal, state, and local health departments do not have enough resources to adequately carry out core disease prevention functions. In collaboration with The New York Academy of Medicine, TFAH convened a panel of experts to analyze how much is currently spent on public health in the U.S. and how much more would be needed to support core public health services at a sufficient level. The panel's professional judgment was that there is currently a shortfall of $20 billion per year in spending on public health.[7] The analysis found that the country currently spends approximately $35 billion per year (based on a review of fiscal year (FY) 2005 spending at the federal, state, and local levels), but that an additional $20 billion would be needed to adequately support basic public health functions that are currently unmet in communities across the country.

The recent American Recovery and Reinvestment Act provided an historic investment for public health, including $650 million in funding for community-based prevention programs. This was an important start -- and important down payment -- toward reducing health care costs over the long term. Or, as President Obama said upon signing the law, these are necessary investments in "wellness initiatives that will keep millions of Americans from setting foot in the doctor's office in the first place."

But it was only one time funding. To realize the full potential return on the investment in keeping Americans healthy, public health needs to be funded at an adequate level year in and year out to have a significant and long-term impact. This means we need to create a sustained and dedicated funding stream for public health. Without this, the promise of prevention could be lost. And we all end up paying the price, both with worse health and

higher costs, particularly as Americans enter Medicare less healthy than they could have been or should have been.

The past five years have seen a dramatic downturn in funding for CDC chronic disease discretionary programs, which are key to preventing heart disease, stroke, diabetes, cancer and obesity. They have suffered a 12 percent cut in real dollars since FY 2005. Moreover, given that public health is a shared responsibility between the federal government and states and localities, the current economic crisis has taken a significant toll on the capacity of states to maintain their investments in public health. We have already seen cuts of over 10,000 public health positions across the country, with at least that many more expected over the next year. Only the federal government has the capacity to assure an increased and stable investment in the very programs that will ensure a healthier America -- and ultimately lower health care costs and a more competitive workforce.

We are hopeful that health reform will result in coverage for all Americans. But many of the gains that are achieved through increased coverage are put at risk if we do not have a strong public health system to help prevent disease and keep Americans health. Federal, state, local, and community public health and prevention programs need to have reliable resources to support a reformed health care system. TFAH believes that ***a reformed health care financing system must include stable and dedicated funding for core public health functions and community-based prevention.***

Therefore, we recommend the establishment of a **Public Health and Wellness Trust Fund** ("Trust Fund") through a mandatory appropriation or set-aside of a portion of new revenues generated through the financing of health reform. Resources from the Trust Fund would be allocated to specific public health programs or activities as directed by the relevant appropriations committees. Funding provided from the Trust Fund would augment, not supplant, current annual baseline funding for Function 550 public health programs.

Specifically, the Trust Fund would support expansion of public health functions and services that surround, support, and strengthen the health care delivery system. The Trust Fund would finance:

- The core governmental public health functions of assessment, assurance, and policy development at the federal, state, and local levels.
- Population-level non-clinical prevention and wellness programs, which can be delivered through governmental agencies and non-governmental agencies.
- Clinical preventive services (such as screenings and immunizations) that are not covered by third party payers and delivered in community settings or by health departments.
- Workforce training and development as well as public health research.

The Trust Fund could make up for the country's current $20 billion annual shortfall in public health spending. Based on the current distribution of responsibility among the federal, state, and local governments, $10-12 billion of that amount should be a federal responsibility. It is assumed that the increase would be phased in to allow sufficient time for the system to absorb such an increase.

Quality Assurance for Evidence-Based Prevention

We know that not all prevention programs lead to cost savings. Some prevention efforts may have health benefits, without financial benefits. The health benefits alone are often reason enough to invest in prevention, to spare people from needless pain and suffering. In a reformed health care system, we recognize that there is a need to focus on investing in treatments that are cost-effective, but the rationale for financing those treatments is not contingent on their ability to save money. We need a similar standard for prevention. We should invest in prevention activities that are determined to be cost-effective for improving health, and should not necessarily be held to "savings-only" standard.

TFAH believes that investments in prevention should support evidence-based programs, and that it is essential to insure that accountability goes along with funding. Americans deserve to see evidence that their tax dollars are being put to effective use and directly helping to improve the health of our communities.

We were extremely pleased to see the provision in the stimulus bill requiring community prevention programs receiving funding to be "evidence based" and to "deliver specific, measurable health outcomes." Every effort should be made to ensure that the government is investing in the most effective programs possible. For clinical services, the U.S. Preventive Services Task Force (USPSTF) exists as an important tool for analyzing the evidence and evaluating the effectiveness and recommendations for preventive services, like immunizations, cancer screenings, diabetes screenings, and obesity counseling, which we can receive inside the doctor's office. As Congress considers comprehensive health reform, TFAH urges you to mandate coverage for *all* preventive services recommended by the USPSTF in public and private plans. We recognize that different sources for an evidence base may be needed to ensure children and adolescents are receiving the preventive services that the medical community recommends for their age groups.

We also urge Congress to support community-based disease prevention programs, since so much of what impacts our health happens outside the doctor's office. As I mentioned earlier, *The Guide to Community Preventive Services* from the CDC reviews more than 200 community-based programs. This guide was designed to assess community programs in an equivalent way to how the USPSTF reviews clinical preventive services. However, it has been sorely underfunded and has not been given the resources needed to systematically evaluate programs. In developing our return on investment model, TFAH was struck by how little systematic evaluation occurs for community prevention programs compared to clinical programs. This does not mean that we do not know that many community programs are effective. In fact, we know many of them are having a

major impact, we just do not have enough evidence to always show it. What this means is we have not invested properly in how to study their outcomes in a systematic and appropriate way. To maximize the effectiveness of our national investment in community prevention, TFAH urges Congress to provide substantially increased federal funding to strengthen this guide, so we have an enhanced *Community Guide* to provide a systematic, ongoing review of the literature and make recommendations for community prevention programs.

To continue to build the evidence base for prevention and help develop the new field of public health systems and services research, TFAH recommends the creation of a Public Health Research Institute – which could be housed either within CDC or in conjunction with the Agency for Healthcare Research and Quality (AHRQ). This Institute would be invaluable for ensuring accountability by evaluating how well tax dollars are being used and building a strong evidence base and standards for public health practices that will help support public health services in every community in the country, from coast to coast.

This Public Health Research Institute should be charged with identifying and disseminating a set of "best practices" for public health. This should include developing accountability measures and providing information about the public health workforce, including career categories, skill sets, and workforce gaps. With this information, states and localities would be better informed to make decisions about policies and program implementation. The Institute should also address serious, complex and emerging public health issues, including social determinants of health and how to set standards and evaluate data on health outcomes.

Conclusion

In short, TFAH believes that prevention and public health must be at the center of any effort to reform our health system. Public health programs are a critical and under-funded component of the nation's health system. We encourage Congress to establish the Public Health and Wellness Trust Fund to make our country healthier, our health system more cost-effective, and our economy more competitive.

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[1] Center on Budget and Policy Priorities. "The Long-Term Fiscal Outlook is Bleak: Restoring Fiscal Sustainability Will Require Major Changes to Programs, Revenues, and the Nation's Health Care System." Center on Budget and Policy Priorities. December 16, 2008. http://www.cbpp.org/cms/index.cfm?fa=view&id=2215

[2] K. Davis, C. Schoen, S. C. Schoenbaum, M. M. Doty, A. L. Holmgren, J. L. Kriss, and K. K. Shea, Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care, The Commonwealth Fund, May 2007.

[3] R. DeVol and A. Bedroussian, et al. *An Unhealthy America: The Economic Burden of Chronic Disease.* Santa Monica, CA: Milken Institute, October 2007. http://www.milkeninstitute.org/publications/publications.taf?function=detail&ID=38801020&cat=ResRep. (accessed October 10, 2007).

[4] Trust for America's Health. *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities.* July 2008. http://healthyamericans.org/reports/prevention08/.

[5] U.S. Centers for Disease Control and Prevention. *REACHing Across the Divide: Finding Solutions to Health Disparities.* Atlanta, GA: U.S. Department of Health and Human Services, Center for Disease Control and Prevention; 2007.

[6] U.S. Centers for Disease Control and Prevention. *The Steps Program in Action: Success Stories on Community Initiatives to Prevent Chronic Diseases.* Atlanta: U.S. Department of Health and Human Services; 2008.

[7] See *Blueprint for a Healthier America: Modernizing the Federal Public Health System to Focus on Prevention and Preparedness* (October 2008) for information on the expert panel and additional funding details; available at http://healthyamericans.org/report/55/blueprint-for-healthier-america.

Mr. PALLONE. Thank you, Dr. Levi. Those bells mean that we have votes. We have three, 15 minutes, a 5 and a 5, so figure I guess about a half an hour. So what we are going to do is have questions when we come back in about a half hour or so. I hope no one has to leave. OK. So the committee stands in recess.

[Recess.]

Mr. PALLONE. The subcommittee will reconvene if the panel could take their seats. I realize I think I said half an hour but it was more like an hour unfortunately. So we will start with questions, and I will begin and yield to myself 5 minutes. Basically, on the disparities issue, I guess I would ask Dr. Satcher and Commissioner Howard this questions. I don't know if you were here when the first panel was here, but I basically said that a lot of these decisions that lead to healthy lifestyles are very personal and so you wonder to what extent public health agencies can really influence them, but I know that they can because I think the anti-smoking efforts on the part of public agencies were very successful, and I used my kids as an example.

But when we hear about disparities, you know, I go back to the same thing again. To what extent are some of these disparities things that we can change, and of course I think, Dr. Satcher, of the fact that often times in the inner city, you know, you don't have as many parks or open spaces so it is more difficult for people maybe to get exercise. I don't know if that is necessarily true but sometimes it is true. And other members have made the argument that sometimes in certain urban areas you don't even have a supermarket where you can get fresh foods or vegetables.

But I could just as well make that argument, I use the example of some of the American Indians. I am very familiar, for example, with some of the Pema tribes in Arizona, and they have some of the highest incidents of diabetes, you know, that comes from a lot of it from obesity, and yet they have plenty of open space although they do have a problem in that their traditional diet ranching, farming, has sort of disappeared in the last few years. So I mean do you think that there are things that we can do that make a difference in terms of these disparities, you know, like creating more open space or providing more fresh vehicles or whatever you think is the case?

Dr. SATCHER. Well, I think it is a very important question, and the answer is, yes, I do. Beginning with our children, I think again it gets back to providing incentives and some of those incentives are being with parents out walking and enjoying, you know, that association. But I really think there are a lot of ways that we can incentivize our children to engage in health efforts. Now one of the reason I spent so much time with the schools since I left office with the Action for Healthy Kids program that is now in all 50 states and the District of Columbia is that schools are the great equalizers.

Some of the kids come from homes with single parents and the parent may only have time to get up and get the kids off to school and try to be there when they get back, but the children spend over 1,000 hours in school every year. We pay for that, and we ought to be committed to an environment that helps habituate children to health lifestyles because children become habituated to

unhealthy lifestyles and that is foods that are high in fat, foods that are high in salt, foods that are high in sugar are really addicting and children become habituated so the time that they spend in school and the resources that we use at school ought to be devoted to helping to habituate children to healthy lifestyles. We can do that. We provide the resources.

And I think what Congress did in 2004 with the WIC reauthorization basically requiring every school district that received funds for free meals to have in place a wellness policy within 2 years has worked well. According to our studies, over 90 percent of the school districts have those. Now the problem is how do we get them to implement them?

Mr. PALLONE. But, you know, and I want to move on to ask Commissioner Howard a question, you know there is a proliferation now in a lot of urban areas and all over like charter schools and smaller public schools. A lot of times they don't have the buildings or the playgrounds and to some extent as we have emphasized, you know, studies and I think of the charter schools, a lot of them started for high tech or math or science or whatever, and then they don't necessarily have the facilities, you know, or the playgrounds or whatever. But, anyway, I have to ask Commissioner Howard this question.

Ms. HOWARD. Just on that point.

Mr. PALLONE. Yes, sure.

Ms. HOWARD. I think that is a great point for you to raise because even when we control for health insurance, we see troubling disparities based on race, so we know that just universal access to health insurance is not the only answer to get——

Mr. PALLONE. That is what I was going to ask you actually, so why don't you just get into it.

Ms. HOWARD. Well, I think it is clear, and I think that is where public health plays a role where we can focus on evidence-based community interventions. And I will just give you one example. In your own district, I visited the FUEC in Long Branch and they are doing an interesting project with pregnant women called the health start model.

Mr. PALLONE. The health center, yes.

Ms. HOWARD. The FUEC that is run by the VNA there. Every pregnant woman who comes in is assigned a nutritionist and a social worker. So I toured, and I said this is better care than I got when I was pregnant. It was amazing the follow-ups she got, so she got nutritional counseling throughout her pregnancy and so her risks were detected early. Then she got the social supports that she needed, and those are the kind of programs that we know are evidence-based that we know work to reduce infant mortality, so I think public health really does play a critical role in reducing disparities since we can't there just on expanding coverage.

Mr. PALLONE. I am going to try to get in my second question to you which was I think the notion that if we do health care reform and somehow we manage to cover everyone that a lot of these public health concerns are going to go away but I don't think that is true, and I wanted you to comment on that. What happens in this post-Nirvana environment when we pass comprehensive health insurance and everyone has health insurance, are you still going to

have a major public health role here and how do we build that into it?

Ms. HOWARD. I think that is a great question to discuss today. I think absolutely public health has a role for two reasons. One, I think public health is critical to the sustainability of the health reform that you all will enact. Public health, as we have talked about today, and you heard from your first panel of the critical role we can play in managing chronic diseases and containing cost will be critical to making health reform work, so I think it is part of health reform. I think we also can't ignore the fact that health reform will probably leave some people behind. We have seen in Massachusetts, for example, that none everyone has been covered.

And actually we have seen, I was looking this up last night, that federally qualified health centers, the community clinics, have seen an increase in the number of visits since they have had their universal health care. So safety net providers like federally qualified health clinics will still play a role because they know how to reach perhaps hard to reach populations in culturally competent ways. They are critical to reducing disparities. So, one, it is critical to the sustainability from a financial perspective, but also we know that coverage is not the only answer to improving the health of Americans, and so public health will still be vital whether it is dealing with making sure that kids go to a day care center that has clean air, whether it is making sure that we don't have food safety problems. All those things we are still getting in public health.

Mr. PALLONE. OK. Thank you. Mr. Deal.

Mr. DEAL. Thank you. Dr. Spivak, I was intrigued by your testimony as to what your group is doing. It is apparently very impressive results that you are achieving. And I notice that you mentioned the Tufts Health Plan Medicare Preferred. I assume that is a Medicare Advantage program, is that correct?

Dr. SPIVAK. That is correct. It is a Medicare Advantage HMO product, so it is different than the Medicare Advantage fee for service products in that the patients choose a primary care physician and choose a network, so it allows us to get information about them because we know who their primary care doctor is and who is responsible for their care, so it give us access to claims data about their pharmacy utilization, what prescriptions they are really filling, and gives us easier access to if they go out of our network getting information about their care as well.

Mr. DEAL. Obviously, you are aware that much of the movement about Medicare Advantage is to do away with those kind of programs. If Medicare Advantage is basically abolished then your network that you have established would virtually disappear because—and you wouldn't have the flexibility that you have described in the way you outreach now, is that right?

Dr. SPIVAK. That is correct. And it is one of the problems that we see if Medicare Advantage goes away that the fee for service medicine just doesn't allow us to give the infrastructure and the support that we need to do this kind of care. The medical home concept that people are talking about goes a little bit towards it but it really doesn't go far enough in the current models to provide the extensive programs that we have today.

Mr. DEAL. Dr. Herrick, following on that same line of questioning from your printed testimony excerpts you say government insurers should also allow doctors and hospitals to repackage and re-price their services under government health care payment systems allowing them to gain financially providing better care. You go on to say entrepreneurs can solve many of the health care problems that critics condemn. One of the concerns I have is that if we move into a system that is as rigid as our current systems are in basically a fee for service format, I think we bill rigidity into the system and we don't allow any room for entrepreneur or even for those providers who want to do things in a little different way. Is that the point you were trying to make?

Mr. HERRICK. Well, the point I was trying to make is under the current system it is a very rigid system. Basically Medicare and Medicaid tend to pay by task. We are not paid for results, we are not paid for outcomes. In a sense, if you have pay for performance often times it is the payers of health care trying to tell the purveyors of health care, the providers of health care, how to practice medicine. It is the doctors and hospitals that know the most about how to practice medicine. Let them propose novel solutions. Let them experiment. And if they can find a way that has higher quality and lower cost let them suggest ways of getting paid.

For example, I gave some anecdotes about how the chronic disease management firms talk to you on the phone. They might e-mail you to tell you, you forgot to take a certain blood glucose test, but Medicare will not pay for those, will not reimburse for that type of advice, neither will Medicare, but yet these are very innovative type of arrangements. Tele-medicine is a very efficient way to prod people into compliance. We need to have ways of reimbursing physicians for doing those very novel ideas.

Mr. DEAL. Dr. Satcher, once again, I compliment you for all the good work you are doing and for things that you are continuing to promote. The Alzheimer's research is particularly important. But I think as we look at children, which has I think been one of your focuses as well in your testimony here today as Georgia has its peach care component of our S–Chip program isn't it important that we give some flexibility to the way that program works so that, for example, there can be coordination between community health centers that may be providing part of the care between primary physicians that may become a medical home and then the traditional providers of health care. I have a sense that we don't have that kind of coordination of care that is allowed under our current silos in which we deliver health care. Do you agree or disagree?

Dr. SATCHER. Oh, I agree. This was about Alzheimer's. One of our major recommendations, in fact, a second recommendation is for enhancing community collaborative care using electronic health records but tying people together all the way from family members who take care of relatives when they are ill with Alzheimer's, tying them together with physicians and other health care providers so the community collaborative system of care is one that I think is very important at every level.

Mr. DEAL. I have to keep shielding my eyes to see the clock up there. I think I am over and exhausted my time. Thank you all for being here.

Mr. PALLONE. Mrs. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. And I want to thank the panelists for their patience. I know you have had a long week. Dr. Howard, you say in your testimony that we need a public health work force to deliver the basic package. Would you elaborate on the components and the characteristics that you see being needed in that work force?

Ms. HOWARD. Thank you. That is a great question. I think one thing we haven't talked about today is the nursing public health work force. We haven't talked enough about nurses, and nurses are a critical component of our public health system, and we are facing a very dire shortage of nurses in New Jersey but nationally. So that is just one example of where we are facing a shortage. We are also facing in New Jersey, and I know this is true nationally and in our urban areas, a shortage of other practitioners as well. And access to dental care is restricted, so we have a number of practice areas where there is a real shortage. I am pleased that in the recovery act there was funding for development of the work force, and I think that will go a long way.

But I encourage you all as you think about reforms to think about that, and I think one of the lessons learned from Massachusetts was that even having universal health insurance was not good enough. People can't see a provider. And then from my own perspective also states are unfortunately having to make lots of cuts in programs, and we are cutting staff in vital programs because of the economy, so it is hitting us on all fronts.

Mrs. CHRISTENSEN. Thank you. Dr. Satcher, references have been made to 2010 and I guess it is now 2020 goals. I think we started at 2000 goals, then to 2010, and now to 2020. Why do you think we have not been doing better achieving our 2010 goals, and if you could also in your answer comment on the importance of diversity in the work force?

Dr. SATCHER. Healthy People started, as you know, in 1980 with Healthy People 90, and then we had Healthy People 2000, so you are right. It has been around. And we have had goals for each decade, and the idea is that we maintain those goals until we achieve them. I think there are several issues related to the achievement of 2010 goals, and one, of course, is we did not anticipate that we would have 8 million more people uninsured than we had in the year 2000. We also, as you know, have not put in place the kind of system we have been discussing here this morning that are going to really be critical for the elimination of disparities in health, and they have got to be programs that target all of the determinants of health, which is why I took time to mention those determinants again.

So I think a real commitment to eliminating disparities in health is a commitment to a public health approach to health care delivery in this country. I also think that the whole issue of cultural diversity is critical. The Institute of Medicine in its 2003 report following our having set the goal of eliminating disparities pointed out that the absence of cultural diversity in health care was a very

dangerous situation. They gave examples from several areas including mental health. When the people providing the care don't understand the language or the culture of the people they are taking care of, and I know that Congressman Gingrey mentioned that this morning.

But it was very clear from that report that it did, in fact, damage health care when the providers didn't understand the culture, not just the language, but the culture of the patients they were taking care of, so I have seen some good examples of programs now where they try to integrate the community into the system of care. We don't have enough African American physicians or Hispanic physicians or Native American physicians to do that or nurses. That is what I was getting to that we have to look beyond just the physicians if we are going to have that kind of diversity. And we can make progress down the line with community health workers, nurses, and others, and that is what some programs are now doing, programs that take care of southeast Asians, Native Americans, African Americans.

Mrs. CHRISTENSEN. Dr. Levi, I was going to ask you how much the public health trust fund—what was your estimate, but you gave me that. We also have been talking about a health disparity elimination trust fund or a health equity trust fund, so I was really interested in that. I wonder if you would want to comment on community health centers and their role. One easy area to get funding for in the Congress has always been community health centers, but I find that we only think about the community health centers and not all of the things that community health centers need. Do you understand my question? Can you speak to that?

Mr. LEVI. I think I do, and I think it is partly again to be thinking about what needs to surround the primary care system in order for it to be effective. And the kinds of community prevention programs that we were talking about really the things that can make a difference to—a community health center doctor can write a prescription, so to speak, for a person to go out and get more exercise.

Mrs. CHRISTENSEN. If you have the staff.

Mr. LEVI. Assuming you have the staff. Making certain assumptions. If you have the staff and someone needs—the prescription is get more exercise and eat healthier, but you live in a community where it is not safe to walk, where there aren't sidewalks, there aren't opportunities to exercise, and where healthy food isn't accessible, then you are not going to have a successful intervention there. So for the community health center to be effective the people who are served by that health center need to live in a healthier community, and that has to be built into what we think about in health reform, and find a way to bring these together.

The return on investment that I spoke about in my testimony was thinking about doing these interventions truly on a population level, the entire country. Is we target it to high risk communities where there is a high prevalence of these conditions the return on investment would be even greater. And we are talking about flexibility in the Medicaid program and the Medicare program. Some flexibility, we would love to see as an opportunity for Medicare and Medicaid dollars to do work in a community. So we know people who are on Medicare and obese have much higher costs than peo-

ple who are not. So let us target people 55 to 64 in their communities with proven evidence based interventions, spend some Medicare dollars up front to get them healthier as they are entering the Medicare program.

As I was going around the country talking about this report, I met with some Medicaid plans, some Medicaid managed-care plans, and they were frustrated that they didn't have the flexibility, for example, to go into their catchment area and give everyone a pedometer. They were absolutely convinced that if they did that, they would save money but that was not an allowable cost because they would also be reaching non-Medicaid beneficiaries which only emphasizes the point that we have to surround whatever is this reformed health care system with true community level interventions.

Mrs. CHRISTENSEN. Mr. Chairman, I plan to introduce a health empowerment zone bill that I hope will do that, and we invite you to look at it when we do.

Mr. LEVI. Great. Thank you.

Mr. PALLONE. Thank you. Mr. Gingrey.

Mr. GINGREY. Mr. Chairman, I want to remind that I waived my opening statement so hopefully I will have time to ask two questions. Dr. Spivak, I think Ranking Member Deal may have addressed this a little bit a moment ago in regard to this independent physician association that you run in Massachusetts and the success rate that you think it has. It is a Medicare Advantage plan as I understand your testimony, is that correct?

Dr. SPIVAK. We also do the similar management for commercial products with Tufts Health Plan, Blue Cross and Harford Pilgrim, so we have about 50,000 commercial lives as well.

Mr. GINGREY. Right, but this plan that you have with Tufts Medical Center is a Medicare Advantage, and as you described it, and that was always—has always been my understanding of what a Medicare Plus Choice and not Medicare Advantage Plan does in contrast to the Medicare fee for service where it is just kind of episodic care, in fact, until we made some recent changes in the law even a routine physical examination was not covered and now it is only covered at the entry into Medicare exam, and yet what the Administration is proposing in the 2010 budget is to really cut significantly the funding to Medicare Advantage, I would say almost to the bone, and take some of that money at least to create this escrow account to help pay for health care reform which would then go toward creating more payment to primary care physicians to man a medical home, to incentivize them by additional payments for wellness.

It seems like it is the very same thing that Medicare Advantage was designed to do, and I realize that maybe we are paying a little bit too much, 115 percent or whatever it is, and maybe some cuts could and should be made, but it is like just scoring in esthetic way and saying, well, this compared to Medicare fee for service is too expensive, but if you look at it over a 10 or 20 or a lifetime period of those Medicare patients who receive their care through that type with an emphasis on prevention and wellness, at the end of the day if you score esthetically or dynamic then the savings, I think,

would be there. If you would quickly comment on that for us, then I will go to Dr. Satcher.

Dr. SPIVAK. I think that one of the things that was not talked about today is that the public health crisis that we face is also the aging population, and as our population ages they are going to need more and more help with their health care. I think that the Medicare Advantage programs allow physicians to work with health plans and with hospitals in a way that forms a network that will give much more support to the elderly than any type of traditional fee for service medicine can, and in the long run will keep costs down. I think we have looked at alternative methods of paying doctors. Paper performance does not seem to—it may improve quality a little bit but it doesn't seem to cut costs down.

All of the programs in public health that we have talked about are critical but at the end of the day when patients are sick, they need a model of health care that will support them. I really believe groups like mine provide the model.

Mr. GINGREY. Reclaiming my time, I believe that too, and I hope we are not about to throw the baby out with the bath water, as they expression goes. I really feel that if we had continued in a cost effective way to let Medicare Advantage provide care for right now 10 million Medicare recipients have chosen that over fee for service, and then to incentivize people through the tax code maybe or through ha reduction in Medicare Part B premium, if they executed a living will advance directive that is actually on line as we get this fully integrated electronic medical system to cut down on those costs and let them say what they want at the end of life. But thank you so much for that.

Dr. Satcher, I want to thank you again for your service to our country and the time you have spent in government and outside government and what you are doing now at Morehouse School of Medicine. It is great to see you again. You stated in your testimony that half of health outcomes come as the result of human behavior and that we must provide incentives and rewards for healthy lifestyles. I agree completely. Do you think that businesses that have implemented programs that let us say reward smoking cessation, a healthy diet, regular exercise are an effective way to better the public health and what kind of benefits come from these types of programs and cost savings associated with this type of program. I would imagine it is pretty significant.

Dr. SATCHER. Yes, I do think that businesses that invest in, for example, work site wellness programs, we have been working with the Technology Association of Georgia, and we have been looking at data from many of those businesses. And it is clear that they can show that for every dollar invested in wellness, in some cases they save $4, in mental health I think it is a little bit more than that. They save by investing. Now they save it by preventing illness in the population that they would have to pay for but they also save it by preventing absenteeism from work and they save it by enhanced productivity.

I would be happy to submit to you data from several of those companies as opposed to naming them because I am on the board of one of those companies, so it wouldn't be fair. But clearly there is data showing that investment in work site wellness programs

saves money in terms of how much we pay for care and how much we pay for absenteeism and lost productivity when people become sick.

Mr. PALLONE. I am going to try to wrap up because——

Mr. GINGREY. Dr. Satcher, thank you, Dr. Spivak, thank you, and thank you, Mr. Chairman, for your indulgence. I yield back.

Mr. PALLONE. And we are going to end with Mr. Engel because otherwise you would have to wait another half hour or an hour for us to come back again because there are more votes. Mr. Engel.

Mr. ENGEL. Thank you, Mr. Chairman. I am going to try to give the abbreviated version of questions. Let me ask Dr. Levi about HIV prevalence in the United States. We found out last year it was higher than we had thought much to our dismay and that the global HIV prevention working group which is comprised of 50 leading public health experts and others released a study last summer called behavioral change in HIV prevention, and in the study essentially what they came to conclusion is they said prevention efforts to be successful will be unsustainable unless there is a comprehensive evidence-based approach employed that targets behavior social norms and other underlying drivers in the HIV AIDS epidemic.

So, Dr. Levi, could you please discuss the contributions the guide to community preventive services has made with regards to reviewing HIV behavioral and social interventions at the community level and where is our research lacking and how much do you believe that increased funding would enable the guide to better assist HIV prevention efforts?

Mr. LEVI. Overall, the guide has been chronically underfunded and so it is unfair to judge the guide on what it has covered and not covered. But one of the things I think we need to be careful about is that there are actually within CDC several efforts, for example, in addition to the community guide in identifying successful interventions. And within the HIV AIDS division of the CDC, they have developed a compendium of what they consider to be approved community-based interventions and successful prevention program from which grantees can choose as they decide to spend federal dollars, so there are multiple ways of approaching it.

I think the real challenge that we have around HIV prevention in this country, and this is something I have been working on since the beginning of the epidemic, is that we haven't fully committed the resources to the kinds of community change that is necessary to implement the policies that we know work so we have had restrictions, frankly, on use of needle exchange, use of federal funds for needle exchange programs. That is an evidence-based approach and countries that adopted it early on in the epidemic, they have not had the same kind of epidemic as they did, you know, among injection drug users, not just for HIV but also for transmission of hepatitis which has resulted in tremendous cost savings in those countries.

We have not had that benefit of that because we failed to adopt evidence-based practices. In terms of community change, I think it really does again come back to community level interventions that reach the multiple communities that are affected by the epidemic. It is not a one size fits all effort. It is not just going to be promoting

use of commons or promoting safe sex or promoting abstinence. It is going to be what works in a particular community and what brings people together to feel empowered to adopt the norm changes that need to happen. That is much more complex than the programs we have been willing to talk about until now, but that is what it is going to take in the same way, as we have been talking about earlier, there isn't a one size fits all for obesity. There isn't a one size fits all for physical activity. There isn't going to be one size fits all for HIV. And I don't think that we have been willing to invest in those affected communities enough to empower them and give them the resources.

Mr. ENGEL. Let me ask you one final question on another topic. Health insurance pays for many clinical preventive services like immunizations and screening tests such as mammograms but important community level prevention services such as fluoridation of water or lead abatement in buildings are not reimbursed by health insurance, so it means that federal, state, and local agencies that provide these services rely on our annual appropriations process to fund these important activities. I would like you to explain what kind of challenges that poses and in your testimony you mentioned there was a need for reliable funding source for public health activities. What would that funding stream look like?

Mr. LEVI. Well, you are absolutely right. The dependence on the fluctuations in the annual appropriations cycle has meant, and Commissioner Howard could probably speak to this better, meant that there isn't a reliable source of revenue and therefore not a predictable source of funding and it is very hard to plan to build programs and to build capacity, and so what we have been seeing, we have seen it in many areas, we have seen it in chronic diseases. We have seen it most evidently, I think, on the preparedness side where there is an initial major investment state staff up using those dollars and then the dollars start withering away literally, I mean 25 percent cut since the peak.

And so it is hard to keep staff. It is hard to retain staff. And, in fact, you know, at a time when we are seeing whole generation of public health workers retiring and we need to fill back fill, we don't have the resources and the stability of resources to make sure that we have a new work force coming in and that this is a viable occupation for people to enter. To resolve that, we think there ought to be the equivalent of a trust fund. If we are going to guarantee funding for health care, we should also be guaranteeing funding for public health. So there is a reliable mechanism that states can depend on, the CDC can depend on, and we can make the investments that over time will indeed pay off.

Mr. PALLONE. We are going to have to—I think we only got a couple minutes.

Mr. ENGEL. OK. I was going to ask the commissioner if she agreed.

Ms. HOWARD. I do.

Mr. ENGEL. Thank you.

Mr. PALLONE. Thank you, Eliot. I hate to rush, but I don't want you to have to wait another hour for us to come back because we have another series of votes. So thank you very much. This has been very helpful. We want to stress the public component of this

health care reform. You may get additional questions in writing within the next 10 days from some of us to respond to, and hopefully you will respond to them. But, again, thank you for all your input and what you do. And without further adieu, the subcommittee hearing is adjourned.

[Whereupon, at 2:35 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Statement of Representative Michael Burgess MD
Committee on Energy and Commerce: Subcommittee on Health
Tuesday March 31, 2009

Thank you, Mr. Chairman for calling this hearing.

We often talk a lot in this Committee about clinical care – as we should. However, public health has to be part of the discussion as well.

We know that engaging the overall public about health conditions and unhealthy behavior can result in a decrease of the problem on the clinical side and in that way public health and clinical health are certainly related.

There is little question that prevention works – even if we can't always get the Congressional Budget Office to show us the savings -- I know as a doctor, and I think I speak for every patient out there – I'd rather prevent an illness than treat it.

However we can't prevent everything and that means we have to talk about how best to maximize our public health workforce.

If we are talking about a significant role for prevention that means we are going to need a robust role for early detection, screening and intervention. However, far too often Congress talks out of both sides of our mouth on this issue.

In healthcare the costs associated with the newest technologies are often the highest.

We say we want to manage chronic conditions – catch a problem early. I agree. But then we can't blame a person for wanting a scan that is going to tell them if they have cancer. And we shouldn't punish the doctor for ordering that test.

If the idea is to prevent conditions then we are talking about universal utilization for prevention and detection related costs. Once again, I think it is the right public policy but we have to be prepared to pay for it.

So I hope we talk about how best to use the health care workforce to encourage Americans to improve their health. Don't tell a doctor that you will pay more to treat a disease then to avoid it – that creates the wrong incentives.

We should have payment policies that align with the laudable goals of our intended public policy that encourages individuals to be healthy but also encourages their doctors to remain part of the discussion to keep them healthy.

That will be what is best for the patient – and that is what we should always be talking about.

Thank You and I yield back.

Written Statement of
Joe Solmonese
President
Human Rights Campaign

To the

Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
Room 2322
Rayburn House Office Building
March 31, 2009

Mr. Chairman and Members of the Subcommittee:

My name is Joe Solmonese, and I am the President of the Human Rights Campaign, America's largest civil rights organization working to achieve lesbian, gay, bisexual and transgender (LGBT) equality. By inspiring and engaging all Americans, HRC strives to end discrimination against LGBT citizens and realize a nation that achieves fundamental fairness and equality for all. On behalf of our over 750,000 members and supporters nationwide, I am honored to submit this statement regarding the role of public health in making health care work for LGBT people.

Our existing health care system poses numerous challenges for the LGBT community. Due to continued and widespread employment discrimination based on sexual orientation and gender identity, many in our community do not have access to employer-provided health insurance, or cannot afford to make use of that coverage for their partners and children. As a result, many LGBT people rely on public health care programs to meet their basic health care needs. Federal programs –including Medicaid, Medicare, and the Ryan White CARE Act— must be strengthened to ensure that all our nation's most vulnerable people, including LGBT families, have access to critical care.

Unfortunately, even in these programs, members of our community face significant obstacles to care. First, treatment for HIV and AIDS, which continues to significantly impact the LGBT community, remains unaffordable for the very Americans most in need. Second, many health plans –including public health coverage- fail to include care specifically impacting LGBT people, most notably the widespread exclusion of coverage related to gender transition for transgender people. Third, even when they have health coverage, LGBT people can face discrimination and ignorance from health care providers who lack cultural competency. To truly improve access to care for all Americans, addressing these challenges must be part of any effort to reform our nation's public health care system.

Benefits Discrimination and Reliance on Public Health Care

A significant barrier for gay and lesbian couples and their children is continued discrimination in the provision of employer-based health insurance. Because they are unable to marry in the vast majority of states, many gay and lesbian employees are unable to obtain any coverage under employer-provided health insurance for their partners and partners' children. While more and more companies, including more than half of the Fortune 500, are voluntarily providing domestic partner health coverage, the discriminatory tax treatment of those benefits means that some couples are unable to afford them.

Transgender individuals face perhaps even more pervasive employment discrimination. Even when they have access to employer-provided health insurance, most transgender people still lack sufficient care because nearly ever health plan excludes treatments related to gender transition from coverage.

As a result, many LGBT people rely on public health care, including Medicaid, Medicare and the Ryan White CARE Act. Safety net programs and services at federally qualified health centers (FQHCs) and community health centers (CHCs) are critical to our community, especially those living with HIV and AIDS. Congress must strengthen these crucial programs for all Americans in need. Unfortunately, LGBT people still experience barriers to care even under public health care, and Congress must also act to improve our community's ability to access it.

Restrictions on Access to Early Treatment for HIV

One significant barrier to health coverage for LGBT people specifically affects people living with HIV and AIDS, an epidemic that continues to disproportionately impact young gay and bisexual men, particularly in communities of color. Currently, low-income people with HIV are not eligible for coverage under Medicaid until they develop full-blown AIDS. Without access to Medicaid, many low-income, HIV-positive individuals lack the ability to receive medical care that would help to slow the progression of the disease and prevent the onset of opportunistic infections.

HRC supports legislation, the Early Treatment for HIV Act, which would permit state Medicaid programs to provide HIV treatment to individuals before they develop AIDS. As a result, more low-income HIV-positive people would have access to critical care, improving their quality of life and reducing long-term costs on the health care system. We urge Congress to include this measure in any health reform effort.

Widespread Exclusion of Transgender Health Coverage

Another tremendous barrier to health coverage for LGBT people is the fact that, nearly universally, public and private health insurance programs, including Medicare and the vast majority of state Medicaid programs, categorically exclude coverage for treatments related to gender transition. Despite decades-old standards of care developed by medical experts and a

resolution of the American Medical Association calling for an end to these exclusions, private insurers and the federal government continue to characterize a range of treatments and services as "experimental" and "cosmetic." As a result, most transgender people must pay for hormone therapy, surgeries or other aspects of gender transition out-of-pocket and those who cannot afford them are forced to forgo medically-necessary treatment. Widespread employment discrimination based on gender identity means that many transgender people go without any employer-provided health insurance, even with exclusions for transgender care.

We urge Congress to address the issue of these exclusions in any health reform effort. Health care related to gender transition should be treated the same as any other medically-necessary treatment or service.

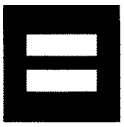
Lack of Cultural Competency

Removing the many barriers to obtaining health coverage will only remedy part of the problem facing LGBT people in seeking medical care. Even the most expansive health insurance does not help a transgender woman who is turned away by doctor after doctor, or a gay man who is kept from his partner's bedside, all because of ignorance, fear, or bias. In times of crisis, LGBT people face the prospect of health care providers who, at best, simply do not understand their health needs or family structures and, at worst, openly display bias based on sexual orientation or gender identity. In addition, despite efforts to legally protect our families in the absence of marriage equality, gay and lesbian couples often encounter a lack of respect for their relationships and their ability to visit and make medical decisions for one another and their children.

We urge Congress to ensure that cultural competency training on LGBT health issues, nondiscrimination and respect for LGBT families in visitation and health care decision-making is part of any health reform effort.

Conclusion

Lesbian, gay, bisexual and transgender people face many challenges in accessing health care, including public health programs, which can and should be addressed in the effort to improve health coverage for all Americans. By removing the barriers to access and supporting the critical programs that I highlighted above, Congress can ensure more LGBT people are healthy and happy parts of our American family. Thank you again for the opportunity to address you today.



HUMAN
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HEALTH REFORM FOR LGBT AMERICANS

The Problem

The existing health care system fails the LGBT community on many levels. LGBT families often do not have access to employer-sponsored health insurance. When benefits are provided, families face tax burdens that their opposite-sex married colleagues do not. Health plans fail to cover treatments specially impacting LGBT people, such as infertility care for lesbians or services related to gender transition for transgender people. In the hospital environment, domestic partners are routinely refused visitation or left out of medical decision-making for their partner or their partner's minor children. Additionally, the lack of data regarding the health status of LGBT people significantly hampers researchers seeking federal funding for LGBT health initiatives, particularly those to improve health outcomes.

Health Care Reform

During the 2008 election, reforming the nation's health care system became a top-level issue. As members of Congress begin to develop and advance proposals, it is vital that they consider the needs of the LGBT community and incorporate initiatives to improve access and delivery of services to our community. HRC has identified a set of LGBT health reform objectives which we will advocate for. These objectives will also serve as a benchmark in evaluating legislative initiatives:

1. Universal access to health care coverage with comprehensive benefits, including transition-related services;

2. Health care decision-making authority is vested in LGBT domestic partners, and they are able to be involved in the care of a sick partner or in the care of their minor children;

3. Employer-provided health benefits will be given equal tax treatment when provided to employees and their domestic partners;

4. Access to culturally competent health care providers is assured and competency training mandatory;

5. Electronic medical records and health information technology have safeguards to protect patients' privacy;

6. Expand federally funded health surveys to include collection of data relating to LGBT populations;

7. Development and implementation of a cohesive, comprehensive national AIDS strategy;

8. Increase funding for HIV prevention and enhance and expand existing programs to meet the unique needs of the community.

Hearing Follow-Up Questions
Congressman Joe Barton
Committee on Energy & Commerce
Subcommittee on Health
"Making Health Care Work for Americans: The Role of Public Health"
March 31, 2009

Richard E. Besser, M.D.
Acting Director, CDC
Acting Administrator, Agency for Toxic Substances and Disease Registry

In Title II, Section 201 --Improving State and Local Public Health Security, of P.L. 109-417, the "Pandemic and All-Hazards Preparedness Act", the law authorizes certain programmatic, as well as, appropriations for specific initiatives to improve situational awareness and local, regional and national capacity building in the event of public health emergencies. As you know, the oversight of this law falls within the jurisdiction of the Committee. The Secretary has directed the CDC to assume responsibility to implement and administer certain parts of the PAHPA program initiatives.

Pursuant to a specific five year programmatic and appropriation authorization found in Section 201 (h) of the law to enhance and improve local, state and national early detection, surveillance, investigative, surge, reporting and technology capabilities of the countries' poison centers in the event of public health emergencies $25 million was directed by the Secretary in FY 2007 to fund grants for real time disease detection enhancements through the nation's poison control centers.

The Committee understands that notwithstanding authorization and appropriation authority for the Secretary to continue this poison control center PAHPA program for fiscal years 2008-2011, no additional funds have been provided for this important effort.

1. Has the poison control center program referenced above accomplished the goals stated in the law at Section 201 (h) (4) (B)?

CDC Response

The Public Health Emergency Preparedness (PHEP) cooperative agreement guidance for Budget Period 8 (August 31, 2007, through August 9, 2008) described Real-Time Disease Detection (RTDD) requirements for the 62 PHEP awardees regarding collaboration with poison control centers (PCCs) or professional organizations in the field of poison control. Awardees were required, in collaboration with PCCs, to improve the early detection, surveillance, and investigative capabilities of poison control centers for chemical, biological, radiological, and nuclear events. The $35 million in funding for RTDD was one-year funding, and the program was considered a pilot during Budget Period 8. A

number of awardees already had long-standing relationships with the PCCs in their jurisdiction and have continued those collaborations.

Sixty of the 62 awardees established contracts/collaborations with PCCs (59) or professional organizations (1 - Palau) in the field of poison control. Two awardees, the Marshall Islands and the Northern Mariana Islands, have been working to identify a PCC or professional organization as there are none in their geographic regions.

Progress has been made in meeting these goals, but the goals represent a long-term endeavor that is part of an overarching public health preparedness capability. Specific examples of the achievements of this collaboration are presented below.

Improving early detection, surveillance, and investigation.

- In Colorado, the Rocky Mountain Poison and Drug Center (RMPDC) collects real-time data and has the ability to monitor, analyze, and report to the Colorado Department of Public Health and Environment in near real time. These data define events of public health significance, such as dead animal reports for plague and West Nile Virus outbreaks and notification of sentinel events such as tuberculosis, Hantavirus and white powder calls. Twenty of 22 acute care hospitals in the seven-county Denver metropolitan area signed data use agreements to participate in data exchange. These data were used to monitor for potential public health emergencies during the Democratic National Convention.
- The District of Columbia Department of Health (DOH) continues long-standing work with the National Capital Poison Control Center (NCPCC). In collaboration with DOH, the NCPCC collects case data in real time for all calls 24/7 and shares automated analysis and alerting. This partnership strengthens the DC Department of Health's ability to enhance surveillance for public health or chemical/bioterrorism incidents by providing near real-time poison exposure and information call data to the DC Department of Health.
- The Iowa Statewide Poison Control Center (ISPCC) collects and analyzes data for syndromic aberrations, suspicious clinical cases, and cases that fit specific disease patterns (called priority health conditions or syndromes). The poison center investigates every aberration within four hours of notification of the aberration. Any aberration or suspicious case that is determined to be of public health significance is rapidly reported to the appropriate state and federal agencies, usually through the Iowa Department of Public Health.
- The Texas Department of State Health Services (DSHS) collaborates with the Texas Poison Center Network (TPCN) to continue increasing the frequency of anomaly analysis to identify and then investigate potential threats. Specialists in poison information (SPIs) were designated at each center to conduct surveillance. Anomaly investigations are performed every eight hours and DSHS and CDC are notified.

Improving emergency response capabilities through surge capacity and communication.

- In Arkansas, seven new work stations at the Poison Control Center have been established and are fully operational for surge capacity during emergency response events.
- The Missouri Regional Poison Center (MPC) and the Missouri Department of Health and Senior Services (MDHSS) collaborate to improve surveillance and response capabilities in the event of chemical, biological, or nuclear events. Monthly conference calls are held with a team of representatives from each agency to review completed tasks and accomplishments and plans for future developments. The success of this partnership includes daily data sharing, increased response to alerts, and chemical health alert templates.
- MDHSS and MPC have also addressed the need to establish priority health conditions and points of contact by the creation of several health alerts which are ready to be distributed in the event of an accidental or intentional chemical release. These documents ensure that MDHSS and MPC are releasing unified information and recommendations in the event of a chemical emergency.
- The Pittsburgh and Philadelphia Poison Control Centers (PCCs) maintain staffing capacity to respond to a call volume surge should a catastrophic event occur or to support the other center should an incident occur in their service area. The PCCs employ medical toxicology consultants to provide advanced medical information. Fifteen specialists are equipped as remote agents to enhance surge capacity and create immediate access in the event of a disaster. The two centers use the same database program and servers to communicate with one another. The telephone and data connections can be switched from one center to the other.

2. If not, what changes in the law or the CDC program management would the Secretary or the CDC recommend to achieve these goals?

CDC Response

The National Biosurveillance Strategy for Human Health was developed by a national group of stakeholders led by CDC. The Strategy's foundation is Homeland Security Presidential Directive-21 (HSPD-21), Public Health and Medical Preparedness, which named biosurveillance as one of four critical priorities for improving public health preparedness. The National Biosurveillance Strategy for Human Health established goals and objectives related to integrating both internal and external surveillance systems and early detection capabilities, including poison control. The Strategy identified that the nation needs to continue to strengthen surveillance processes, including improving, expanding, and enhancing biosurveillance systems for priority exposures and health events. For example, the Strategy outlines the need to improve surveillance for chemical and radiologic exposures, improve the speed and quality of coding and reporting of nature-of-injury and external-cause-of-injury data from emergency departments,

and increase the number of states covered by poison control center surveillance. CDC is currently developing a National Biosurveillance Concept Plan that will outline ways to operationalize the Strategy and encouraging the coordination of other federal agencies, other levels of government, and non-governmental entities that will play an important role in achieving the goals and objectives of the Strategy.

3. If the goals have been achieved, why has funding not been sought by the CDC to continue this program?

CDC Response

CDC is committed to supporting and improving state and local public health preparedness, including the capabilities of poison control centers, and the President's Budget request continues support for the Public Health Emergency Preparedness cooperative agreement.

The Public Health Emergency Preparedness cooperative agreement provides funding to build and upgrade the preparedness infrastructure of public health departments to improve their ability to respond to the public health consequences of not only terrorism threats, but also infectious disease outbreaks, natural disasters, and biological, chemical, nuclear, and radiological emergencies. CDC has awarded more than $6 billion in Public Health Emergency Preparedness funding as of 2008 to 62 grantees, which include 50 states, eight territories and four metropolitan areas (Washington, D.C., Chicago, Los Angeles County and New York City).

The Public Health Emergency Preparedness cooperative agreement supports a variety of critical functions, including:

- Collaboration among state, local, tribal, and territorial public health departments, research universities, and other responder agencies;
- Rapid identification of biological and chemical agents by public health laboratories across the country;
- Quick and accurate communication across local, state, and federal levels;
- Ongoing enhancements of state and local public health programs through a cycle of planning, exercising, and improvement plans;
- Protecting the health of the community and first responders during an emergency; and
- Helping communities recover from emergencies.

In addition, CDC supports the American Association of Poison Control Centers in collecting national data on toxic exposures through the National Poison Data System.

