

This is a preliminary transcript of a Committee Hearing. It has not yet been subject to a review process to ensure that the statements within are appropriately attributed to the witness or member of Congress who made them, to determine whether there are any inconsistencies between the statements within and what was actually said at the proceeding, or to make any other corrections to ensure the accuracy of the record.

1 {York Stenographic Services, Inc.}

2 HIF090.140

3 HEARING ON MAKING HEALTH CARE WORK FOR AMERICAN FAMILIES: THE

4 ROLE OF PUBLIC HEALTH

5 TUESDAY, MARCH 31, 2009

6 House of Representatives,

7 Subcommittee on Health

8 Committee on Energy and Commerce

9 Washington, D.C.

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

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

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

|

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

38 Health reform isn't just about improving coverage and
39 access. It is also about making our Nation healthier. We
40 spend more than any other country on health care and still we
41 have higher morbidity and mortality rates than any other
42 industrialized Nation. More than half of our population
43 suffers from at least one chronic condition, which not only
44 increases our health care cost but also lowers our
45 productivity, and this is simply not sustainable especially
46 in these difficult economic times. What is frustrating is
47 that these diseases for the most part are preventable. Too
48 many people are dying of illnesses such as cardiovascular
49 disease, respiratory diseases, and diabetes-related
50 illnesses, and if the current obesity epidemic continues on

51 the path it is on now, we will see even further increases in
52 many of these diseases.

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

68 We must start investing in the prevention of these
69 horrible diseases rather than just focusing on those who are
70 already sick. This shift in our resource allocation could
71 potentially save the system billions of dollars per year, not
72 to mention the benefits to patients. Public health really
73 means improving the quality of life for individual people,
74 communities, and our society as a whole. Many of the

75 federal, state, and local public health initiatives have
76 already had huge impacts on our society's health. Diseases
77 that once were life threatening are now all but extinct thanks
78 to vaccination efforts, for example.

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

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

99 statement.

100 [The prepared statement of Mr. Pallone follows:]

101 ***** COMMITTEE INSERT *****

|

102 Mr. {Deal.} Thank you, Mr. Chairman. I too want to
103 welcome both panels to our discussion here today, especially
104 to thank Dr. Besser for being here and to congratulate him on
105 his acting role as acting director of the CDC, a facility
106 which all of Georgians and all of the people of this country,
107 I think, can be very proud of. Thank you for being here.
108 And, also, Dr. David Satcher, who is here representing the
109 Morehouse School of Medicine, another facility in my great
110 State of Georgia that we are very proud of, and thank him for
111 the continuing contribution that they make to the delivery of
112 health care in our Nation.

113 Today we will focus on the role of public health and
114 disease prevention which are critical components of our
115 Nation's health care delivery system. From specialized
116 research on infectious diseases, wellness, and prevention
117 that is taking place at the CDE community outreach programs
118 which promote health conscious behaviors, the role of the CDC
119 in fulfilling the needs of the public is indeed substantial.
120 As we move forward with health care reform this year, we must
121 ensure that we continue to support those programs and
122 activities which have proven to be successful. They provide
123 a critical role, and we must ensure public health efforts are
124 provided with the tools that they need to do the job well.

125 In conjunction with these efforts, an equally important
126 objective must be to incorporate incentives for individuals
127 to make responsible choices about his or her health and thus
128 adding value to prevention efforts in an avoidance of costly
129 medical care in the future.

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

142 Another key component is coordination of patient care.
143 All too often we hear of health care dollars being wasted by
144 duplicative testing and unnecessary referrals, which are all
145 a result of our silo system of health care delivery.
146 Fortunately, with the incorporation of health information
147 technology and patient electronic medical records and
148 improved coordination among providers access to necessary

149 information to administer the best care is vastly improved.
150 Prevention efforts can be coordinated through the use of this
151 technology. Home care can be assessed and patients can
152 receive a continuum of care which our current system fails to
153 support many times.

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

164 [The prepared statement of Mr. Deal follows:]

165 ***** COMMITTEE INSERT *****

|
166 Mr. {Pallone.} Thank you, Mr. Deal. Next is Chairman
167 Waxman.

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

180 Fluoridation of water for a town is, for instance,
181 vastly better than simply filling every citizen's cavities.
182 Exercise programs to prevent obesity are better than having
183 to treat diabetes among people who become obese. It is
184 tailoring health insurance and health care to prevent and
185 diagnose disease early rather than simply treating it in its
186 later stages. Immunization is always better than outbreaks.
187 Screening for hypertension is better than simply waiting for
188 strokes. It is providing for safety net services where the

189 insurance market alone fails to do so. Community health
190 centers, HIV service providers, and family planning clinics
191 provide care to people who might not otherwise be able to
192 find a provider.

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

206 As we approach health reform, we must consider what
207 aspects of the Nation's health are based on public health and
208 make these investments at the same time as we invest in
209 coverage. We need to provide as firm a funding and
210 organizational base for these services as we do for insurance
211 because they are essential in making insurance efficient and
212 productive and in making the Nation healthier. We will

213 continue to debate insurance plans, Medicare Advantage health
214 savings account and acute care on other days, but today's
215 hearing is about these public health activities that we
216 seldom think about and we even more rarely provide for. I
217 hope health reform will make us change that. Thank you very
218 much, Mr. Chairman.

219 [The prepared statement of Mr. Waxman follows:]

220 ***** COMMITTEE INSERT *****

|
221 Mr. {Pallone.} Thank you, Chairman Waxman. The
222 gentleman from Pennsylvania, Mr. Pitts.

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

239 It offers other benefits such as a 24-hour hot line
240 staffed by registered nurses, services to help people manage
241 chronic conditions, and incentives designed to promote
242 healthier lifestyles. Where there are barriers to small
243 group plans offering incentives such as these, we should re-

244 evaluate current law and make necessary changes. Also,
245 patients must be more involved in their own care and
246 treatment. Health savings accounts can play a key role in
247 active patient participation. We know that when people's own
248 money is on the line they make wiser decisions. Mr.
249 Chairman, I look forward to hearing the thoughts and
250 testimony of our witnesses today, and I thank you and yield
251 back my time.

252 [The prepared statement of Mr. Pitts follows:]

253 ***** COMMITTEE INSERT *****

|
254 Mr. {Pallone.} Thank you. The gentleman from Texas,
255 Mr. Green.

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

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

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

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

295 [The prepared statement of Mr. Green follows:]

296 ***** COMMITTEE INSERT *****

|
297 Mr. {Pallone.} Thank you, Mr. Green. The gentleman
298 from Georgia, Mr. Gingrey.

299 Mr. {Gingrey.} Mr. Chairman, I am going to waive my
300 opening statement.

301 [The prepared statement of Mr. Gingrey follows:]

302 ***** COMMITTEE INSERT *****

|
303 Mr. {Pallone.} The gentleman from Kentucky, Mr.
304 Whitfield.

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

316 [The prepared statement of Mr. Whitfield follows:]

317 ***** COMMITTEE INSERT *****

|
318 Mr. {Pallone.} Thank you. Our subcommittee vice-chair,
319 Ms. Capps.

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

334 [The prepared statement of Ms. Capps follows:]

335 ***** COMMITTEE INSERT *****

|
336 Mr. {Pallone.} Thank you. The gentlewoman from
337 Tennessee, Ms. Blackburn.

338 Ms. {Blackburn.} Thank you, Mr. Chairman, and welcome
339 to our witnesses. We are looking forward to the hearing
340 today. And, Dr. Besser, I want to thank you for your
341 testimony and point out one thing that I think is so
342 important that we focus on. When you say we are not
343 achieving an acceptable return for the investment we made on
344 health care despite spending more than any other nation, and
345 I think it does point out the importance of personal
346 responsibility. We have some good pilot projects that have
347 taken place in some of our states. Some of them have been
348 successful. Some have not, but it does give us some good
349 evaluated data and outcomes that we can look at, lessons that
350 should have been learned, and I think it also points out how
351 one size does not fit all in health care delivery. And I
352 look forward to the testimony and the discussion today.
353 Thank you, Mr. Chairman. I yield back.

354 [The prepared statement of Ms. Blackburn follows:]

355 ***** COMMITTEE INSERT *****

|
356 Mr. {Pallone.} Thank you. The gentleman from Utah, Mr.
357 Matheson.

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

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

376 [The prepared statement of Mr. Matheson follows:]

377 ***** COMMITTEE INSERT *****

|
378 Mr. {Pallone.} Thank you. The gentlewoman from
379 California, Ms. Harman.

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

391 The only level 1 trauma center near LAX and the ports of
392 LA and Long Beach, both top terror targets, which could be
393 attacked simultaneously, is Harbor UCLA Hospital, a first
394 class teaching hospital. Harbor's emergency room was cited
395 for overcrowding and no terror attacks have even been
396 contemplated yet. It has tried to address this problem but I
397 worry that we are not ready and that should something like
398 this happen in any city in America or near simultaneously in
399 many cities in America, we won't be ready so this has to be
400 part of health care reform. Level 1 trauma centers will have

401 to take care of huge numbers of victims should we have near
402 simultaneous terror attacks. And just as we think about the
403 rising waters in Fargo, North Dakota, let us think about the
404 rising numbers of people who will need health care and we are
405 not ready. Thank you, Mr. Chairman.

406 [The prepared statement of Ms. Harman follows:]

407 ***** COMMITTEE INSERT *****

|
408 Mr. {Pallone.} Thank you. The gentlewoman from the
409 Virgin Islands, Ms. Christensen.

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

425 And while prevention and individual care will produce
426 some savings but mostly through a healthier, happier, and
427 more productive and competitive populous as we heard at the
428 last hearing it is primarily through community prevention
429 approaches, public health approaches, that we will reap the
430 most savings, reduce our Nation's soaring health care costs,

431 and recapture our role of leadership as we improve our health
432 standing among the nations of the world. So welcome to all
433 of our panelists. Thank you for your leadership, and I look
434 forward to the testimony.

435 [The prepared statement of Ms. Christensen follows:]

436 ***** COMMITTEE INSERT *****

|
437 Mr. {Pallone.} Thank you. Our chairman emeritus, Mr.
438 Dingell.

439 Mr. {Dingell.} Thank you. I commend you for this
440 hearing. I ask unanimous consent to put my entire statement
441 into the record.

442 Mr. {Pallone.} Without objection, so ordered.

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

457 I would urge, Mr. Chairman, that this hearing be used as
458 a mechanism to enlighten the Congressional Budget Office and
459 doubters about the need for the kind of prevention and

460 wellness concerns that you are showing in having this
461 hearing. With that, I yield back the balance of my time.

462 [The prepared statement of Mr. Dingell follows:]

463 ***** COMMITTEE INSERT *****

|
464 Mr. {Pallone.} Thank you, Mr. Dingell. Thank you,
465 Chairman Dingell. Next is the gentleman from Connecticut,
466 Mr. Murphy.

467 Mr. {Murphy of Connecticut.} Thank you very much, Mr.
468 Chairman. I join my colleagues in looking forward to the
469 testimony on this very important subject. I hope today that
470 we explore a number of subjects but at the very least these
471 two. First, as Mr. Pitts has pointed out, there are enormous
472 opportunities to look at the private sector for the work that
473 they have done in public health. In my district the company,
474 Pitney Bowes, has been a leader in this respect. I hope that
475 we talk about both the opportunities for public health within
476 the private context but also the limitations. It works well
477 if you are at a large employer but relying on the private
478 sector certainly has limitations for those people who work
479 for smaller employers or who have individual insurance.

480 Second, I hope that we will be able to explore who is
481 doing it right out there and who is doing it wrong. In
482 Connecticut, we have done a wonderful job of using public
483 funds to pay for breast cancer and cervical cancer
484 screenings. And I think one of the things that we need to
485 talk about is how we go out to different either political
486 subdivisions or private employers who have done this right,

487 get that information disseminated out to others so that we
488 can standardize best preventive practices across this great
489 country. Thank you, Mr. Chairman, for the hearing today, and
490 I yield back my time.

491 [The prepared statement of Mr. Murphy follows:]

492 ***** COMMITTEE INSERT *****

|
493 Mr. {Pallone.} Thank you, Mr. Murphy. The gentlewoman
494 from California, Ms. Eshoo.

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

511 I have often wondered why we have not progressed over
512 the years to strengthen public health. And just as a
513 physician would say to a patient, you can't starve yourself
514 in order to lose weight, that is exactly what has happened to
515 the public health system in our country. We have not funded

516 it properly for it to go forward and do the magnificent work
517 that it is capable of that it already has done and the role
518 that we want it to play. So this is more than appropriate to
519 have this hearing. I look forward to hearing from the very
520 distinguished witnesses that are at the forefront of the
521 public health system and our country, and I look forward to a
522 bill that is going to strengthen the arm, that long arm that
523 has a great reach to the American public to prevent bad
524 things from happening, and when we do that we promote
525 wellness at the same time.

526 And what I hope we will also look at, Mr. Chairman, in
527 terms of policy, and that is that I think in one fell swoop
528 we could do so much in terms of obesity if we look at what
529 food stamps will actually buy and pay for. If we continue to
530 allow food stamps to buy junk and bad foods in the
531 supermarkets or the small markets in the neighborhoods in the
532 areas where poor people live then it is the federal
533 government that really is promoting the worst. We can't just
534 beat our chests about obesity in our country. We should just
535 do something policy wise that really overnight could
536 revolutionize what poor people ingest and what they buy with
537 the food stamps that we provide. So thank you very much.

538 [The prepared statement of Ms. Eshoo follows:]

539 ***** COMMITTEE INSERT *****

|

540 Mr. {Pallone.} Thank you. The gentleman from Texas,

541 Mr. Gonzalez.

542 Mr. {Gonzalez.} I waive opening.

543 [The prepared statement of Mr. Gonzalez follows:]

544 ***** COMMITTEE INSERT *****

|
545 Mr. {Pallone.} Thank you. Next is the gentlewoman from
546 Florida, Ms. Castor.

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

560 [The prepared statement of Ms. Castor follows:]

561 ***** COMMITTEE INSERT *****

|
562 Mr. {Pallone.} Thank you. The gentleman from Maryland,
563 Mr. Sarbanes.

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

578 And one of the hopes I have for the health care reform
579 effort that is under way is that we will emerge from this
580 debate with a public health system in place. Many have
581 critiqued the way we approach health in this country as
582 having developed a sick care system rather than a health care
583 system. Obviously, prevention is critical to changing that
584 orientation, and public health is critical to that. So I

585 look forward to your testimony. I am particularly interested
586 in this notion of place-based initiatives. In other words,
587 what do you do in schools, what do you do in clinics, what do
588 you do in employment, in work places, and so forth, going to
589 where people are to provide the kind of prevention, wellness,
590 and fitness services that really will represent a true public
591 health system is absolutely fundamental. So I look forward
592 to your testimony. I thank you, Mr. Chairman. I yield back
593 my time.

594 [The prepared statement of Mr. Sarbanes follows:]

595 ***** COMMITTEE INSERT *****

|
596 Mr. {Pallone.} Thank you. Ms. Schakowsky.

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

609 A small example. There is an organization called
610 Mainstay in Illinois where I am from, estimates that Illinois
611 could save over \$160 million a year by adjusting obesity in
612 people with developmental disabilities who live in group
613 homes, a setting really amenable to that kind of effort.
614 STDs, we all were shocked, I think, or some anyway, earlier
615 this month when the D.C. health department reported over 3
616 percent of the city's population, 7 percent of African
617 American men, infected with HIV AIDS. Local experts put that
618 number closer to 5 percent because of under reporting. And

619 we have measures today that would help to stop STD
620 transmission that need to be implemented.

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

628 [The prepared statement of Ms. Schakowsky follows:]

629 ***** COMMITTEE INSERT *****

|
630 Mr. {Pallone.} Thank you. The gentleman from Texas,
631 Mr. Burgess.

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

649 [The prepared statement of Mr. Burgess follows:]

650 ***** COMMITTEE INSERT *****

|
651 Mr. {Pallone.} Thank you. The gentlewoman from
652 Wisconsin, Ms. Baldwin.

653 Ms. {Baldwin.} Thank you, Mr. Chairman, and before I
654 begin, I would like to request unanimous consent to submit
655 for the record testimony prepared by the Human Rights
656 Campaign that addresses the issue of access to health care
657 for LGBT Americans.

658 Mr. {Pallone.} Without objection, so ordered.

659 [The information follows:]

660 ***** COMMITTEE INSERT *****

|

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

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

682 [The prepared statement of Ms. Baldwin follows:]

683 ***** COMMITTEE INSERT *****

|

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

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

|
701 ^STATEMENT OF RICHARD E. BESSER, M.D.

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

715 Today, it is evident that our health system is not fully
716 achieving its primary goal, protecting and improving our

717 health. If our vision for health reform is too narrow, we
718 still won't achieve our ultimate goal of health for all
719 Americans. For too long, in discussions of health reform,
720 health care delivery and public health approaches have been
721 treated separately, as if they were disconnected and mutually
722 exclusive systems. With a discussion of health reform
723 currently a focus for the Nation, it is time instead to start
724 talking about solving our national health needs through a
725 comprehensive system that seamlessly integrates health care
726 delivery, prevention, and public health.

727 CDC and our public health partners are already working
728 to create these connections, connections between patients,
729 providers, and public health officials. By creating more
730 seamless integration between clinical care, which focuses on
731 the health of a single person, and the public health system,
732 which focuses on the health of an entire community or
733 population, a truly reformed health system could increase
734 access to needed health care services in the short term, and
735 reduce demand for treatment services through prevention over
736 time. For Americans to truly be healthier, we must not only
737 have access to treatment when sick, but they should receive
738 recommended screenings to detect the risk of disease early,
739 have access to evidence-based interventions to prevent
740 disease and injury before they occur, be supported by care

741 systems that minimize progression of disease once it occurs,
742 and live, work, and play in environments that promote healthy
743 choices and behaviors.

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

758 We are pleased to be able to work closely with Dr.
759 Fielding and the task force on community preventive services,
760 which has conducted exacting reviews of the evidence and
761 success to help guide our programmatic and policy
762 interventions, something that will be particularly critical
763 in a reformed health system. I am also happy that the
764 committee will have the opportunity to hear from other public

765 health leaders to help assess the value that can be delivered
766 from these types of interventions. We are anxious to
767 continue and accelerate this work with funding provided to
768 HHS under the American Recovery and Reinvestment Act to
769 address immunization, health-care associated infections, and
770 prevention and wellness.

771 Turning to what can be done to advance the public's
772 health through reform of our Nation's health system, it is
773 our goal that all Americans live in communities that create
774 positive opportunities for health, including opportunities
775 for physical activity and access to healthy food choices,
776 live in communities that provide greater access to effective,
777 evidence-based clinical and community prevention
778 interventions, provide effective support for management of
779 health conditions, starting with costly chronic diseases, so
780 that the consequences, both cost and health, are minimized,
781 and protect citizens from harm, including from tobacco use,
782 environmental hazards, contaminated food, hazardous work
783 sites, risk of injury, and unsafe medical practices.

784 We can put prevention to work across America. This can
785 be accomplished through a broad, national prevention agenda
786 through which we will need to provide tools and support the
787 individuals to enable them to take responsibility for their
788 own health, provide solid evidence upon which personal

789 community, and policy decisions that promote prevention and
790 wellness can be made, ensure rigorous tracking, monitoring,
791 and evaluation so that we can measure performance and ensure
792 accountability, more effectively support state and local
793 health agencies with the tools and technical support to
794 achieve positive health outcomes in communities across the
795 United States, tailor interventions to reduce health
796 disparities and improve health outcomes for populations most
797 at risk, use policy levers to improve health, including those
798 in areas not traditionally recognized as health-related
799 policies, such as food, education, and transportation to
800 create greater opportunities for physical activity and
801 improved nutrition, address the health crisis caused by
802 tobacco use through policy interventions, as well as
803 comprehensive tobacco control programs, and reform the
804 delivery system to promote a more seamless integration of
805 individual, clinical, mental health, and community approaches
806 that in combination can make us healthier.

807 Mr. Chairman, and members of the committee, the problems
808 in the health system remain a fundamental concern of
809 families, communities, businesses, and policymakers. A
810 deepening recession adds urgency to already recognized
811 shortcomings in the current health system. I share the
812 President's commitment to reform that makes health care

813 affordable and accessible, and I look forward to working with
814 the subcommittee to help make prevention a practical reality
815 as part of this national health reform effort. Thank you
816 very much.

817 [The prepared statement of Dr. Besser follows:]

818 ***** INSERT A *****

|
819 Mr. {Pallone.} Thank you. Dr. Fielding.

|
820 ^STATEMENT OF JONATHAN E. FIELDING, M.D.

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

834 As a background, health reform is very important to
835 assure everybody has access to quality, affordable health
836 care. However, the World Health Organization ranked the
837 health system of the United States 37th in the world despite
838 the fact that we spent 50 percent more of our GDP on health
839 care than any other country. We need to pair health care
840 reform with health reform, which requires changes in personal
841 habits that relate to health and underlying causes of

842 preventable health problems. The majority of the incredible,
843 unprecedented 37-year gain in life expectancy during the 20th
844 Century occurred because largely we had policies and programs
845 urged by the public health community, including purer food
846 and water, better environmental protection, occupational
847 health laws, improved housing standards, better nutritional
848 standards, and more sanitary waste disposal, as well as a
849 general increase in the standard of living.

850 But serious opportunities to improve health and reduce
851 the terrible disparities in health among subgroups remain.
852 Today, 1/3 of all deaths in the United States are caused by
853 tobacco use, physical inactivity, poor nutrition, and abuse
854 of alcohol and other substances. In addition, we
855 increasingly understand that poor education, low income,
856 problems in our physical and social environments are the
857 underlying causes of many diseases, and we have opportunities
858 not only at the retail level, which is what we do in the
859 health care system, but to work wholesale, which is working
860 at the determinants of health in all of us where working on
861 one can affect many diseases.

862 Fortunately, we are learning what works to keep
863 Americans healthy, to make improvements in their health
864 behaviors, and to address the underlying causes of ill health
865 in the physical and social environment. This progress is due

866 to the work of great CDC staff with the independent external
867 task force that I chair that develops the guide to community
868 preventive services. We do systematic reviews and make
869 recommendations that are based on the best evidence. Over
870 200 reviews and recommendations have been completed and we
871 know that these recommendations make a difference. For
872 example, our recommendation to reduce blood alcohol
873 concentration limits for drivers to 0.8 helped to spur
874 congressional legislation to limit access to transportation
875 funds to states that permitted higher alcohol level. That
876 contributed not only to safer roads but we saved many lives.

877 The recommendation can also assist HHS in determining
878 the best use of the Recovery Act funds. For example, to
879 prevent smoking and increase cessation the guide has shown
880 that social marketing campaigns are very effective. A
881 public-private partnership could rapidly apply the Recovery
882 Act resources to a national tobacco media campaign that could
883 substantially reduce the one behavior, smoking, that causes
884 the greatest number of preventable deaths. The guide also
885 provides essential recommendations for how the health care
886 system can increase its efficiency and effectiveness. Its
887 companion clinical guides tells us what preventive services
888 individuals should receive like mammography, while the
889 community guide tells us how the health care system can most

890 efficiently and effectively organize itself and deliver the
891 services that maximize uptake continuity and health impact.

892 Nonetheless, we face major challenges. First, because
893 of insufficient core funding the 210 completed reviews and
894 accompanying recommendations represent only a fraction of the
895 highest priority opportunities and topics identified.

896 Second, the recommendations are of little value if they are
897 not used. The guide has been passively disseminated so
898 awareness of its recommendation remains low and they have not
899 become part of standard practice. Third, the guide often
900 finds insufficient evidence to make a recommendation because
901 the needed studies that could answer that question have not
902 been done. One major gap is lack of information on how to
903 reduce health disparities.

904 Another priority opportunity is to quantify the health
905 effects of decisions that are outside the health sector such
906 as an education and transportation and criminal justice.
907 Health impact assessment is an effective tool for such
908 analyses that could basically help every congressional
909 committee understand how the decisions they are considering
910 would effect the health of all of their constituents. I have
911 four recommendations for your consideration. First and
912 foremost, the guide to community preventive services needs
913 full, financial, and personnel support. A one-time infusion

914 of \$50 million would allow us to provide recommendations for
915 all the high priority topics and intervention needed by
916 communities within 3 years.

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

931 Global warming is one example and other policy issues
932 through health impact assessment and other novel approaches.
933 Fourth, the guide and these initiatives need evaluation to
934 make sure recommendations are being implemented and determine
935 if the expected health improvements are being realized.
936 Finally, Healthy People 20-20 currently under development
937 will provide health objectives for our Nation. These

938 objectives need to be fully informed by the guide
939 recommendation and results of the studies that we have looked
940 at so that the objective set can be realistic and based on
941 the best evidence. These two major initiatives need to be
942 tightly linked to maximize the value of both. Thank you
943 again for providing the opportunity for me to talk with you,
944 and I look forward to discussing these issues and responding
945 to your questions.

946 [The prepared statement of Dr. Fielding follows:]

947 ***** INSERT B *****

|

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

961 And the other thing is the community-based prevention
962 like education campaigns, and these things are very
963 important. I am going to use my kids as an example, and I
964 hate to do that sometimes but it is the easiest thing for me.
965 I do think that like education campaigns about, for example,
966 not smoking are very effective. I mean I find that they see
967 smoking as a very bad thing like almost socially
968 unacceptable. And I think a lot of that has had to do with
969 the campaigns. But I also question the limits of what we can
970 do in these two categories because it just seems that so much

971 of prevention is personal and individual. And, again, I will
972 use my kids as an example. You know, they just want to watch
973 TV. They want to play videos. In the old days, and I am
974 really dating myself, you would be in the neighborhood and
975 you would go out and play on the street or in the back yard.
976 Today it is like watching the videos, watching TV, and,
977 unfortunately, as members of Congress you are not with them
978 every day so on the weekend I will try to get them out of the
979 house but is very tough.

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

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

999 Dr. {Besser.} Thanks very much for that comment and
1000 question, Mr. Chairman. And you raise a very challenging
1001 question, how do you change behavior. When we are talking
1002 about things like smoking, you are talking about things like
1003 obesity, how do you work to help support an individual to
1004 make those changes. And educational campaign is part of
1005 that, but when you are looking at behavior change, we try and
1006 look at it in a more comprehensive way. Educating and
1007 informing is part of that. But what can you do to support
1008 that individual? I volunteer in a clinic in Atlanta, and I
1009 have just been astounded by the increasing number of children
1010 I see who are obese, and I talk to that child about activity
1011 and why aren't you going outside and playing and engaging in
1012 sports programs.

1013 Mr. {Pallone.} Doctor, not to interrupt you, but I am
1014 very active with Native American issues.

1015 Dr. {Besser.} Yes.

1016 Mr. {Pallone.} And the more I go to the different
1017 reservations and meet the tribes, the more I see younger and
1018 younger kids with the adult onset diabetes. I mean 20 years

1019 ago you would find somebody who was maybe 21. Now you find
1020 kids that are 10 or 11 years old.

1021 Dr. {Besser.} There is an epidemic of diabetes taking
1022 place in this country, and we are seeing it younger and
1023 younger. American Indian populations, Latino populations, it
1024 is absolutely out of control, and if we are going to handle
1025 the problem of ever increasing health care costs prevention
1026 has to be part of that. But the children I am seeing, when
1027 they go to school they don't have access to physical
1028 education programs. When they come home, they are not in
1029 communities that encourage physical activity. When they go
1030 to a fast food restaurant, there is no posting of nutritional
1031 information to allow families to make healthy choices.

1032 When we think about these problems, there are things
1033 that we can do on a policy level. There are things we can do
1034 on a community level. There are things we can do to help
1035 their clinician provide them with counseling, and there are
1036 things that we can do to help that individual make healthy
1037 choices. But it has to be a concerted effort not just
1038 focused on that individual. The public health solutions are
1039 the long-term solutions to many of these problems.

1040 Mr. {Pallone.} I just think we need to do so much more.
1041 I don't know if it is money or whatever it is to counteract
1042 the trend that we have no idea how much effort it is going to

1043 take and--go ahead.

1044 Dr. {Besser.} I think resources is part of it, evidence
1045 is part of it. As Dr. Fielding was saying, the more we know
1046 what works from various pilots in communities the more we can
1047 expand that to other communities. There is definitely a gap
1048 in research in many areas of the most effective ways to
1049 change behavior. We are very excited about the resources
1050 that are going into comparative effectiveness research on the
1051 clinical side, but we clearly feel that there needs to be
1052 more work done on comparing different interventions on the
1053 community level to see which ones give you the best bang for
1054 the buck.

1055 Dr. {Fielding.} Let me just mention a couple of things.
1056 With medicine, we are kind of taught that there is a single
1057 answer to a single problem. It is kind of one to one. When
1058 you take the issue as complex as obesity there isn't a magic
1059 bullet. You need to do a variety of things. Some of those
1060 are policies, as Dr. Besser said. Menu labeling, for
1061 example. I worked very hard with others in California to get
1062 menu labeling in the fast food restaurants right up on the
1063 order board. That is going to happen in the next 2 years.
1064 And so you and I as parents are going to look at that and say
1065 you want what? How many calories does that have? And, by
1066 the way, there is some confounding information. When you

1067 look at that, you wouldn't know that there is a yogurt shake
1068 that actually has over 1,000 calories. Oh, it is yogurt, you
1069 know, how bad can it be. So part of it is changing consumer
1070 information. Part of it is changing the opportunities in the
1071 school.

1072 We have worked with the school system in Los Angeles
1073 County to increase physical activity but again the funding is
1074 being cut so it is tough. Now we have changed the food in
1075 the vending machines there so there is not junk food
1076 available in the vending machines. But there is also an
1077 aggregation of fast food restaurants that are near high
1078 schools where kids go out from school and in fact buy that
1079 instead of eating the food that is available in school. So
1080 we have to take a variety of approaches. One thing is very
1081 clear that I as a physician talking to a patient is not the
1082 only answer. It is not going to be the whole problem solver
1083 for obesity. The same way with tobacco control. We know
1084 that physician very brief advice in a standardized way the
1085 research has shown that can be effective. That is not
1086 enough.

1087 You reference the truth campaign, which has been very
1088 effective by the American Legacy Foundation. But that
1089 requires tens of millions of dollars a year. Now one of the
1090 opportunities would be the federal government to say as part

1091 of the recovery act, we are going to put substantial dollars,
1092 match that with what is already available from the American
1093 Legacy Foundation, and do not only the prevention through
1094 truth but become an X like program which is the cessation
1095 program tied to quit lines. So there have to be a variety of
1096 mechanisms. No one is going to do it, and that is why it is
1097 confusing because it is not the medical paradigm. We need a
1098 very strong public health infrastructure with states and
1099 local public health agencies taking the lead in convening and
1100 letting people know the evidence and in working across the
1101 aisle.

1102 Mr. {Pallone.} Thank you. I know I went too long here.
1103 Mr. Deal.

1104 Mr. {Deal.} Thank you. Thank you both for your
1105 testimony. You know, there are categories that we can look
1106 at. One category is whether we know enough to know to do the
1107 right thing. For adults, most of us probably know what we
1108 ought to do. We just don't do it. But for children, they
1109 are in the formative stages, and I am concerned about the
1110 things that the government can and can't do, things
1111 government should or shouldn't do. And for adults pretty
1112 much there is a freedom of choice there that government has
1113 very little ability to change other than maybe to educate,
1114 but in children I think it is a different area.

1115 And I agree with what my colleague, Ms. Eshoo, brought
1116 up in her opening statement about the food stamp programs,
1117 and I want to enumerate a couple of things here and ask you
1118 if you all have looked at these things, and they primarily
1119 relate to children. Of course, I am a big proponent for
1120 recess. I have a theory that when recess went out obesity
1121 went up, but in Atlanta you mentioned, and my understanding
1122 is the school board in Atlanta has now made a decision to do
1123 away with the physical education classes because they had to
1124 use the time to meet the academic requirements that the state
1125 has imposed and maybe even we have imposed from the federal
1126 level down.

1127 Things like school nurse programs, things like putting
1128 restraints on what products can be used with food stamp
1129 purchases, which I understand we do have some restraints I
1130 the WIC program already, things like the school lunch
1131 program. Now I know most school lunch programs now have a
1132 salad bar. That is for the teachers primarily. It is not
1133 the students who are utilizing it. What are we doing, what
1134 can we do, what can we do in those environments because for
1135 children the majority of the time that anybody other than
1136 their parents have control over is in a school environment.
1137 Would you all address that as it relates to children and
1138 either what they eat in the school lunch program, what many

1139 of them eat as a result of food stamp purchases, et cetera?

1140 Dr. {Besser.} I think this relates to the concept of
1141 health in all policies, and how do we look to ensure that we
1142 are promoting health or not by implementing policies
1143 promoting un-health through what takes place. Your comments
1144 about requirements, education requirements, and their impact
1145 is a really telling one. The reason that classes were
1146 increased was to try and improve the academic qualifications
1147 of students coming out of school. But we do know that
1148 students learn better when they are physically active, and
1149 the untoward consequences of some of those policies was
1150 squeezing physical education out of schools. We need to be
1151 able to look at that, and as public health practitioners we
1152 need to ensure that we have linkages, not just within the
1153 Department of Health and Human Services, but across
1154 government so that we are looking at how do you promote
1155 health in these other areas.

1156 The idea of a health impact assessment when policies are
1157 moving forward is very attractive because it would force us
1158 to say, okay, as we are looking to construction project, we
1159 are looking for new roads. Well, does that road project have
1160 sidewalks? Does it have bicycle lanes? Does it have things
1161 that actually could encourage people to be physically active
1162 or is that something that was not considered as part of that.

1163 The more creative we are and the more we are able to look at
1164 things that don't necessarily require new dollars the more
1165 effective we are going to be at building healthy communities
1166 that promote health for children and the entire population.

1167 Dr. {Fielding.} I think you are absolutely right. The
1168 WIC program has made important strides that can be emulated
1169 for the broader food stamp program, the SNAP program, but in
1170 the schools we changed the vending machines so they only have
1171 healthier snacks and taken out the soda, which has a lot of
1172 calories that kids--

1173 Mr. {Deal.} You have to be careful about that with Coca
1174 Cola in Atlanta as does Dr. Besser.

1175 Dr. {Fielding.} Well, my guess is Coca Cola probably
1176 makes more on the water they sell than on the Coke so maybe
1177 it helps--

1178 Mr. {Deal.} They have made a concerted effort as an
1179 organization to deal with that.

1180 Dr. {Fielding.} Exactly, so I think the large beverage
1181 manufacturers, they have a very broad range so whether it is
1182 A or B they certainly can do as well. But also the food that
1183 is served, a lot of that is bought through USDA so what
1184 percentage fat can that food be, what about portion size.
1185 You have people in the cafeteria who we have had to teach not
1186 to give huge amounts on a plate. There is also issues of

1187 plate waste. We can serve vegetables but what if kids don't
1188 eat them. So part of it is what we can do externally. Part
1189 of it is what has to be done in the family. In school, for
1190 example, physical activity needs to be real physical
1191 activity. As an example, playing softball or playing
1192 baseball, most people are sitting around. They are
1193 standing. Well, what if everybody ran around the bases every
1194 time somebody got a hit? That is the way to change the game,
1195 if you will.

1196 And the same way out of school. We have to make sure
1197 that kids have a safe environment in which to play. Are
1198 schools available after hours? What about those general
1199 after school programs? Is there lighting in neighborhoods?
1200 So you can't separate these. And then parents. For example,
1201 as Chairman Pallone said, you know, what about the kids
1202 watching television? Well, they are spending too much time
1203 in front of the screens. Well, some parents may say, you
1204 know, there is a limit on how much you can do or you can only
1205 do it after you have done some physical activity. Not easy
1206 for us as parents but we have to take charge of part of that
1207 ourselves.

1208 Mr. {Deal.} Thank you both.

1209 Mr. {Pallone.} Chairman Waxman.

1210 The {Chairman.} I want to ask a question for both of

1211 you. In a little while, we are going to hear from Dr.
1212 Satcher, and he notes in his written testimony that racial
1213 and ethnic health disparities result in at least 83,500
1214 excess deaths among African Americans each year. That is
1215 simply unacceptable. We have to address it in health reform.
1216 My question is what contribution can public health make to
1217 reducing racial and ethnic health disparities? Are there
1218 specific clinical preventive services that will reduce
1219 disparities if we cover them in health reform? Are there
1220 specific community-based preventive services that will reduce
1221 disparities if we fund them in health reform? Dr. Besser,
1222 why don't we start with you?

1223 Dr. {Besser.} Thank you, Mr. Chairman, for that
1224 question. I think that your comment that this is
1225 unacceptable is right on target. It is absolutely
1226 unacceptable the degree of disparities we see in health. CDC
1227 has undertaken a number of initiatives to try and address
1228 racial and ethnic disparities, but not on the scale that they
1229 need to be done. There is a program at CDC called REACH,
1230 which is racial and ethnic approaches to community health
1231 that has been done in a number of communities to specifically
1232 address within those communities the racial and ethnic
1233 disparities that occur.

1234 Where this program has been enacted, we have seen a

1235 removal of the disparity in rates of mammography among
1236 African American women. We have seen removal of disparity in
1237 the rates of blood pressure screening for African American
1238 men, an increase in the use of blood pressure medication. We
1239 have seen a decrease in smoking among Asian American men. We
1240 know how to address these disparities, and again it takes a
1241 community approach. It is not a one size fits all approach.

1242 And with appropriate scale up of these programs, I think
1243 that we can see the removal of a lot of these disparities.
1244 We have seen it in immunization programs where you have seen
1245 universal immunization. You have seen elimination or at
1246 least a closing of many of those disparities, and it is time
1247 for us to ensure that those programs are available to all of
1248 our communities.

1249 Dr. {Fielding.} Thank you very much. As your
1250 constituent, I am happy to add a couple of thoughts. First
1251 of all, we are not going to get to parity in terms of health
1252 unless we address some of the underlying determinants. I was
1253 asked the other day at a RAND conference, what is the single
1254 thing you would do to improve the health of the American
1255 people particularly focused on reducing disparities, and I
1256 said increase the graduation rate from high school for a
1257 number of minority groups. They are very poor in Los Angeles
1258 as in other parts of the country, and the differences in

1259 health that come along with that are substantial. The issues
1260 of transportation, the issues of access to nutritious foods,
1261 fruits and vegetables.

1262 The {Chairman.} Well, how would you address this, in a
1263 community-based way or would you do it in a clinical way? I
1264 know that you can solve all the world's problems and it would
1265 change the disparities but if we are doing health reform,
1266 what do you recommend we do in health reform? Should we
1267 provide money for community programs? Should we provide
1268 certain clinical practices for those who are going to now be
1269 insured if we get a health reform bill through?

1270 Dr. {Fielding.} Yeah, I think that, as you suggest, Mr.
1271 Chairman, at all levels in a health care reform system, you
1272 want to make sure that there are not only the ability but the
1273 incentives so that the providers have incentives to make sure
1274 that there are not disparities in terms of the access to
1275 services, but we also know that we have to use a lot of
1276 efforts. It is not simply that one has to have services
1277 accessible. They have to use them. And so one of the things
1278 we do in the community guide is to develop interventions
1279 which basically help people to use the services. And with
1280 different groups that may be different so for one group it
1281 may be that recall reminders make a difference. For another
1282 group it may be that you need to call their cell phones.

1283 For another group it may be that they have to have a
1284 case manager. It is trying to understand that that we are
1285 trying to do in the community guide working with the clinical
1286 guide, so I think the opportunity for all of those should be
1287 included in health system reform but we also, if we are going
1288 to reduce disparities, need to focus on the core of public
1289 health and the underlying problems. For example, in Los
1290 Angeles County African American men and women have a 25
1291 percent smoking rate. The average rate in Los Angeles County
1292 is 14 percent. So we need programs, for example, social
1293 marketing programs that are particularly focused on the
1294 African American population there on tobacco.

1295 We need programs on obesity for Latinos as well as
1296 African Americans, so I think it needs to be a combination of
1297 what can go in the health care reform and the other parts of
1298 health reform that are outside the strict health care system.

1299 Dr. {Besser.} Chairman Waxman, if I could add to that.
1300 I think that it also ties into comments that were made by
1301 many members about the importance of a strong state and local
1302 public health system. In a community you need to have a
1303 public health infrastructure, epidemiologists and public
1304 health specialists, who can look at what are the risk factors
1305 in that particular community and address those. It is not a
1306 one size fits all, and those in the community, as Dr.

1307 Fielding is saying, in a community that got higher rates of
1308 smoking in one particular population, they have to look at
1309 what is driving that, who the community leaders are, and how
1310 you build a public health program that targets the drivers I
1311 that particular community, and to do that you need a strong,
1312 local public health system.

1313 The {Chairman.} Thank you, Mr. Chairman.

1314 Mr. {Pallone.} Thank you. Our ranking member, Mr.
1315 Barton.

1316 Mr. {Barton.} Thank you, Mr. Chairman. One of the
1317 things that we can do to promote congressional health would
1318 be to stop scheduling simultaneous subcommittee hearings of
1319 this committee, which causes--but I guess it does promote de-
1320 obesity because it makes us run back and forth, up and down
1321 the stairs. I just have one question for this distinguished
1322 panel, and it is the idea of universal coverage. The
1323 President has said that every American should have health
1324 care insurance and you almost have to have--you don't have to
1325 but you almost have to have a mandate that every American has
1326 to have it, so my question is should that be an individual
1327 mandate or should it be some sort of a universal mandate that
1328 if you are not covered under a group plan there be a national
1329 kind of a backup fail safe plan for any individuals that
1330 don't have group coverage, so could you two gentlemen give us

1331 your ideas on how to get universal coverage for every
1332 American regardless of their employability and employment
1333 status?

1334 Dr. {Besser.} Thank you very much for that question.
1335 From a public health perspective, and that is the hat I wear
1336 and where my expertise lies, the critical factor is access to
1337 care and ensuring as a Nation that we move to a point where
1338 everyone has access to care and that care is not just being
1339 delivered in emergency rooms when people are sick. And I
1340 think there are many ways to get there. Which way we get
1341 there, I think is not one where CDC has the expertise. One
1342 thing that we hopefully over time will be able to bring more
1343 light to is the impact particular insurance or particular
1344 systems may have on an individual's health. We collect a lot
1345 of information on the health status of Americans through
1346 various surveys and one is the national health interview
1347 survey.

1348 And through that survey, we are now starting to collect
1349 information about type of insurance, type of insurance plan,
1350 whether it is a health savings plan or such so that over time
1351 we should be able to look at does that particular type of
1352 system have an impact on health drivers.

1353 Dr. {Fielding.} Sir, I don't know which is the best way
1354 to get there. I think what is important is that there be

1355 however you get there a core of services which is going to
1356 contribute to health because health then allows us to be more
1357 competitive, more productive as a Nation by reducing
1358 preventable problems. I think if we focus on that aspect
1359 there are probably a number of ways to get there but
1360 providing the emphasis on what we can do within that system
1361 and then working together with public health is probably our
1362 best opportunity to improve the health of every American and
1363 to reduce disparities at a time when unfortunately our health
1364 is not as good as that of our trading partners in many cases.

1365 Mr. {Barton.} Thank you, Mr. Chairman.

1366 Mr. {Pallone.} Mr. Dingell.

1367 Mr. {Dingell.} Thank you, Mr. Chairman. This question
1368 is to Dr. Fielding and Dr. Besser. Question, public health
1369 has a cost benefit to the society, does it not, yes or no?

1370 Dr. {Fielding.} Yes, it has a very substantial benefit
1371 to society, sir.

1372 Mr. {Dingell.} Dr. Besser?

1373 Dr. {Besser.} Yes, sir, I would agree with that.

1374 Mr. {Dingell.} All right. Now the reason for that
1375 question is the dealings in this committee with national
1376 health insurance or getting a program which will cover every
1377 American, that cost benefit may get dropped out of the
1378 equation because of the Congressional Budget Office which has

1379 a rather stingy attitude of quantifying things which they
1380 view as being unquantifiable. How do we then see to it that
1381 we get this question resolved in a way which is quantifiable
1382 so that we can get some discernable, visible, and calculable
1383 benefits to the society from public health so that we can get
1384 CBO to give us a proper estimate of savings and benefits that
1385 could be achieved by public health service, by CDC and other
1386 entities which work towards this end? Starting first with
1387 Dr. Fielding and then Dr. Besser.

1388 Dr. {Fielding.} Thank you very much. A very important
1389 question, Chairman. I think several things. First of all,
1390 you will hear from Jeff Levi from Trust for America's Health
1391 the kind of studies that they have done suggest a very good
1392 return on investment for some of the things we could do in
1393 public health. It is clear to me that we are not going to
1394 get where we need to with the national system of strong local
1395 public health and state public health unless the federal
1396 government is a partner with the states and localities,
1397 unless there is a sustainable amount of money that goes to
1398 make sure that the spine of public health is strong.

1399 With respect to the Congressional Budget Office with
1400 which I have had some discussions as well, I think that they
1401 tell me that the Congress is asking them to look very
1402 narrowly, and I don't think that looking narrowly answers the

1403 question. What they need to look at is the value. What is
1404 the relative value of different kinds of investments, and I
1405 think if you look at the relative value you get better.

1406 Mr. {Dingell.} That is an outfit, Doctor, that
1407 sometimes knows the cost of everything and the value of
1408 nothing and they have great difficulty in converting value to
1409 cost that is discernible and can then be included as
1410 justification in the legislation. I am asking your help
1411 about how do we get this quantification step done. And
1412 remember my time is running.

1413 Dr. {Fielding.} Okay. What I am suggesting is that we
1414 look not only at the dollar savings in a very short period of
1415 time to the federal government, but we do two things--

1416 Mr. {Dingell.} Let me put it to you this way, Doctor.
1417 If we had Black Death there would be a--to spring back, we
1418 would all of a sudden have a very major cost to the society.
1419 AIDS has a very major cost to the society. If tuberculosis
1420 were to come back and break loose in the society, we would
1421 have a cost. How do we quantify these things and how do we
1422 request quantification from CBO so that they will give us
1423 something that will be useful in this discussion?

1424 Dr. {Fielding.} We can quantify the cost of epidemics
1425 in terms of health care costs, in terms of productivity loss,
1426 in terms of cost to the Social Security system and the like.

1427 That is easy. What is hard to know is what exactly it takes
1428 to prevent those because it comes from a number of different
1429 places. I think if we ask the CBO to look at what is the
1430 health benefit for a dollar invested in alternative ways,
1431 that is what I mean by value. Instead of just saying what is
1432 the dollar back, what is the health value? We are spending
1433 right now \$1 out of every \$6 in this country on health care.
1434 We don't know in many cases what the value of those dollars
1435 is. We need to compare that with the value of public health.

1436 Mr. {Dingell.} If you give preventive care, you could
1437 shrink those numbers. Let me get to Dr. Besser.

1438 Dr. {Besser.} Thank you, Mr. Chairman. I think that
1439 you raise a critical question and a critical problem. When
1440 we look at many of the interventions and programs in public
1441 health the return on investment is long term. When we are
1442 talking about promoting physical activity and appropriate
1443 nutrition in children, that will have major payoffs to those
1444 individuals but also to our economy over the lifetime of that
1445 individual.

1446 Mr. {Dingell.} Or alcohol or smoking.

1447 Dr. {Besser.} Exactly. Alcohol or smoking. Those
1448 behaviors, if presented early, will have lifetime benefits
1449 and will have lifetime impacts on our economy.

1450 Mr. {Dingell.} How do we insist CBO assist us in

1451 quantifying those benefits?

1452 Dr. {Besser.} Well, I think that that is a real
1453 challenge. It is very promising, some of the data, Trust for
1454 America's Health, and Jeff Levi is going to be talking about
1455 short-term return on the investment. And that is promising,
1456 but I do think that for the broader consideration of public
1457 health that can't be the only part of the conversation
1458 because even if we were not seeing the return on investment
1459 that Trust for America's Health was seeing, we are seeing a
1460 very good value on the investment over the lifetime of
1461 individuals and over the lifetime of the economic return over
1462 the lifetime of those individuals. So the issue of time
1463 frame, cost to whom, who is paying the cost and who is the
1464 benefit being accrued by are very important parts of that
1465 discussion and one that we have to find a way around if we
1466 are going to see a long-term commitment to supporting public
1467 health.

1468 Mr. {Dingell.} Thank you, Mr. Chairman. My time has
1469 expired.

1470 Mr. {Pallone.} Thank you, Chairman Dingell. Ms.
1471 Blackburn.

1472 Ms. {Blackburn.} Thank you, Mr. Chairman, and thank you
1473 all for your testimony. Listening to you, it seems like we
1474 could--and listening to the questions, we are coming back to

1475 three things, which are lack of education, lack of physical
1476 activity, and then tobacco as three things that are really
1477 detrimental to health and good healthy lifestyles. Dr.
1478 Besser, you mentioned linkages with other resources and other
1479 agencies, and I just wanted to ask a couple of quick
1480 questions. Number one on the tobacco issue, we know that the
1481 Sinar amendment, the Sinar program, has been effective in
1482 helping states reduce their tobacco usage, their underage
1483 tobacco usage, but we also know that after the master
1484 settlement agreement that very little of that money is being
1485 used on tobacco.

1486 I was in the state Senate in Tennessee when that was
1487 passed, and of course like so many states it went to fund a
1488 program, a health care delivery program, and the general fund
1489 and things of that nature that really weren't dealing with
1490 tobacco education. And some of us, myself included, who had
1491 been active with smoking cessation education, and as chairman
1492 of a former lung association, were disappointed in that. So
1493 would you all support a proposal that would require states to
1494 use a certain percentage or an expanded percentage of that
1495 master settlement money for tobacco education? Just a quick
1496 yes or no from you all.

1497 Dr. {Besser.} Congresswoman, I have to confess that I
1498 am not familiar with the Sinar legislation and so I need some

1499 information around that. What I can say is that tobacco
1500 control is one of those areas where we have seen major public
1501 health successes both in terms of reduction in rates of
1502 smoking in adults, children who decide not to start smoking,
1503 decrease in second hand smoke, and I also know that if we
1504 don't keep up those efforts around tobacco control, we are
1505 going to see those benefits go away. It is not something
1506 where you do it and you are done.

1507 Ms. {Blackburn.} Dr. Fielding.

1508 Dr. {Fielding.} I don't know legally what can be done.
1509 It really is disappointing that the attorney general
1510 settlement did not specify that some of that money be used
1511 for tobacco control because a lot of states have not--tobacco
1512 control is an area we know a lot. We know a lot what can
1513 make a difference, and it is very disappointing that in many
1514 states unfortunately we are not putting the resources in that
1515 we need in order to reduce the rate. How that could be
1516 achieved, I am not sure legally, but it would be very
1517 important to have money consecrated to that problem because
1518 we know how to use it well.

1519 Ms. {Blackburn.} Okay. On the linkages, coming back to
1520 that, I am one of those that believe that when you took
1521 physical education classes and consumer science or life skill
1522 classes out of the high schools that you started seeing lack

1523 of education with people, individuals, that did not
1524 understand, Dr. Fielding, as you were saying, what calories
1525 exist in food and what those choices should be. But along
1526 that line, have either of you worked with the U.S. Department
1527 of Agriculture and the Agricultural Extension Service, their
1528 FSC program or 4H club programs, anything like that on
1529 education because they have staff and they have materials
1530 that are developed to address that, either of you?

1531 Dr. {Besser.} I have not personally but let me get back
1532 to you about any collaboration CDC would have with USDA in
1533 that area.

1534 Ms. {Blackburn.} Okay. That would be great. Dr.
1535 Fielding.

1536 Dr. {Fielding.} We have worked with WIC programs which
1537 we think are moving in the right direction and we have tried
1538 to change what is served in the schools and that works with
1539 USDA but we have not had direct contact.

1540 Ms. {Blackburn.} Well, and the WIC program for many of
1541 us that come from state governments when we did welfare
1542 reform, what we did was to require some of that education,
1543 and then in Tennessee one of the things we did was to move
1544 some of that education back out to our local county extension
1545 services because they do have the individuals there that not
1546 only can provide the education but can mentor, which is a

1547 critical component of changing the habits and the behavior.
1548 And I know when Dr. Satcher does his testimony, he is going
1549 to speak a little bit to the influence of lifestyle and
1550 behavior. Thank you. I yield back. Thank you, Mr.
1551 Chairman.

1552 Mr. {Pallone.} Thank you. Mr. Matheson.

1553 Mr. {Matheson.} Thank you, Mr. Chairman. Dr. Besser, I
1554 was going to mention to you, have a discussion with you about
1555 issues about MRSA, if I could. Last year, a study was
1556 reported that caught a lot of our eyes about the effect that
1557 MRSA is having. Specifically, the study estimates that in
1558 2005 more than 94,000 invasive MRSA infections occurred in
1559 the United States and over 18,000 of these infections
1560 resulted in death which was many more than had previously
1561 been thought. But there are many infections and other
1562 resistant bugs that aren't receiving as much attention and
1563 certainly should be adequately monitored as we discuss
1564 prevention and public health.

1565 You may be familiar with legislation I introduced last
1566 year and plan to reintroduce that is called the STAR Act. It
1567 would establish a network of 10 sites across the country
1568 which could be part of existing surveillance sites or health
1569 departments. These sites would provide an early warning
1570 system to monitor anti-microbial resistance. I look forward

1571 to working with you as we try to develop that legislation as
1572 a way to strengthen this country's ability to respond to what
1573 I see as an emerging public health problem. I wonder if you
1574 could just discuss with me any gaps you see in our current
1575 surveillance capabilities. Specifically, I would ask do we
1576 have an early warning surveillance system to monitor anti-
1577 microbial use and the emergence and spread of resistance?

1578 I would also like to ask you if you think our current
1579 systems are reactionary or are they geared at preventing
1580 outbreaks. And, third, I would ask your sense of how we
1581 compare with other countries in this set of issues.

1582 Dr. {Besser.} Thank you, Mr. Matheson, for these
1583 questions about a very important public health problem. MRSA
1584 is one type of resistant infection and it is one that has
1585 gained a lot of national attention. One of my areas of focus
1586 early in my career at CDC was around appropriate antibiotic
1587 use, and I started CDC's program, Get Smart, Know When
1588 Antibiotics Work, so that is directed around trying to
1589 prevent the increasing rise or the academic of antibiotic
1590 resistant strains. We are absolutely thrilled that the ERA
1591 funds that have come down have \$50 million in there to look
1592 at health care acquired infections because when you look at a
1593 site where resistance is likely to occur and develop health
1594 care settings are one of those places where you are seeing a

1595 lot of bad bacteria and a lot of antibiotics. You put those
1596 together and you are going to promote resistance.

1597 There are major gaps in our ability to detect infectious
1598 diseases and detect resistant infections, and those ERA funds
1599 are going to help with that to some extent. Our ability to
1600 look at antibiotic use and behaviors around that, we have
1601 some surveys in the NCHS, National Center for Health
1602 Statistics, that allow us to get a window on how antibiotics
1603 are being used in clinical practice. As we move toward
1604 electronic health records, that is going to improve our
1605 ability to look at practices across providers and for
1606 providers to look at their own practice and see how are they
1607 complying with recommendations, how is their use of
1608 antibiotics.

1609 When we look across different countries, there are some
1610 countries that we have higher rates of resistance in and some
1611 that we have lower rates of resistance, and it is important
1612 that we work with other countries to see what strategies and
1613 solutions have been effective at reducing infections and
1614 resistance. We do know how to reduce infections in health
1615 care settings. We have programs that have been very
1616 effective that we have developed jointly with the Agency for
1617 Health Care Research and Quality. These demonstrated in
1618 southwestern Pennsylvania, implementation of these reduced

1619 bloodstream infections by 70 percent. And so for many states
1620 and localities, it is how do we help them go to scale and how
1621 do we provide the assistance and resources to make that
1622 happen.

1623 Mr. {Matheson.} Well, I appreciate that response, and
1624 again I look forward to continuing to work on this issue.

1625 Dr. {Besser.} Likewise.

1626 Mr. {Matheson.} I yield back, Mr. Chairman.

1627 Mr. {Pallone.} Thank you, Mr. Matheson. Next is Mr.
1628 Burgess.

1629 Mr. {Burgess.} Thank you, Mr. Chairman. I got a number
1630 of things I want to get through. Of course, Mr. Pitts and
1631 Mr. Shimkus said before they left that they would yield me
1632 their time as well. Dr. Besser, let us stay on the subject
1633 of infection for just a moment, and you reference it in your
1634 written testimony but can you talk just a little bit about
1635 your approach to this or perhaps delineate what would be a
1636 preferred approach to controlling particularly central line
1637 infections and do so in a way that so that we don't inhibit
1638 reporting if we come at it. And I worry about this because
1639 we do this over and over and over again in Congress and CMS.
1640 We come at things punitively and then we tend to drive
1641 reporting underground so can you address that?

1642 Dr. {Besser.} Thank you, sir, for that question. It is

1643 a challenge. There is an inherent difficulty when reporting
1644 of an infectious disease could have negative consequences to
1645 the individual that is reporting that. The national health
1646 care safety network that CDC supports and is in place in many
1647 states allows for confidential reporting and provides to
1648 health care institutions an ability for them to look at their
1649 own rates of infection and develop strategies to reduce rates
1650 of infection.

1651 Mr. {Burgess.} Now under HIPA at CDC can you accept
1652 that data at CDC if someone wants to compile that data on a
1653 state level? Can they export it to you?

1654 Dr. {Besser.} CDC is able to receive anonymized data
1655 from many sources and when we work with states around this
1656 area there are provisions that protect those data that come
1657 to CDC. What we found is that when hospitals start to do the
1658 surveillance around line infections and implement what have
1659 been shown to be effective control strategies that they see a
1660 dramatic decline in those infections. They are entirely
1661 preventable, and that is something that where we think there
1662 could be major improvements.

1663 Mr. {Burgess.} Sure. That is the epidemiologist
1664 mantra. To measure is to control. I guess I am concerned
1665 because our tendency is to be punitive on this and I know
1666 certainly from the physician community we are so goal

1667 directed. If you are not going to pay me if I diagnose a
1668 surgical site infection, I will never diagnose another
1669 surgical site infection through my professional career
1670 because after all I want to get paid. So we contend to
1671 obscure the data by how we focus on things. I want to touch
1672 on something else because you have got in your testimony
1673 about HIV prevention, and nowhere in there do I see--I will
1674 just tell you the problem that I have in my community in
1675 southeast Fort Worth is that we have individuals who are
1676 arrested for one thing or another, incarcerated and returned
1677 to the community and now with an HIV infection and it then
1678 spreads outward from that exposure. Are we doing anything to
1679 look at our exposure to our prison population and then their
1680 subsequent re-integration into society?

1681 Dr. {Besser.} Mr. Burgess, I will need to get back to
1682 you on that in terms of specific programs in that setting. I
1683 think that when it comes to HIV prevention and control as
1684 with other infectious diseases understanding where
1685 transmission is occurring and ensuring that we have programs
1686 to address that route of transmission is absolutely
1687 essential. Earlier we heard someone mention the 3 percent
1688 HIV prevalence in African American males in the district.
1689 That is unacceptable. We need to understand what is driving
1690 transmission and put in place control efforts so that that

1691 will not be the case. But let me get back to you in terms
1692 of--I know we do a lot of work with health care--with
1693 infectious disease transmission in prison settings but I want
1694 to make sure I get back to you with accurate information.

1695 Mr. {Burgess.} Okay. Very good. And I appreciate
1696 that, and of course we know that if we are seeing that high a
1697 rate in African American men it will just be a very short
1698 period of time before we see a similarly high rate in African
1699 American women, and part of our job is to prevent that from
1700 happening in the first place through educational activities.
1701 One last thing that I will just mention and I have heard
1702 access mentioned several points this morning. I have an area
1703 that I represent. Two or three of my zip codes have some of
1704 the highest infant mortality rates in the Nation, and it is
1705 in Tarrant County, which of course has a robust county
1706 hospital district, county tax supported facility and
1707 literally within the shadow of these facilities are some of
1708 these neighborhoods where infant mortality is so high and the
1709 problem therein is utilization and not access because access
1710 is clearly available but we don't have clinics where the
1711 people are, and trying to work through the cumbersome
1712 bureaucracy that exists in HERSA and HHS has made it all but
1713 impossible to get a community health center, a federally
1714 qualified health center, developed in those areas.

1715 And one of the most meaningful things we can do as we go
1716 forward is to try to unravel some of that so that we don't
1717 put these barriers up to getting the care were it is actually
1718 needed. I hear testimony from other members on both sides of
1719 the dais where they talk about 10, 12, or 14 federally
1720 qualified health centers they have in their districts. I
1721 have zero in my district, and I have got infant mortality
1722 rates that are third world, and it is unconscionable that we
1723 will continue this program where--it is not just a racial
1724 disparity. It is a geographic disparity that is of startling
1725 proportions and I really hope that going forward this
1726 committee will spend some effort in looking at that, and
1727 certainly where CDC can give us some help, I hope they will
1728 do so. So I thank you, Mr. Chairman, and I will yield back.

1729 Mr. {Pallone.} Thank you. Next is Ms. Capps.

1730 Ms. {Capps.} Thank you, Mr. Chairman, and, boy, what an
1731 excellent panel. This could go all day. And I have a
1732 question for each of you and I have tried to make it narrow
1733 but it is impossible. Dr. Besser, you discussed examples
1734 that make it clear that accurate information about key public
1735 health indicators such as infant maternal health is essential
1736 to improving the overall health of the public. Maybe this is
1737 what Chairman Dingell was kind of getting at as well. There
1738 are currently barriers to surveillance that make it difficult

1739 to gather public health data. We have to have the data in
1740 order to make the case for more access and better ways of
1741 implementing public health. Can you describe briefly some of
1742 those barriers, what we could do to help accomplish the
1743 positive health outcomes that comprehensive surveillance data
1744 could give us?

1745 Dr. {Besser.} Thank you very much for that question.
1746 There are a number of things that I can think about that
1747 would improve our ability to understand the health status of
1748 Americans. Right now there is so much discussion around
1749 electronic health records and what these are going to provide
1750 to improve clinical care by providing to that clinician
1751 information about screenings that need to take place. Well,
1752 this also is a potentially very powerful tool for population
1753 health and insuring that as this moves forward there are
1754 fields that are in there that represent the important
1755 components that we need to look at for public health, and
1756 that the clinics are not just connecting to each other but
1757 they are connecting to public health departments.

1758 That is one thing that would be extremely effective. We
1759 at CDC have seen over time a decline in support for our
1760 National Center for Health Statistics. The National Center
1761 for Health Statistics is critically important to measuring
1762 health of people around this country. It is important for us

1763 in terms of measuring the impact of programs that we put in
1764 place and ensuring that we are spending our resources
1765 appropriately. It is important for identifying disparities
1766 and issues that need to be addressed in particular
1767 communities. And we have had to make tough choices over time
1768 in terms of decreasing the frequency of surveys or decreasing
1769 the size of a population under a survey, and it is very
1770 difficult when we are doing that to really get a measure of
1771 the health status of all Americans.

1772 Ms. {Capps.} Even though I know you could talk more
1773 about this topic, I just want to from that as we look for a
1774 comprehensive health legislation, we do need to be cognizant
1775 that data collection is an integral part of doing that. Dr.
1776 Fielding, you have done so much for the metropolitan Los
1777 Angeles area. Thank you. As we work to reform the health
1778 care system public hospitals and community health centers are
1779 essential to ensuring that rising numbers of uninsured and
1780 underinsured patients can access health care during a
1781 recession which we are seeing right before our eyes. In the
1782 future, safety net health systems must remain intact to
1783 provide the services that newly insured patients will need to
1784 effectively access care if we are really going to implement
1785 an increased number of people getting care.

1786 We have got to find a place for that to happen,

1787 including language translation and social work services.
1788 Safety net providers will also continue to provide money
1789 losing services such as trauma and burn care that many other
1790 hospitals choose not to offer. So what kind of policy
1791 questions should we be addressing in our health reform
1792 dialogue to insure that the safety net stays viable for the
1793 future and that kind of topic particularly now if we
1794 transition into a broader based health delivery system?

1795 Dr. {Fielding.} Thank you very much. You are
1796 absolutely right. We need to maintain a safety net. These
1797 are providers who are very sensitive to the population for
1798 whom language is not a barrier who understand the morays, the
1799 culture, the beliefs, and that has been lacking is sufficient
1800 funding to try and knit all the pieces together so that, for
1801 example, community health centers might have the same record
1802 as the hospital or primary care and secondary care might have
1803 the same ability and to transport things back and forth
1804 easily electronically. That is one need. Another need, of
1805 course, is simply to give people the tools so that they can
1806 maintain the infrastructure necessary.

1807 In some cases, public systems have not done as well in
1808 trying to maintain themselves just physically as others have.
1809 But I also think that we have to look over time in the local
1810 situation to see what impacts a broader mandate will have and

1811 in some cases it may transform systems. In other cases, it
1812 may not change them very much. To what degree are there
1813 going to be competitive opportunities or not, so I think it
1814 is going to be a situation by situation issue. I would add
1815 one point to answer your last question. We do a local health
1816 survey. We have the LA health survey, and we do over 8,000
1817 people every other year in Los Angeles County of over 10
1818 million people. And we get a lot of interesting and
1819 important information on issues as diverse as breast feeding
1820 and what are the barriers to that, one of our most important
1821 opportunities, or emergency preparedness. What percentage of
1822 our population are prepared for emergencies and have a family
1823 communication plan, have the 10 essential items that they
1824 need?

1825 We have more than our share of natural disasters and we
1826 worry, of course, about others so I think having local data
1827 collection is also important to supplement the very important
1828 role that NCHS plays. And I just want to echo that the
1829 National Center for Health Statistics has not had the funding
1830 they need, and if we are doing to coalesce our Nation around
1831 the 2020 objectives for the Nation, then we have to have the
1832 data on which to base that, and we have to know if we are
1833 tracking in the right direction or not and not just
1834 nationally but at the local level, so robust funding for that

1835 effort is going to be essential.

1836 Ms. {Capps.} Thank you both.

1837 Mr. {Pallone.} Thank you. Mr. Gingrey.

1838 Mr. {Gingrey.} Mr. Chairman, thank you. And I wanted
1839 to ask both Dr. Besser and Dr. Fielding, all Americans of
1840 course should have quality health care regardless of income,
1841 race or age. Dr. Besser, let me start with you. I believe,
1842 of course, that any disparity should be a major part of
1843 health care reform, and I know we have talked about this this
1844 morning and several of my colleagues on both sides of the
1845 aisle touched on that issue. And, Dr. Fielding, I think in
1846 your testimony you talked about a lot of things, situations,
1847 education, but I guess really what I want to find out is if
1848 either one of you think that there are other reasons for
1849 racial disparity in regard to receiving the kind of high
1850 quality health care.

1851 An example, in the Medicaid program, there might be a
1852 tendency, might, I would hope not but I think likely there is
1853 for health care providers to be a little bit prejudice
1854 towards people who come in the door who obviously are not
1855 taking care of themselves. Maybe they are obese, maybe they
1856 are unkempt, maybe they are smoking cigarettes, whatever.
1857 But I really am concerned there could also be that same sort
1858 of attitude towards different minority groups. And so this

1859 is a little touchy subject but I think it is hugely important
1860 that we talk about it, so I would like for you to address
1861 that.

1862 Dr. {Besser.} Thank you, Mr. Gingrey. Dr. Fielding, in
1863 his discussion earlier was talking on issues around social
1864 determinants of health, and I do think those are critically
1865 important. Where you live, whether your parents graduated
1866 from school, what type of occupation they may have and what
1867 type of occupation you have are things that do impact on your
1868 health. We know that children who live in the inner city
1869 have rates of asthma that are far greater than individuals
1870 who don't live in an urban environment. We know that
1871 children who are born to a single parent have a lower
1872 likelihood of graduating from school, and if you don't
1873 graduate from high school then your health future is more
1874 bleak.

1875 And so there are a lot of factors that go into issues of
1876 health, some having to do with access to care. In the clinic
1877 I work in in Atlanta, I would say that it is a fraction of
1878 the children I see there have any health insurance at all.
1879 Those who do, the state pays Medicaid, and whenever I have
1880 one of those children it is like a blessing because I know
1881 that I can refer them to the dentist down the hall to get
1882 their teeth taken care of, and I can refer them to other

1883 services. So I think access to care is part of the issue
1884 when we look at promoting health, but it is important to look
1885 in each community to see what are the barriers for the entire
1886 population to get the health services and the health that
1887 they deserve.

1888 Mr. {Gingrey.} Dr. Fielding.

1889 Dr. {Fielding.} Yes. I think one of the needs is to
1890 develop a work force which is reflective of the population
1891 and I think there are a lot of efforts, and Dr. Satcher has
1892 been a real leader and can talk about both his leadership
1893 training and other efforts. I think that is a very important
1894 initiative. I think it is also important to realize that a
1895 lot of the health disparities are really inequities. They
1896 arise from social and economic disadvantage, and we have some
1897 responsibility to try and overcome those. We are not always
1898 entirely successful but we need to do that and sometimes it
1899 will take some extra effort.

1900 The third point though is that we have a very
1901 heterogeneous population. In Los Angeles County, for
1902 example, there are no minorities because there is no majority
1903 currently. Now there will be a majority within 10 years and
1904 that will be Latino in this largest county in the country, so
1905 the whole issue of minorities is an interesting one in terms
1906 of definition. But I think there is real opportunities, and

1907 we have to marry what we do at the individual level with what
1908 we do at the community level. That is why having core public
1909 health is so essential to helping to reduce disparities, and
1910 we need a lot more research on that.

1911 When we in the community guide look at each of these
1912 policies and programs we find often times that there isn't
1913 data on which programs have reduced disparities, and we need
1914 a very focused research effort to do that, realizing of
1915 course that not all disparities are ones that come from
1916 social or economic disadvantage, sickle cell among African
1917 Americans, Tay-Sach's among Jews and northern Europe origin,
1918 et cetera, et cetera, so there are some differences that are
1919 not real disparities in the same sense.

1920 Mr. {Gingrey.} And thank you, Dr. Fielding, as well.
1921 As I read my book and material, and I think I noticed the
1922 figure of 58,000 or so deaths per year in a minority
1923 population, all these things considered, which both you and
1924 Dr. Besser discussed, over and above that there are still
1925 this many deaths over what it should be for minority groups,
1926 and I look forward to the second panel. I will bring up this
1927 same issue with Dr. Satcher because I think it is very
1928 important. I would like to know is there any evidence that
1929 providers of health care whether they are in Los Angeles
1930 County or in Atlanta, Georgia that for reasons of maybe

1931 unrecognized prejudice within themselves are not ordering the
1932 necessary tests or not taking the necessary amount of time
1933 with certain populations, and if that is the case obviously
1934 that is something that we need to stop whether it is through
1935 educating our young people in medical school or what, but I
1936 thank you for your response. I know my time has expired.
1937 And, as I say, I look forward to the next panel as well. I
1938 appreciate that. I yield back, Mr. Chairman.

1939 Mr. {Pallone.} Thank you, Mr. Gingrey. Ms.
1940 Christensen.

1941 Ms. {Christensen.} Thank you, Mr. Chairman. I am
1942 tempted to answer Dr. Gingrey's question, but I am going to
1943 leave it to Dr. Satcher in the interest of time. But I am
1944 glad that just about every one of the panelists speak to the
1945 importance of the social determinants, and I am particularly
1946 interested in the health impact assessment, something that I
1947 have been advocating for as well. I have two questions. I
1948 am going to try to get two questions in. Dr. Besser, all of
1949 us are very pleased with the \$1 billion for prevention and
1950 you have outlined broadly how CDC plans to use that money,
1951 but in the \$650 million for prevention and wellness, how much
1952 of that is going to be used to target health disparities,
1953 maybe expand on reach programs, for example, and we also
1954 within the three minority caucuses are working on a bill to

1955 create health empowerment zones, which would allow health
1956 communities to have the resources and develop the plans,
1957 address the health disparities, and then give them priority
1958 for funding from any one of the agencies in the federal
1959 government to not only address the disease entities but also
1960 the social determinants. What do you think about that
1961 program? How are you using the money?

1962 Dr. {Besser.} Thank you, Ms. Christensen. In terms of
1963 the prevention and wellness funds, we are absolutely thrilled
1964 to have \$650 million to work on that. Those funds were
1965 appropriate to the department, and I chair the group, the
1966 subgroup within the department that is looking at how best to
1967 utilize those funds. We have put together a working group
1968 from across the department and it has been an incredible
1969 process because when we look at the areas that CDC has
1970 control over, we see what we know, but when we sit down in
1971 the same room with people from the Agency on Aging, folks
1972 from SAMSA, folks from HERSA, we get additional ideas, and so
1973 we are in the process of formulating this signature
1974 initiative. Disparities is going to be one of those factors
1975 that is looked at here because in everything we do in public
1976 health, we need to ensure that we are addressing disparities.
1977 At this point, I can't tell you what the entire program will
1978 look like but disparities will be part of that.

1979 Ms. {Christensen.} Thank you. And I am going to ask
1980 the other question about the health empowerment zones on the
1981 next panel as well. So, Dr. Fielding, I am interested to
1982 know how the task force over 200 proven methods relates to
1983 communities of color and if they go far enough to help
1984 eliminate health disparities. A lot of people have made
1985 reference to diabetes so let me just focus on that. ADA
1986 recommends, for example, screening for pre-diabetes if one is
1987 a racial or ethnic minority or over 45. The task force
1988 really as best as I understand it doesn't recommend pre-
1989 diabetic screening. And in terms of diabetes screening,
1990 Medicare covers screening for if one has two out of seven
1991 risk factors the task force recommends if there is
1992 hypertension present, but do you think that CMS
1993 recommendations or the task force recommendations are
1994 adequate to address the issues of people of color when, as we
1995 have heard, Mexican Americans have twice as much--twice as
1996 more likely to have diabetes, African Americans and Native
1997 Americans as well.

1998 And you, yourself, have said in your testimony that
1999 there is this major gap in information on health disparities
2000 that needs to be closed. What can be done to close that gap
2001 and to make sure that the solutions that we recommend address
2002 all Americans?

2003 Dr. {Fielding.} Well, thank you. A very well crafted
2004 and complicated set of questions that I hope I can answer
2005 easily, but it is not so easy because, first of all, we have
2006 to make sure that if we screen for something that we have the
2007 ability to change the course of the disease based on
2008 screening. Fortunately, for diabetes the evidence growing
2009 for Type II diabetes that we can, that there are programs
2010 that can help people, particularly through nutrition and
2011 physical activity can, in fact, reduce the likelihood that
2012 they are going to get frank diabetes, so that is very
2013 important.

2014 There are huge differences with Latinos and African
2015 Americans having much higher rates associated with higher
2016 rates of overweight and obesity. There has not been enough
2017 research on what the differences are, and are there any
2018 specific ways that we should be treating people based on
2019 genetic differences, cultural differences, and the like. One
2020 of the opportunities, I think, is to take some of the money
2021 that is being allocated for comparative effectiveness and to
2022 look at not only comparative effect of different methods but
2023 look at them with respect to different populations.

2024 Ms. {Christensen.} We had a big major battle in trying
2025 to make that happen, but I think we were successful.

2026 Mr. {Pallone.} Thank you. Mr. Murphy.

2027 Mr. {Murphy of Connecticut.} Thank you, Mr. Chairman.
2028 I think one of the most exciting things about the more
2029 broader comprehensive health care debate that is happening
2030 right now is that we are focusing not just on the financing
2031 piece of the equation but also trying to challenge Congress
2032 to step up and look at the way we deliver health care. And
2033 one of the, I think, emerging consensus points is the role of
2034 primary care providers in that equation, and our lack of
2035 focus on trying to give those primary care doctors the space
2036 with which to really engage in good preventive medicine.

2037 One concept that has been talked a lot about is the
2038 medical home model which would give primary care doctors a
2039 much greater role in coordinating care. And it strikes me
2040 that to the extent that we are going to return to a much more
2041 primary care based model it is an opportunity for public
2042 health as well. And so my question to both of you is simply
2043 this. What is the space in which a greater focus on primary
2044 care intersects with public health and what are the things
2045 that we need to do as a Congress to try to create a greater
2046 role for primary care physicians to be able to do real
2047 coordination with public health systems that surround them?
2048 I will ask Dr. Besser first and then Dr. Fielding.

2049 Dr. {Besser.} Thank you, Mr. Murphy. I spent 5 years
2050 as a pediatric residency director in California and served on

2051 a commission that was trying to see what we could do to
2052 encourage more people to go into primary care. Clearly,
2053 there are major gaps in the number of primary care physicians
2054 in this country and in particular in isolated areas that
2055 contribute to disparities. I think to make primary care more
2056 attractive in addition to the balance on reimbursement being
2057 different than what it currently is, we need to have
2058 community services available that primary care physicians can
2059 tie into, so that when they see an adult with pre-diabetes
2060 they can connect to something in the community that will help
2061 address that issue.

2062 I visited Vermont a couple weeks ago and was exposed to
2063 the Vermont blueprint for health, and what they are
2064 experimenting with is just that, how do they--they have a
2065 system where if they have a patient who has a medical
2066 condition that has partially a community solution, they can
2067 connect to a team in the community to address that. And it
2068 is profound what that does in terms of your ability as a
2069 primary care physician to impact on the health of your
2070 patients.

2071 Mr. {Murphy of Connecticut.} Dr. Fielding.

2072 Dr. {Fielding.} Yeah, I would agree entirely. We need
2073 to have ways of interfacing between those in primary care and
2074 those in public health who are doing community services.

2075 When I say public health, it is not just governmental public
2076 health, it is all the voluntary agencies and the other
2077 supporting and social agencies that are equally important and
2078 that aren't always well coordinated. There is a real problem
2079 in getting those in training to go into primary care. And I
2080 think the reimbursement issue is probably going to have to be
2081 addressed if we are going to redress some of that balance
2082 between those who want to go into specialty care and those
2083 who want to do primary care.

2084 But I also feel it is important to point out that even
2085 if we have good primary care and good linkages unless we are
2086 addressing the other determinants of health, we are not going
2087 to become the healthiest Nation. We are going to be still
2088 pretty low on that list despite spending \$1 out of \$6 on
2089 health care. So the question is, and one of the things that
2090 would be helpful would be to have the physicians who are more
2091 understanding and knowledgeable about public health, I think
2092 the amount of training that a physician has, for example, in
2093 public health as part of their residency, as part of their
2094 medical school, varies tremendously, and in some cases not
2095 very much, so they don't have an understanding of how there
2096 can be a better fit between what goes on in the office and
2097 what goes on in the community.

2098 Mr. {Murphy of Connecticut.} Thank you for those

2099 responses. Dr. Fielding, I want to take a right turn and
2100 just move to a different subject and ask your quick thoughts.
2101 About the structure of health care delivery through the
2102 public sector, in Connecticut we have a very disjointed
2103 system where we have some municipal offices of health, we
2104 have some regional offices of health, and in more rural areas
2105 we have part-time offices of health where there is just a
2106 doctor, a physician in the community, who is that local
2107 health director. And it is of great worry to me that if
2108 something big and terrible was to happen that we might not
2109 have the sort of aligned and consistent infrastructure to
2110 respond. I would ask very quickly if that is a concern of
2111 yours and to Dr. Besser as well.

2112 Dr. {Fielding.} It is a real concern. There is great
2113 diversity in the capacities. One of the things that I think
2114 has to happen is there has to be some coalesce. There need
2115 to be networks. Whether you want to do that structurally or
2116 simply through memos of agreement and joint training or
2117 whatever, but we have too many. In some cases we have
2118 departments with very, very limited. The accreditation
2119 process will help that that will coalesce, will push people
2120 to try and come together but there needs to be statewide and
2121 even regional systems around metropolitan areas where people
2122 can respond as one.

2123 Mr. {Murphy of Connecticut.} Thank you very much. I
2124 yield back, Mr. Chairman.

2125 Mr. {Pallone.} Thank you. Ms. Eshoo.

2126 Ms. {Eshoo.} Thank you, Mr. Chairman. I guess the
2127 benefit of staying for a long time in a hearing is that you
2128 get to hear a lot, and I appreciate what you have said, both
2129 in terms of your testimony, and I respect the work that you
2130 do. It seems to me that we already know a lot. It doesn't
2131 mean that we shouldn't continue to comply to do the research
2132 that is necessary, to drill down, to understand better the
2133 composition of a community, what the various factors are that
2134 contribute to the bad outcomes that we know that we have, and
2135 so I support all of that. I am looking forward to a really
2136 great surgeon general of the United States because I think we
2137 need someone that is going to really market public health and
2138 what we can do.

2139 Now I think that we have a lot of structure. I am not
2140 saying that we shouldn't add to it and make sure that we
2141 target our investments very well, but we also know what the
2142 tremendous contributors are to very poor public health. I
2143 mean is there any community in the country, rich or poor,
2144 black, white, green, purple, yellow that benefits from
2145 smoking? I mean we just know that it is bad. It is worse in
2146 some communities because they are targeted. They are

2147 targeted because they may be uneducated, because they are
2148 poorer, because they are that much more vulnerable. What
2149 community is it terrific to be overweight? I mean we know
2150 what obesity does. We know what it does in children. We
2151 know what it does in adults. Everything from heart attacks
2152 to juvenile onset of diabetes and on and on. I think that
2153 the public health system in the country really needs to
2154 concentrate or take a fresh look at how you can do better
2155 marketing.

2156 Don't you think it would be powerful to do even ads that
2157 show maybe a bag of sugar, a 10-pound bag of sugar? I mean
2158 where is it--children are sweet by nature but they don't need
2159 to consume 40 to 60 pounds of sugar, refined sugar, a year,
2160 in order to be sweeter or better or healthier. So I think
2161 that there are some things that we may be overlooking that
2162 are very, very powerful messages, and I don't know, there
2163 must be a national association of public health directors in
2164 the country. Why not look at some of this outreach money
2165 from the stimulus package that will really target those
2166 communities that are being mauled by these terrible things.

2167 It is more of a statement than a question. I was very
2168 taken with the public health service did in Japan. They
2169 required adults, men and women, to come in and have their
2170 waist measurements taken, and if they were over a certain

2171 number of inches for males, over a certain number of inches
2172 for females, they had to go back in 3 months to have that
2173 taken again. Why? They made a pointed effort to bring it to
2174 every person that if they are overweight that they are
2175 subject to that we may not be able to do that in our country
2176 that way. But the whole issue of food stamps. Why don't you
2177 all come out with a great campaign and come here and advocate
2178 the hell out of the Congress and say let us link obesity and
2179 food stamps and do something about that together?

2180 So while my colleagues have come up with a hundred good
2181 items today, I think that we need to look at just marketing
2182 the heck out of the country on some of these things that we
2183 know are bad, awful, that are killers, that are contributors
2184 to the heavy, heavy costs in our system and to the agony and
2185 tragedy that takes place in families and also to give kids a
2186 chance, give kids a break. So, I don't know, you may not
2187 want to respond to that. I got 20 seconds left. I think
2188 that you have some power that you may be overlooking to tell
2189 you the truth, and I want you to have the maximum amount of
2190 dollars to do what needs to be done. I am not going to go
2191 into that. But do you have anything to say about this? Do
2192 you have anything that you can tell us that you are going to
2193 be marketing as kind of the marketing directors for public
2194 health across the country?

2195 Dr. {Besser.} Two comments. Thank you for that
2196 statement. One is that I think you are on target that for
2197 many things we know what works, and we need to implement it.
2198 And what we are working on with the stimulus dollars is
2199 implementing evidence-based programs.

2200 Ms. {Eshoo.} Yeah, I don't want any wild marketing that
2201 can't keep a promise or isn't based in sound science, but it
2202 seems to me we got a pile of science about some of these
2203 things already.

2204 Dr. {Besser.} The other comment I want to make is that
2205 there is a \$20 million pilot in the Farm Bill to look at what
2206 you can do to promote healthy food in food stamps. And we
2207 have seen improvements in WIC and hopefully there will be
2208 evidence that doing that with food stamps will also be
2209 effective.

2210 Ms. {Eshoo.} Well, you know, see, I kind of disagree
2211 with that. I think that that has got to be the slow man's
2212 approach in order not to go anywhere. We know that food
2213 stamps purchase junk in plain English and it seems to me that
2214 the public health directors in the country would be a great
2215 antidote to the lobbyists that come here and say really this
2216 junk is okay, but let us do a study in a slow walk. So you
2217 can tell where I am headed. I have a legislative impatience,
2218 but I think outside of legislation but advocacy in some of

2219 these areas here that we could really make some headway.

2220 Thank you, Mr. Chairman.

2221 Mr. {Pallone.} Thank you. Mr. Gonzalez.

2222 Mr. {Gonzalez.} Thank you very much, Mr. Chairman. And

2223 to the witnesses, thank you for your testimony. We are

2224 having hearings, multiple hearings, just about every week in

2225 preparation for what will be landmark legislation, health

2226 care reform, so in the context of that, first, a general

2227 proposition is what is the role of public health, but

2228 specifically and in the context of what we are contemplating

2229 doing here in Congress, which I know that you have been

2230 following because there is impact to you, but I guess not

2231 everyone agrees that we should have this reform and surely

2232 not everyone--we will have witnesses that will follow you

2233 that don't agree even about your particular role. There are

2234 some that believe that for contagious diseases public health

2235 has an appropriate role but when it comes to treatment and

2236 prevention of chronic diseases that public health does not.

2237 And I believe that one of the witnesses will testify

2238 specifically to that. I could be incorrect about that, but

2239 that is the first question. What is the role when it comes

2240 to contagious versus chronic? It really kind of sets the

2241 stage for what is the appropriate role for public health.

2242 And, secondly, there are those that are saying, well, if we

2243 do revolutionize the availability of access to health
2244 insurance with a public option that has tremendous impact,
2245 and so I want to know what you bring to the table. What does
2246 public health bring to the table in this greater equation
2247 when it comes to expanding where we were talking about
2248 accessibility, affordability, and quality health care as we
2249 attempt to fashion legislation?

2250 Dr. {Besser.} Thank you very much for that question,
2251 and I think it is a fundamental question that we are dealing
2252 with today, and that is what is the relative roles between
2253 access to care and providing health care services and public
2254 health which focuses on prevention and health promotion. I
2255 think that if we solely look at access to care, and don't get
2256 me wrong, access to care is critically important, but if we
2257 only look at access to care, we are not going to see an
2258 improvement in the health status of our Nation in the long
2259 run. We need programs that are looking at what is driving
2260 the diabetes epidemic, what is driving the rise in heart
2261 disease, what is driving these issues. And that is where
2262 public health comes in.

2263 If our entire country has access to care, we still have
2264 a critical role for public health setting aside the health
2265 protection issues of emerging infectious diseases and
2266 responding to public health emergencies. Public health is

2267 responsible for ensuring that the environment we live in is
2268 healthy and looking to ensure that there aren't toxins in the
2269 environment that are putting people at risk. Public health
2270 looks at addressing disparities. Even with access to care,
2271 there will be disparities that need to be addressed by the
2272 public health community. Public health is critical for
2273 occupational safety and health and ensuring that the work
2274 environments in our community are safe.

2275 And we know through so many programs that public health
2276 can have a dramatic impact by promoting health, by addressing
2277 those issues of physical exercise, nutrition, and smoking.
2278 We keep hearing those three. Those are the big three. There
2279 are also additional ones, alcohol use, substance abuse, but
2280 public health and what public health does within the
2281 community setting is fundamental to ensuring that in the long
2282 run we are spending less on health care and that our
2283 population is healthy.

2284 Mr. {Gonzalez.} Thank you.

2285 Dr. {Fielding.} I think Dr. Besser said it extremely
2286 well. Our job is to provide conditions in which people can
2287 be healthy, and we are going to get there just by increasing
2288 access as important as that is. We also need to be clear
2289 what we are talking about when we talk about public health.
2290 I think we have been using it here in different ways. One

2291 way is governmental public health, very important. The state
2292 and local public health agencies, that is the core
2293 infrastructure. But public health also means working with
2294 non-profits, working with businesses, working with voluntary
2295 organizations at the community and state and national level.

2296 And we need that broader conception of public health to
2297 be effective, but we are not going to solve a tobacco problem
2298 or unintentional injuries or substance abuse problems just by
2299 providing more medical care. We have to focus on the
2300 prevention side. We have to focus on the community support
2301 side and that can't all be done through the health care
2302 system. We have already medicalized perhaps too much and it
2303 is time perhaps to redress that balance.

2304 Mr. {Gonzalez.} Thank you. Mr. Chairman, I have a
2305 minute left, and I just really want to make a statement in
2306 appreciation for some of the things that you have said. You
2307 have eluded though to health information technology or
2308 electronic medical records. I can think of no greater
2309 beneficiary than public health in making sure that we have
2310 wide acceptance and adoption of HIT. It is called
2311 information gathering, analysis and dissemination which is
2312 basically the essentials in what you all do, so I commend
2313 you, thank you for your comments, and I hope that you will be
2314 pushing hard every initiative that we have regarding the

2315 adoption of HIT. I yield back.

2316 Mr. {Pallone.} Thank you. The gentlewoman from
2317 Florida, Ms. Castor.

2318 Ms. {Castor.} Thank you very much. Yesterday morning I
2319 visited a community health center in my district in Tampa and
2320 we were announcing additional recovery funds, grants, under
2321 President Obama's recovery plan. The Tampa Bay area
2322 community health center has received a little more than \$3-
2323 1/2 million. The center I visited, they are going to hire
2324 doctors and physician assistants and nurses, and they are
2325 very appreciative, and they will be able to see more
2326 patients. And they took me on a tour afterwards, and I was
2327 not aware that all of the community health centers in most of
2328 the urban areas in Florida have already converted to
2329 electronic medical records. And they raved about it. They
2330 said we really are able to provide better patient care.

2331 They also said we are able to cut down on fraud because
2332 there is a picture of each patient. If they have someone
2333 come in and ask for certain pharmaceuticals and the picture
2334 doesn't match that they call security. But following up on
2335 some of the discussions there are requirements in place right
2336 now for health centers and other providers to collect data
2337 and to transmit it, whether it is a community level, a state
2338 health level or to the National Center for Health Statistics

2339 that you mentioned, are there requirements in place now?

2340 Dr. {Besser.} No. Within particular states and
2341 localities, there may be individual requirements but at a
2342 federal level there is not a requirement for reporting of
2343 that information. When I was talking earlier about the
2344 National Health Safety Network that is looking at infections
2345 in health care settings, that is a voluntary system of
2346 collaboration between states or health care facilities and
2347 the CDC. I look forward to a day when all of our health care
2348 settings are connected electronically and that information is
2349 flowing to public health at all levels because that can
2350 really have a dramatic impact on improving health.

2351 Dr. {Fielding.} There is one exception though and that
2352 is reportable diseases through the states and to the Centers
2353 for Disease Control, and one of the real advantages of having
2354 electronic systems that work through laboratories is that we
2355 get much faster reporting and much more complete reporting
2356 because it is one thing if you have to ask a busy doctor to
2357 fill out this report and send it in, and maybe it comes in
2358 and maybe it doesn't and maybe it is timely and maybe it
2359 isn't. When you are getting direct feeds from the laboratory
2360 as we are in Los Angeles County from a lot of the large
2361 laboratories, we know about identification of problems of
2362 reportable diseases much more quickly and are able to get a

2363 jump on them. And from the standpoint of controlling
2364 outbreaks and potential epidemics, that is a crucial
2365 advantage.

2366 Ms. {Castor.} So as we build this infrastructure, there
2367 needs to be data collection points. What is the logical
2368 location? Is it community based, state based? Is it
2369 reporting to this National Center for Health Statistics? How
2370 do we build that infrastructure? What is your
2371 recommendation?

2372 Dr. {Besser.} There are a number of different models
2373 that look at this and there are several critical pieces. As
2374 Dr. Fielding was saying, being able to transmit laboratory
2375 data that way is essential to early detection and control of
2376 outbreaks. But creating a health information community so
2377 that the data can be viewed at different levels. It can be
2378 viewed within a health system. It can be viewed at the local
2379 or state public health level. It can be viewed at the
2380 federal level. Clearly, there have to be protections within
2381 those systems that protect the identity of individuals but
2382 having that kind of common space for looking at data would
2383 have enormous benefits.

2384 Ms. {Castor.} Okay. In my 1 minute that I have left,
2385 Dr. Besser, you have experienced environmental justice
2386 issues. Can you provide your priority recommendations for

2387 health care reform and public health relating to
2388 environmental justice in 1 minute or less?

2389 Dr. {Besser.} Thank you. Clearly, health is not
2390 something that takes place in a doctor's office. It takes
2391 place in all settings, and we have to ensure that our
2392 population is living in healthy environments. So looking at
2393 schools, work places, where you reside is critically
2394 important, and that is an essential protective value of
2395 public health. Public health is there to look to ensure that
2396 our communities are safe. From an environmental perspective,
2397 we need to make sure that we are not being exposed to
2398 chemicals and toxins that could impact on our health, and the
2399 resources need to be there for public health at all levels to
2400 fulfill that function.

2401 Ms. {Castor.} Thank you very much.

2402 Mr. {Pallone.} Thank you. Mr. Sarbanes.

2403 Mr. {Sarbanes.} Thank you, Mr. Chairman. Thanks for
2404 your testimony today. I am fighting the same battle you are,
2405 Mr. Chairman, with my kids and getting them outside, and so I
2406 wanted to pick up on that theme and develop it a little bit
2407 more because there is such huge benefits to getting our kids
2408 outdoors. I have authored something called the No Child Left
2409 Inside Act, which I invite you to learn more about. It began
2410 with a coalition of 12 organizations in Maryland. We now

2411 have 1,200 organizations across the country that represent 40
2412 million members among them, and this coalition is comprised
2413 of educators who understand that when you get kids outdoors
2414 and have a chance to apply what they are learning outside,
2415 they learn better. It consists of environmentalists, of
2416 course, who want the next generation to have a heightened
2417 awareness of the environment typically when we are facing
2418 issues of climate change.

2419 But it is also comprised of many, many public health
2420 advocates who recognize that getting kids outdoors and
2421 engaging them, not just saying go outside, but giving them a
2422 reason to be there and excited about being outside is
2423 fundamental to improving their health, health of the next
2424 generation. And so I would for starters invite you to join
2425 the coalition and be a supporter of that. But the
2426 information that underpins the effort is showing, for
2427 example, that the average child today spends 4 to 5 hours
2428 indoors on television, the Internet, the video games, and
2429 notwithstanding the arrival of Wii and its contribution to
2430 physical exercise in a virtual world, there are still reasons
2431 to get kids outdoors.

2432 The data also shows that kid spend an average of about 4
2433 minutes a day outdoors in unstructured play and recreation.
2434 We have predictable consequences for their health, both in

2435 terms of attention span and their physical health and so
2436 forth. So I am very excited about the potential to link our
2437 efforts with No Child Left Inside, which is to try to create
2438 a federal source of funding, grant funding, to promote
2439 environmental education to really integrate it in the
2440 instructional program across our public school system to get
2441 kids outdoors to link that effort to the public health
2442 effort.

2443 And what I would love to hear you speak about for just a
2444 few moments is the extent to which you think environment
2445 education efforts of that kind can represent kind of a
2446 leading edge of public health effort with respect to the next
2447 generation in particular although I will add that when you
2448 talk to these kids who have gotten so jazzed and engaged by
2449 being outdoors, they are telling you that they are going back
2450 to their families insisting that their parents and their
2451 siblings go for hikes on the weekends and get outdoors. So
2452 they are dragging the rest of their family into the light at
2453 a time when we need that for so many reasons.

2454 So I wonder if you have brought this lens in thinking
2455 about public health and maybe a revolution of public health,
2456 this lens on education and environmental education in
2457 particular to the effort. And I invite either one to address
2458 it.

2459 Dr. {Besser.} Thank you, Mr. Sarbanes. First, I love
2460 the title No Child Left Inside and look forward to reading
2461 more about that particular legislation. I think that this
2462 fits in very well with our view of how public health can
2463 contribute to health and the idea that health occurs in all
2464 settings. Schools that foster a culture that values the
2465 environment, that values getting out into the environment
2466 will create adults who do the same and that will be a more
2467 active society and a healthier society. The Academy of
2468 Pediatrics has standard recommendations on how much time
2469 should be allowed in front of a television or a computer
2470 screen but your point is very well taken that there have to
2471 be alternatives to that.

2472 When I talk to a parent about getting their child
2473 outside to play either on structured play or on team play if
2474 those options aren't available there is not a lot of value in
2475 my spending that time with that parent going through that
2476 counseling, so I look forward to reading about your
2477 legislation. I think the intent of it is right on target in
2478 terms of promoting health in all areas.

2479 Mr. {Sarbanes.} We will make sure it is on your desk
2480 when you get back to your office. Mr. Chairman, I won't name
2481 the particular video game that does this, but it is not
2482 atypical, and there is one game in particular where I think

2483 after about an hour of playing on it, it invites the child to
2484 blink their eyes, close their eyes and open them 10 times
2485 before they embark on the next level of the game and so this
2486 is meant to represent the compensation for the fact that they
2487 are not getting exercise or need a break from that virtual
2488 engagement, so we have got a lot--and I just want to say
2489 obviously the next generation has to be well versed in
2490 technology. That is not what I am talking about. We are
2491 trying to achieve a balance at a time when things are way out
2492 of whack. I yield back my time.

2493 Mr. {Pallone.} Thank you. You are right. Ms. Baldwin.

2494 Ms. {Baldwin.} Thank you, Mr. Chairman. As you have
2495 heard, our committee has had a lot of focus on addressing
2496 health care disparities especially based on race and
2497 ethnicity, and you have already been questioned a lot about
2498 those issues. I believe that there are serious health
2499 disparities that exist based on sexual orientation and gender
2500 identity and that belief is based on much input from and
2501 discussion with leaders of community-based organizations that
2502 provide direct services to lesbian, gay, bisexual, and
2503 transgender youth and adults, and also based on some of the
2504 few local survey tools that actually ask questions. But it
2505 is really quite frustrating to get a clear understanding of
2506 the scope of these disparities because most of the data

2507 collection tools at the national level don't ask questions
2508 about sexual orientation or gender identity.

2509 Dr. Besser, you have noted that you have learned about
2510 the importance of tracking health data and monitoring changes
2511 in health. I am wondering if you are aware that the national
2512 health interview survey, the federal government's most
2513 comprehensive and influential survey, does not include a
2514 question on either sexual orientation or gender identity.

2515 Dr. {Besser.} That is not something that I was aware of
2516 but something that I think I need to learn more about.

2517 Clearly, if we are going to address a particular health
2518 issue, we need data to be able to look at that clearly.

2519 Ms. {Baldwin.} Would you support adding such a question
2520 to that survey tool if you find that it indeed doesn't exist?

2521 Dr. {Besser.} What I would like to do is understand
2522 first whether it is there and, if not, why it is here,
2523 whether there are any legal restrictions to collecting any
2524 particular data. I think that in order to make informed
2525 health decisions, we have to know. In addition, I think we
2526 need to do work on the health care delivery side to improve
2527 the core competencies of health care providers to address
2528 issues of gender and sexual orientation. My experience
2529 coming through medical school and even as a residency
2530 director, it is not something where there is a lot of

2531 education in how to address those issues.

2532 Ms. {Baldwin.} I think that is a very important
2533 companion inquiry. I want to share that it is my
2534 understanding that none of the surveys that are conducted
2535 through the National Center for Health Statistics inquire
2536 about issues of sexual orientation or gender identity, and it
2537 is my understanding that the only mention of such issues in
2538 the 2020 objectives is that there is a statement basically
2539 that we need more data on LGBT populations because we cannot
2540 currently understand the depth of the problem. So I think we
2541 have a very serious issue that it is really hard to make
2542 evidence-based recommendations when you are not collecting
2543 any evidence. Can you tell me in any way right now how does
2544 the CDC currently track and monitor the health of the LGBT
2545 population?

2546 Dr. {Besser.} I can't answer that question, but I will
2547 get back to you on that. I think that is an important area
2548 for us to be pursuing.

2549 Ms. {Baldwin.} I have some time left, and I want to ask
2550 some really broad questions about the public health
2551 infrastructure. I wonder if you could each give me an
2552 assessment of the current local, state, and federal public
2553 health surveillance system, what you think the infrastructure
2554 status is right now. As I noted in my opening statement, I

2555 author a bill with my colleague, Congressman Terry, to make
2556 some infrastructure investments there. And the second quick
2557 comment I would like you to make is whether epidemiology
2558 struggles with the same work force shortage issues that we
2559 are seeing in the medical system generally.

2560 Dr. {Besser.} Addressing your second question first,
2561 since it is an easy one, there are major gaps in our public
2562 health work force and a number of organizations have
2563 developed estimates of how great those gaps are. Of great
2564 concern is with the current state of our governments at all
2565 levels, we are seeing a loss of the work force at the state
2566 and local level, tens of thousands of state and local public
2567 health employees who will be let go and so that is a gap.
2568 Your question about surveillance, I will answer briefly and
2569 would be happy to follow up in more detail but there is great
2570 variability in our ability to detect laboratory capacity is
2571 extremely variable. Some states have wonderful systems.
2572 Others are much more rudimentary, and we need a system that
2573 protects our entire country.

2574 Dr. {Fielding.} Let me just add a couple of things to
2575 that. We also have pipeline issues, not just those that are
2576 being laid off because of the economic climate but in
2577 epidemiology, laboratorians and those that can do the
2578 analysis work as those techniques become more and more

2579 sophisticated there is serious gaps in that. With respect to
2580 surveillance, I think that we need to be very broad in what
2581 we look at. Increasingly, we need to look at the environment
2582 and a lot of aspects of the environment. Some of that is the
2583 physical environment, some of that is the social environment,
2584 and we need to have good core indicators to look at those.
2585 With respect to the LGBT community, we have done some--we
2586 have, in fact, in Los Angeles asked those questions in our
2587 survey and find that there are serious gaps in the delivery
2588 system, found, for example, that the highest rate of tobacco
2589 use was among the LGBT community, and have, in fact, devoted
2590 specific programs to some of the problems that we found.

2591 Certainly, with respect to HIV, you know, in Los Angeles
2592 County a very disproportionate burden is on men who have sex
2593 with men. So I think that information is very important
2594 information and we can't develop effective programming
2595 without that.

2596 Mr. {Pallone.} Thank you. I think that concludes our
2597 questions and thanks for bearing with us. I know we have a
2598 lot of members of the subcommittee now. When they all show
2599 up it goes on a for a while. But this is very helpful, and I
2600 don't think that we stress public health enough but it is
2601 also difficult to get a handle on what exactly we should do.
2602 But I think you gave us some very good ideas so thank you

2603 very much.

2604 Dr. {Fielding.} Thank you very much. Mr. Chairman, if
2605 you can indulge me just 30 seconds. I just want to make the
2606 point that if we do the things that we already know work in
2607 terms of things from the community guide and the clinical
2608 guide, we can save very many lives today with what we know,
2609 not that we don't have to know more, but we need to make sure
2610 we put in place what we know. And that has not been fully
2611 done and I think we need more work to get that out to
2612 everybody who can work on it. Secondly, I would like to
2613 suggest that the Partnership for Prevention, which is a good
2614 non-profit here has suggested some model legislative language
2615 for health reform in the areas of public health and
2616 prevention. If you don't mind, I would submit that for the
2617 record so that others can--

2618 Mr. {Pallone.} We would certainly appreciate that.
2619 Without objection, so ordered.

2620 Dr. {Fielding.} Thank you so much.

2621 [The information follows:]

2622 ***** INSERT H *****

|
2623 Mr. {Pallone.} And thank you both.

2624 Dr. {Besser.} Thank you, Mr. Chairman.

2625 Mr. {Pallone.} I appreciate it. Let me welcome all of
2626 you, and I will just basically introduce each of you. From
2627 my left certainly no stranger to this process is Commissioner
2628 Heather Howard, who is the Commissioner of the New Jersey
2629 Department of Health and Senior Services. Thanks for being
2630 here today, Heather. And then we have Dr. David Satcher, who
2631 is the former U.S. Surgeon General, and now Director of the
2632 Satcher Health Leadership Institute at Morehouse School of
2633 Medicine. And then we have Dr. Barbara Spivak, who is
2634 President of Mount Auburn Cambridge Independent Physician's
2635 Association, and Dr. Devon Herrick, who is Senior Fellow at
2636 the National Center for Policy Analysis, and, finally, Dr.
2637 Jeffrey Levi, who is Executive Director of the Trust for
2638 America's Health.

2639 And, as I said before to the previous panel, we ask you
2640 to basically make a presentation for about 5 minutes and then
2641 we will have questions from the panel. And I will start with
2642 my New Jersey Commissioner Heather Howard.

|
2643 ^STATEMENTS OF HEATHER HOWARD, J.D., COMMISSIONER, NEW JERSEY
2644 DEPARTMENT OF HEALTH AND SENIOR SERVICES; DAVID SATCHER,
2645 M.D., PH.D., FORMER U.S. SURGEON GENERAL, DIRECTOR, SATCHER
2646 HEALTH LEADERSHIP INSTITUTE, MOREHOUSE SCHOOL OF MEDICINE;
2647 BARBARA SPIVAK, M.D., PRESIDENT, MOUNT AUBURN CAMBRIDGE
2648 INDEPENDENT PHYSICIANS ASSOCIATION, INC.; DEVON HERRICK,
2649 PH.D., SENIOR FELLOW, NATIONAL CENTER FOR POLICY ANALYSIS;
2650 AND JEFFREY LEVI, PH.D., EXECUTIVE DIRECTOR, TRUST FOR
2651 AMERICA'S HEALTH

|
2652 ^STATEMENT OF HEATHER HOWARD

2653 } Ms. {Howard.} Good afternoon. Thank you, Chairman
2654 Pallone, Ranking Member Deal. New Jersey is very, I have
2655 said it before but it bears repeating, we are very lucky to
2656 have your leadership, Chairman Pallone. I am pleased to be
2657 here today as the Commissioner of the New Jersey Department
2658 of Health and Senior Services, and also as a representative
2659 of the Association of State and Territorial Health Officers.
2660 I represent more than 50 public health officers today. We
2661 know that public health has been the cornerstone for most of
2662 the health achievements of the 20th Century. Advances in
2663 maternal and child health, sanitation and clean water,

2664 immunizations, infectious disease control, food safety,
2665 declines in death from heart disease and stroke and
2666 environmental health protection, these were all spearheaded
2667 through public health initiatives.

2668 During the 20th Century, the health and life expectancy
2669 of people living in the U.S. improved dramatically.
2670 According to the CDC, 85 percent of that increase, fully 25
2671 of the 30 years gained in life expectancy is attributable to
2672 public health. So I am optimistic today that we are talking
2673 about the importance of public health, and I am optimistic
2674 that significant health reform is going to happen this year
2675 and it is long overdue. Part of that health reform package
2676 together with universal health insurance coverage and health
2677 systems reforms must be a strengthening of our capacity to
2678 protect public health, to encourage wellness and to prevent
2679 illness.

2680 Too often when we talk about health policy in the United
2681 States, we talk primarily about the financing of health care
2682 and we don't focus as much on improving health and preventing
2683 disease. That is why today's hearing is so important. We
2684 know that nearly 80 percent of our health care dollars are
2685 spent on chronic illness, and until we do what we need to do
2686 to improve the health of all Americans, we will never be able
2687 to get those costs under control. We need to take a system

2688 approach to prevention. Everyone should have access to
2689 essential preventive services and screenings, and we need a
2690 public health work force to deliver that basic package.
2691 These investments in public health and prevention are
2692 essential elements in transformation of health reform.

2693 In fact, a focus on public health is what will make
2694 health care reform sustainable, both as finances and
2695 improving people's well being. As we enhance prevention by
2696 preventing and managing chronic diseases better and reducing
2697 obesity rates, we will reduce skyrocketing health costs and
2698 achieve significant cost savings over the long run. Simply
2699 put, public health both improves lives and saves money, and
2700 health care reform cannot be successful without a strong
2701 public health foundation. It is clear that President Obama
2702 and the Congress understand this critical link because of the
2703 \$1 billion investment in the Recovery Act and the creation of
2704 a prevention and wellness trust. I want to thank the members
2705 here for that achievement.

2706 As the President has said, investing in prevention will
2707 lower health care costs, improve care, and lower the
2708 incidents of heart disease, cancer, asthma, and diabetes,
2709 which are among New Jersey's leading killers just as they are
2710 around the Nation. Public health is the responsibility of
2711 all levels of government starting at local and county level

2712 through the state and to the federal government, but the role
2713 of a state public health agency is distinct. We must work to
2714 ensure a clean and healthy environment for the entire
2715 community. The state public health system ensures that the
2716 water along the Jersey shore is safe to swim in and that the
2717 beaches are clean, something I know is very important to the
2718 chairman. The state public health system ensures that the
2719 water we drink is safe and that our children play in day care
2720 centers that are free of hazardous contaminants.

2721 One of the ways that state public health agencies work
2722 to reduce health disparities is by promoting healthy
2723 lifestyles, providing services like services like tobacco
2724 quit lines for those who want to kick the habit and obesity
2725 prevention programs. Recently, I visited several WIC
2726 clinics, that is the Women, Infant and Children program, as
2727 part of a public education campaign to promote healthy
2728 mothers and healthy babies, and I saw first hand the valuable
2729 work that peer counselors do to promote breastfeeding and
2730 provide new mothers with the support and education they need
2731 to successfully breast feed their babies.

2732 In addition, thousands of women at these clinics learn
2733 the importance of feeding their family nutritious meals.
2734 Just this year, WIC will soon be introducing fruits and
2735 vegetables as part of the basic food package. That is a

2736 reform that is long overdue, and I am sorry Congresswoman
2737 Eshoo is not here. She was talking about the importance of
2738 improving what we do with food stamp dollars, but we are
2739 doing that already with our WIC dollars. This healthy
2740 mothers equals healthy babies campaign was a key
2741 recommendation of a prenatal care task force I created to
2742 improve access to early prenatal care for women across New
2743 Jersey.

2744 We know that public health has been responsible for a 90
2745 percent reduction in infant mortality over the last 100 years
2746 but as a public health leader, I recognize there is more to
2747 be done until all children are born with a healthy start in
2748 life, and when we know that in New Jersey a black infant is
2749 more than 3 times as likely to die in its first year of life
2750 than a white infant, we have more work to be done. In
2751 addition to educating the public about public health the New
2752 Jersey Department of Health is responsible for testing
2753 chemical and biological agents in its lab and coordinating
2754 the state's response to a flu pandemic that would immobilize
2755 business, cripple the food supply, and sicken millions.

2756 The state public health agency is also responsible for
2757 licensing, regulating, and inspecting nursing homes and
2758 hospitals, insuring access to quality health care for
2759 everyone, reducing the incidents of adverse medical events

2760 and supporting our safety net providers. In short, the state
2761 public health agency is where the rubber hits the road in
2762 terms of protecting and promoting the health status of New
2763 Jersians and all across the country. Let me give you a few
2764 key examples. Mr. Chairman, I know that food safety is one
2765 of your top priorities and you have worked with your
2766 colleagues to introduce a comprehensive bill to reform the
2767 FDA. We need to look no further than the recent salmonella
2768 outbreak to know how important our work is in this area.

2769 When New Jersey was at the center of the anthrax attacks
2770 in the fall of 2002 the state's health department lab
2771 functioned as New Jersey's only CDC approved facility in the
2772 quest to identify anthrax. During this national crisis, the
2773 state lab rotated teams of trained scientists working 15-hour
2774 shifts for 2 months processing more than 3,000 specimens and
2775 positively identifying 106 samples for the presence of
2776 anthrax. Since then, New Jersey has developed a national
2777 reputation as a leader in emergency preparedness. We are
2778 developing and implementing a statewide response to public
2779 health emergencies and with critical federal financial
2780 support we built a health command center, the first and only
2781 facility of its kind in the Nation which coordinates
2782 situational updates, medical assets, and resources to provide
2783 a timely and efficient response to an emergency.

2784 Coordination among federal, state, and local agencies is
2785 also key in addressing environmental conditions that can
2786 threaten the public health of our residents. New Jersey is
2787 the most densely populated state in the Nation and many of
2788 our residents live in an urban environment where the
2789 potential for exposures to hazardous chemicals and
2790 contaminants is a very real threat. We have an estimated
2791 20,000 contaminated sites and more superfund sites than any
2792 state in the Nation. Because of this, the work of the
2793 department is so important to coordinate with the federal,
2794 county, and local partners to protect the public health by
2795 preventing potential exposures to harmful environmental
2796 substances. Just 2 years ago after high levels of mercury
2797 were discovered in a day care center on the site of a former
2798 thermometer factory the public health system responded by
2799 closing the center.

2800 Then Governor Corzine quickly enacted legislation
2801 requiring the department to establish evaluation and
2802 assessment procedures for the interior buildings used as day
2803 care centers--

2804 Mr. {Pallone.} I am going to have to ask you to
2805 summarize a little bit.

2806 Ms. {Howard.} Wrap it up?

2807 Mr. {Pallone.} Yeah.

2808 Ms. {Howard.} Well, thank you. There are many other
2809 examples of how we are working together, many other great
2810 examples of New Jersey, but in sum, as I said earlier, I am
2811 extremely hopeful that transformation of health reform will
2812 happen this year and that that will include a strengthening
2813 of our capacity to protect the public health, to encourage
2814 wellness, and prevent illness. I look forward to working
2815 with you.

2816 [The prepared statement of Ms. Howard follows:]

2817 ***** INSERT C *****

2818 | Mr. {Pallone.} Thanks a lot. Dr. Satcher.

|
2819 ^STATEMENT OF DAVID SATCHER

2820 } Dr. {Satcher.} Thank you, Chairman Pallone, Ranking
2821 Member Deal, and members of the committee for this
2822 opportunity. I appreciate the discussion that has taken
2823 place this morning around the public health approach to
2824 health system reform. I want to just say a word about my
2825 background because I think it may be the basis for some of
2826 the discussion. I had the opportunity to direct the Centers
2827 for Disease Control and Prevention from 1993 to 1998, served
2828 as Surgeon General from 1998 to 2002. Three of those years,
2829 I also served as assistant secretary for health which made me
2830 responsible for leading the development of health to 2010.
2831 As Surgeon General, I had the opportunity to release the
2832 first ever report from a Surgeon General on mental health but
2833 also to release the first report on sexual health, and
2834 finally in 2001 the report on overweight and obesity.

2835 Since leaving government, I have had the opportunity to
2836 serve as founding chair of Action for Healthy Kids which
2837 focuses on programs in the schools to create the kind of
2838 environment that help children develop habits of healthy
2839 living. I have also served on WHO's Commission on Social
2840 Determinants of Health, and more recently on the Alzheimer's

2841 study group, co-chaired by Speaker Newt Gingrich and Senator
2842 Bob Kerry.

2843 I want to make four quick points. Today, I think based
2844 on our discussion the health care system is the patient, and
2845 the patient is clearly sick. You have talked about the
2846 problems of runaway cost, restricted access, questionable
2847 quality of care, and disparities in health, not just among
2848 racial and ethnic groups but different socio-economic groups,
2849 rural versus urban, and certainly disparities in the way we
2850 approach mental health when compared to physical health. I
2851 think in order to respond to these health systems problems we
2852 must revisit the major determinants of health. And again I
2853 think the four major determinants, access to quality health
2854 care, which according to our data, accounts for about 10 to
2855 15 percent of the variation in health outcome,
2856 biological/genetics, which accounts for 15 to 20 percent,
2857 environment, both physical and social, accounting for 25 to
2858 30 percent, and then human behavior or lifestyle, which
2859 accounts for 40 to 50 percent of the variation.

2860 I point this out because any health system that is going
2861 to be effective must respond to all of these determinants,
2862 not just access to health care. Public health is the only
2863 approach that will allow us to respond to all of these
2864 determinants of health. Only a health system that is

2865 balanced at the community level that balances health
2866 promotion, disease prevention, early detection, and universal
2867 access to care including mental health parity. Finally, in
2868 order to implement such a system, I would make points of the
2869 following recommendation.

2870 Clearly, we need the appropriate incentives in place.
2871 As you have heard, most of the incentives today are for the
2872 provision of medical care. That is very costly. We pay for
2873 procedures. We do not encourage students to go into primary
2874 care because primary care does not pay the way specialty care
2875 does if we are going to encourage people to go into primary
2876 care. We need to really reimburse appropriately. I heard a
2877 recent example which is very interesting, and that is if we
2878 had a building that we were trying to improve, and it had,
2879 say, 12 to 15 stories, and we focus all of our attention on
2880 the 10th floor and not on the foundation, then that building
2881 would be very weak. Primary care, which coordinates public
2882 health and medicine, is in fact the foundation. A population
2883 database is critical and I strongly support the electronic
2884 health records system.

2885 After Hurricane Katrina, one of the major problems we
2886 had was that most of the people who left New Orleans not only
2887 didn't know their diagnosis, not only did not know what
2888 medications they were taking, they didn't know the diagnosis,

2889 so we need an electronic health record, but it will also
2890 significantly improve data management for improving our
2891 system. We need a community-based collaboration for health
2892 care, and we need a work force that is balanced, balanced in
2893 terms of the different levels of health care and not just
2894 physicians but nurse practitioners, physician assistants,
2895 community health workers, a balanced work force. And that
2896 work force needs to represent a diversity of cultures and
2897 language, race and ethnicity. So, Mr. Chairman, I strongly
2898 recommend that we pay much more attention to public health as
2899 we move forward in this system, that we incentivize
2900 prevention and health promotion, as many businesses, by the
2901 way, are doing right now, and they are answering some of
2902 those questions about the cost benefits. So I again
2903 appreciate the opportunity. I look forward to the question
2904 and answer period.

2905 [The prepared statement of Dr. Satcher follows:]

2906 ***** INSERT D *****

|

2907

Mr. {Pallone.} Thank you, Dr. Satcher. Dr. Spivak.

|
2908 ^STATEMENT OF BARBARA SPIVAK

2909 } Dr. {Spivak.} Thank you. My name is Barbara Spivak. I
2910 am a practicing physician in Watertown, Massachusetts, and
2911 President of the Mount Auburn Cambridge Independent Physician
2912 Association, which is a member organization of approximately
2913 500 physicians affiliated with Mount Auburn Hospital and
2914 Cambridge Health Alliance, the public hospital in Cambridge.
2915 I appreciate this opportunity to testify about the important
2916 role coordinated care plans play in helping us both align as
2917 incentives and give us the resources to create a
2918 comprehensive program to deliver higher quality care at
2919 reasonable cost. I would like to share with you today the--
2920 give you some flavor of the infrastructure that we have in
2921 our organization that provides care coordination, case
2922 management, pharmacy management, referral management,
2923 utilization management, and does quality programs that
2924 encourages prevention strategies as well as improvement in
2925 chronic disease outcomes.

2926 Our arrangement with our hospital and Tufts Health Plan
2927 through the Tufts Medicare Preferred HMO product allows us to
2928 provide different levels of care for patients depending on
2929 their health status, their social status, and their frailty.

2930 For example, in patients who are severely ill who are at
2931 home, we have programs that send nurse practitioners into the
2932 home. When people are in rehab facilities, we have nurse
2933 practitioners and physicians who go in not once a month like
2934 in traditional fee for service but go in up to four or five
2935 times a week to keep them in the facility.

2936 Our lowest level of care was where a case manager may
2937 just call the patient on a monthly basis, make sure they are
2938 taking their medicines properly and help them arrange rides
2939 for their doctor's appointments. In some cases, nurse
2940 practitioners actually go with patients to physician's
2941 appointments because the patients themselves may not be able
2942 to hear everything that the physician says and organize all
2943 the med changes that happen. We use case managers who follow
2944 patients through the continuum of care so that when a patient
2945 is in the hospital in a rehab and then goes home that case
2946 manager know their family and social situation and can help
2947 set them up with most appropriate services to keep them at
2948 the lowest level of care possible.

2949 We have a pharmacist who works with us full time who
2950 works with patients who are on eight or more medicines to
2951 simply their regime, encourage the use of generics, and when
2952 patients with chronic diseases are out of control in terms of
2953 cholesterol management, for example, or diabetic control,

2954 they work with specialists to make recommendations to the
2955 primary care doctor for better medical management. We have
2956 utilization management programs that do not deny care but
2957 work with physicians to make sure that they are ordering the
2958 right test for the right patient for the right disease or
2959 referring to the right doctor the first time. This avoids
2960 both duplication of testing and unnecessary testing.

2961 We work with a health plan in doing disease management
2962 programs in CHF and COPD, and the health plan provides us with
2963 a care alert program that takes claims data and runs it
2964 against 1,500 rules based on evidence-based medicine that
2965 provides us with gaps in care that our physicians can then
2966 address. Our hospital works aggressively on decreasing med
2967 errors, improving quality so that we have not had an
2968 ventilation assisted pneumonia in over a year. Many of these
2969 programs are not funded in traditional fee for service
2970 medicine. Traditional fee for service medicine leaves the
2971 doctor alone in the room with the patient and when the
2972 patient walks out, they are on their own.

2973 In our system, we have multiple levels of support for
2974 the physician, the patient, and their families. We use
2975 education as a prime method of improving care. We just try
2976 to help physicians do a better job. We help to keep patients
2977 at the lowest level of care possible, mainly trying to keep

2978 them at home when we can. Traditional medicine really does
2979 not allow for the infrastructure that we have had to do that,
2980 and I would encourage the committee as they look forward to
2981 funding plans that continue to allow us to have the networks
2982 and the support and the infrastructure. I also would like in
2983 my testimony, I made reference to some quality data because I
2984 think it is important for people to see that we actually do
2985 what we say we do.

2986 So if you look at our mammogram rates, they are 14
2987 percent higher than in fee for service medicine. Diabetic
2988 eye exams are 21 percent higher. Colon cancer screening
2989 rates are 18 percent higher. Diabetic patients go to the
2990 hospital 35 percent less often. Our readmission rates are 58
2991 percent fee for service Medicare, and our ER utilization is
2992 over 20 percent lower. Our diabetic patients have heart
2993 disease that is 23 percent lower than Medicare patients and
2994 have strokes that are 46 percent less often. So I think the
2995 statistics show that what we are doing actually works. Part
2996 of what this does is it really aligns the incentives so that
2997 the health plans, the hospitals, and the physicians all work
2998 together in a collaborative way to do the right thing.

2999 [The prepared statement of Dr. Spivak follows:]

3000 ***** INSERT E *****

3001 | Mr. {Pallone.} Thank you, Dr. Spivak. Dr. Herrick.

|
3002 ^STATEMENT OF DEVON HERRICK

3003 } Mr. {Herrick.} Mr. Chairman and members of the
3004 committee, I am Devon Herrick, a Senior Fellow at the
3005 National Center for Policy Analysis, a nonprofit, nonpartisan
3006 research institute. We strive to solve problems by relying
3007 on the strength of the competitive entrepreneurial private
3008 sector. I welcome the opportunity to share my views, and I
3009 look forward to your questions. Community-based public
3010 health has a very important role in our society in our health
3011 care system, and it has achieved some very significant
3012 results over the past century. I mean, for example, like I
3013 mentioned before, vaccination, safe foods, fluoridation. The
3014 London cholera epidemics in the late 1800's are a classic
3015 example of a public health initiative that was very
3016 successful as are controlling contagious diseases.

3017 Yet, over the past few decades public health has
3018 struggled to tackle many of the problems through community-
3019 based initiatives that don't particularly lend themselves to
3020 community-based solutions. Most Americans who suffer from
3021 chronic ailments don't really consider their problems to be
3022 public health problems. Rather, people who suffer from
3023 diabetes, from asthma, from hypertension to them their

3024 problems are very real and very personal. That is to improve
3025 public health. We also need to free the doctors and free the
3026 patients to find innovative solutions that meet their
3027 individual needs. America is unlikely to mitigate the
3028 increasing problem of chronic diseases unless patients
3029 themselves become more involved, and moreover patients are
3030 not likely to become more involved unless they have a
3031 financial incentive for doing so and control more of their
3032 own health care dollars.

3033 For example, approximately 125 million Americans have a
3034 chronic ailment and many of these are not receiving the
3035 appropriate care from their physicians. One reason for this
3036 poor compliance is because the physicians often lack the
3037 integrated systems to care for their patients but a bigger
3038 reason is they often lack the financial incentives to provide
3039 appropriate care. For example, consider diabetes. Nearly 24
3040 million Americans have diabetes, about a third of which don't
3041 even know they have it. This constitutes around 8 percent of
3042 the population arising to nearly one in four seniors the
3043 leading cause of death. We spend several billion dollars a
3044 year for diabetes complications that could have been averted
3045 through appropriate care.

3046 But, yet, numerous studies have shown that considerable
3047 benefit from self management training for Type II diabetes,

3048 patients can be trained to inject insulin, monitor and
3049 maintain a log of blood glucose levels, and use the results to
3050 appropriately adjust dietary intake, activity levels, and
3051 medical doses. I recently came across a firm that helps
3052 patients manage diabetes remotely using tele-medicine. For
3053 example, an enrollee is given a wireless blood glucose
3054 monitor. They are instructed to test their blood glucose or
3055 blood sugar at selected times a day. They can send the
3056 results wirelessly to their physician's office. If they fail
3057 to test on schedule, they are given an e-mail or a phone call
3058 to prompt them to repeat the test or take the test. A
3059 particularly high reading might prompt a phone call from a
3060 diabetes nurse inspecting them, inquiring what have I just
3061 eaten, and don't do it again.

3062 This all becomes part of their electronic medical
3063 record, the result of which can be used and shared with their
3064 health coach to help them maintain better compliance. A
3065 great example of what is often times considered a community-
3066 based approach was the Ashville project in North Carolina,
3067 which helped enrollees and self-insured health plans better
3068 control their diabetes, but yet on closer inspection what it
3069 really was was individual pharmacists being compensated and
3070 being paid to help individual patients manage their diabetes.
3071 Another area I want to talk about is asthma self management.

3072 Nearly 20 million Americans suffer from asthma, around 2.5
3073 million school kids who miss around 15 million school days
3074 per year because of asthma.

3075 A Dutch study comparing self management to usual care
3076 found that those that were trying to monitor their own
3077 conditions received a savings of about 28 percent in their
3078 second year compared to additional physician care alone.
3079 They can also use software packages just to track and monitor
3080 their conditions and their readings. These become part of
3081 their electronic medical records, the data which can be
3082 shared with their physicians. A recent study of asthma
3083 patients trained to perform in-home asthma self-monitoring
3084 found that their readings were consistent to establish
3085 guidelines. Another study of bleeding and clotting disorders
3086 by the VA and the home self-monitoring of clotting of those
3087 taking Warfarin therapy was superior to standard monitoring
3088 alone. Tele-medicine holds significant promise to allow
3089 patients with chronic ailments who are motivated to better
3090 manage their conditions and interact with physicians in ways
3091 not possible just a few years ago. I think this is critical
3092 to better self-management of chronic conditions.

3093 In conclusion, community based health care has a place
3094 in our health care system. However, disease is very
3095 personal. The solution to the public health problems

3096 associated with increasing chronic disease is to allow
3097 patients to control more of their own health care dollars and
3098 to allow patients and providers to benefit from new
3099 arrangements that produce higher quality and lower cost. For
3100 example, government insurers, Medicare and Medicaid should
3101 also allow doctors and hospitals to repackage and re-price
3102 their services under government health care payment systems
3103 allowing them to gain financially from providing better care.
3104 The most important lesson is entrepreneurs can solve many of
3105 the problems that plague our health care system. Public
3106 policy should encourage these efforts, not discourage these
3107 efforts. Thank you.

3108 [The prepared statement of Mr. Herrick follows:]

3109 ***** INSERT F *****

|
3110 Mr. {Pallone.} Thank you, Dr. Herrick. Dr. Levi.

|
3111 ^STATEMENT OF JEFFREY LEVI

3112 } Mr. {Levi.} Thank you, Mr. Chairman. Good afternoon.
3113 My name is Jeffrey Levi and I am the Executive Director of
3114 Trust for America's Health, a nonpartisan, nonprofit
3115 organization dedicated to saving lives by protecting the
3116 health of every community and working to make disease
3117 prevention a national priority. I would like to thank the
3118 members of the subcommittee for the opportunity to testify on
3119 the role of prevention and public health as a component of
3120 the health reform debate. This afternoon I would like to
3121 make 2 major points. First, the critical importance of
3122 public health programs, in particular, population and
3123 community-based prevention in improving the health of
3124 Americans and making a reformed health care system more
3125 effective.

3126 Second, the need to create a reliable, stable funding
3127 stream for public health programs and services as part of
3128 health reform. Otherwise, the potential benefits of public
3129 health to the health care system will be lost. My written
3130 testimony also addresses the need to build the evidenced-
3131 based prevention programs and invest in public health systems
3132 and services research, to improve the quality of public

3133 health that is delivered in the U.S. Much of what is said
3134 there has been covered in Dr. Fielding's testimony. Health
3135 care in the United States has become an expensive burden on
3136 our economy. High rates of chronic disease are among the
3137 biggest drivers of the American health care costs. What this
3138 means in real terms is that Americans are not as healthy as
3139 they could be or should be and that is translating into huge
3140 growth in our health care costs.

3141 The country will never be able to contain health care
3142 costs until we do a better job of preventing people from
3143 getting sick in the first place. That is where public health
3144 comes in. The Nation's public health system is responsible
3145 for keeping Americans healthy and safe by preventing disease
3146 and promoting healthy lifestyles including those that prevent
3147 or mitigate chronic disease, diseases that are driving up
3148 health care costs. The goal is to prevent disease, prevent
3149 people from having to enter the clinic and need disease
3150 management, which is really what Dr. Herrick was talking
3151 about. He was talking about disease management rather than
3152 primary prevention. Yet, there are proven community-based
3153 programs that actually prevent disease that promote healthy
3154 environments and behavior making it easier for people to make
3155 healthy choices.

3156 Shifting community norms about tobacco use, the social

3157 marketing campaigns, changing the physical and social
3158 environment in which people live by making communities more
3159 walkable through better street lighting and sidewalks,
3160 creating group walking or exercise programs to encourage
3161 physical activity or improving access to healthy foods are
3162 all examples of community interventions that work to prevent
3163 or mitigate chronic diseases. And we know that investing in
3164 prevention, especially community-based programs, can have a
3165 big payoff. A study, Trust for America's Health, issued last
3166 summer found that an investment of \$10 per person per year in
3167 improving community-based programs to increase physical
3168 activity, improve nutrition and prevent smoking and other
3169 tobacco use, with that the country could save more than \$16
3170 billion annually within 5 years.

3171 This is a return of investment of \$5.60 for every dollar
3172 spent based on an economic model developed by Urban Institute
3173 and an extensive review of evidence-based studies by the New
3174 York Academy of Medicine. Out of that \$16 billion in savings
3175 Medicare could save more than \$5 billion, Medicaid \$1.9
3176 billion, and private payers could save more than \$9 billion.
3177 That is the good news. We have proven community-based public
3178 health interventions that work but to fully realize this
3179 potential return on investment and keeping Americans healthy
3180 requires a larger and sustained investment in public health.

3181 The bad news is right now the public health system is
3182 structurally weak in nearly every area and that is the system
3183 which ranges from federal agencies such as the CDC from whom
3184 you heard earlier to the nearly 3,000 state and local public
3185 health agencies to countless non-governmental organizations.

3186 That system does not have enough resources to adequately
3187 carry out core disease prevention functions. In
3188 collaboration with the New York Academy of Medicine, Trust
3189 for America's Health convened a panel of experts to analyze
3190 how much is currently spent on public health in the United
3191 States and how much more would be needed to support core
3192 public health services at a sufficient level. The panel's
3193 professional judgment was that there is currently a shortfall
3194 of \$20 billion per year in spending on public health.

3195 Therefore, we believe that a reformed health care financing
3196 system must include stable and dedicated funding for core
3197 public health functions and community-based prevention. We
3198 recommend the establishment of a public health and wellness
3199 trust fund through a mandatory appropriation or set aside of
3200 a portion of new revenues generated from the financing of
3201 health reform. Resources from the trust fund would be
3202 allocated to specific public health programs or activities as
3203 directed by the relevant appropriations committees those
3204 public health functions and services that surround, support,

3205 and strengthen the health.

3206 The trust fund would fund core governmental public
3207 health functions. It would also fund population level non-
3208 clinical prevention and wellness programs which can be
3209 delivered both through governmental and non-governmental
3210 agencies. It would support clinical preventive services such
3211 as screening and immunizations that are not covered by third
3212 party payers, and it would also support work force training
3213 and development, as well as public health research. The
3214 trust fund could help make up for the country's current \$20
3215 billion annual shortfall in public health spending. Based on
3216 the current distribution of responsibility along with
3217 federal, state, and local governments, \$10 to \$12 billion of
3218 that amount should be a federal responsibility. In short,
3219 Trust for America's Health believes that prevention and
3220 public health must be at the center of any effort to reform
3221 our health system. Public health programs are critical and
3222 underfunded component of the Nation's health system. We
3223 encourage Congress to establish a public health and wellness
3224 trust fund to make our country healthier, our health system
3225 more cost effective and our economy more competitive. Thank
3226 you, Mr. Chairman.

3227 [The prepared statement of Mr. Levi follows:]

3228 ***** INSERT G *****

|
3229 Mr. {Pallone.} Thank you, Dr. Levi. Those bells mean
3230 that we have votes. We have three, 15 minutes, a 5 and a 5,
3231 so figure I guess about a half an hour. So what we are going
3232 to do is have questions when we come back in about a half
3233 hour or so. I hope no one has to leave. Okay. So the
3234 committee stands in recess.

3235 [Recess]

3236 Mr. {Pallone.} The subcommittee will reconvene if the
3237 panel could take their seats. I realize I think I said half
3238 an hour but it was more like an hour unfortunately. So we
3239 will start with questions, and I will begin and yield to
3240 myself 5 minutes. Basically, on the disparities issue, I
3241 guess I would ask Dr. Satcher and Commissioner Howard this
3242 questions. I don't know if you were here when the first
3243 panel was here, but I basically said that a lot of these
3244 decisions that lead to healthy lifestyles are very personal
3245 and so you wonder to what extent public health agencies can
3246 really influence them, but I know that they can because I
3247 think the anti-smoking efforts on the part of public agencies
3248 were very successful, and I used my kids as an example.

3249 But when we hear about disparities, you know, I go back
3250 to the same thing again. To what extent are some of these
3251 disparities things that we can change, and of course I think,

3252 Dr. Satcher, of the fact that often times in the inner city,
3253 you know, you don't have as many parks or open spaces so it
3254 is more difficult for people maybe to get exercise. I don't
3255 know if that is necessarily true but sometimes it is true.
3256 And other members have made the argument that sometimes in
3257 certain urban areas you don't even have a supermarket where
3258 you can get fresh foods or vegetables.

3259 But I could just as well make that argument, I use the
3260 example of some of the American Indians. I am very familiar,
3261 for example, with some of the Pema tribes in Arizona, and
3262 they have some of the highest incidents of diabetes, you
3263 know, that comes from a lot of it from obesity, and yet they
3264 have plenty of open space although they do have a problem in
3265 that their traditional diet ranching, farming, has sort of
3266 disappeared in the last few years. So I mean do you think
3267 that there are things that we can do that make a difference
3268 in terms of these disparities, you know, like creating more
3269 open space or providing more fresh vehicles or whatever you
3270 think is the case?

3271 Dr. {Satcher.} Well, I think it is a very important
3272 question, and the answer is, yes, I do. Beginning with our
3273 children, I think again it gets back to providing incentives
3274 and some of those incentives are being with parents out
3275 walking and enjoying, you know, that association. But I

3276 really think there are a lot of ways that we can incentivize
3277 our children to engage in health efforts. Now one of the
3278 reason I spent so much time with the schools since I left
3279 office with the Action for Healthy Kids program that is now
3280 in all 50 states and the District of Columbia is that schools
3281 are the great equalizers.

3282 Some of the kids come from homes with single parents and
3283 the parent may only have time to get up and get the kids off
3284 to school and try to be there when they get back, but the
3285 children spend over 1,000 hours in school every year. We pay
3286 for that, and we ought to be committed to an environment that
3287 helps habituate children to health lifestyles because
3288 children become habituated to unhealthy lifestyles and that
3289 is foods that are high in fat, foods that are high in salt,
3290 foods that are high in sugar are really addicting and
3291 children become habituated so the time that they spend in
3292 school and the resources that we use at school ought to be
3293 devoted to helping to habituate children to healthy
3294 lifestyles. We can do that. We provide the resources.

3295 And I think what Congress did in 2004 with the WIC
3296 reauthorization basically requiring every school district
3297 that received funds for free meals to have in place a
3298 wellness policy within 2 years has worked well. According to
3299 our studies, over 90 percent of the school districts have

3300 those. Now the problem is how do we get them to implement
3301 them?

3302 Mr. {Pallone.} But, you know, and I want to move on to
3303 ask Commissioner Howard a question, you know there is a
3304 proliferation now in a lot of urban areas and all over like
3305 charter schools and smaller public schools. A lot of times
3306 they don't have the buildings or the playgrounds and to some
3307 extent as we have emphasized, you know, studies and I think
3308 of the charter schools, a lot of them started for high tech
3309 or math or science or whatever, and then they don't
3310 necessarily have the facilities, you know, or the playgrounds
3311 or whatever. But, anyway, I have to ask Commissioner Howard
3312 this question.

3313 Ms. {Howard.} Just on that point.

3314 Mr. {Pallone.} Yeah, sure.

3315 Ms. {Howard.} I think that is a great point for you to
3316 raise because even when we control for health insurance, we
3317 see troubling disparities based on race, so we know that just
3318 universal access to health insurance is not the only answer
3319 to get--

3320 Mr. {Pallone.} That is what I was going to ask you
3321 actually, so why don't you just get into it.

3322 Ms. {Howard.} Well, I think it is clear, and I think
3323 that is where public health plays a role where we can focus

3324 on evidence-based community interventions. And I will just
3325 give you one example. In your own district, I visited the
3326 FUEC in Long Branch and they are doing an interesting project
3327 with pregnant women called the health start model.

3328 Mr. {Pallone.} The health center, yeah.

3329 Ms. {Howard.} The FUEC that is run by the VNA there.
3330 Every pregnant woman who comes in is assigned a nutritionist
3331 and a social worker. So I toured, and I said this is better
3332 care than I got when I was pregnant. It was amazing the
3333 follow-ups she got, so she got nutritional counseling
3334 throughout her pregnancy and so her risks were detected
3335 early. Then she got the social supports that she needed, and
3336 those are the kind of programs that we know are evidence-
3337 based that we know work to reduce infant mortality, so I
3338 think public health really does play a critical role in
3339 reducing disparities since we can't there just on expanding
3340 coverage.

3341 Mr. {Pallone.} I am going to try to get in my second
3342 question to you which was I think the notion that if we do
3343 health care reform and somehow we manage to cover everyone
3344 that a lot of these public health concerns are going to go
3345 away but I don't think that is true, and I wanted you to
3346 comment on that. What happens in this post-Nirvana
3347 environment when we pass comprehensive health insurance and

3348 everyone has health insurance, are you still going to have a
3349 major public health role here and how do we build that into
3350 it?

3351 Ms. {Howard.} I think that is a great question to
3352 discuss today. I think absolutely public health has a role
3353 for two reasons. One, I think public health is critical to
3354 the sustainability of the health reform that you all will
3355 enact. Public health, as we have talked about today, and you
3356 heard from your first panel of the critical role we can play
3357 in managing chronic diseases and containing cost will be
3358 critical to making health reform work, so I think it is part
3359 of health reform. I think we also can't ignore the fact that
3360 health reform will probably leave some people behind. We
3361 have seen in Massachusetts, for example, that none everyone
3362 has been covered.

3363 And actually we have seen, I was looking this up last
3364 night, that federally qualified health centers, the community
3365 clinics, have seen an increase in the number of visits since
3366 they have had their universal health care. So safety net
3367 providers like federally qualified health clinics will still
3368 play a role because they know how to reach perhaps hard to
3369 reach populations in culturally competent ways. They are
3370 critical to reducing disparities. So, one, it is critical to
3371 the sustainability from a financial perspective, but also we

3372 know that coverage is not the only answer to improving the
3373 health of Americans, and so public health will still be vital
3374 whether it is dealing with making sure that kids go to a day
3375 care center that has clean air, whether it is making sure
3376 that we don't have food safety problems. All those things we
3377 are still getting in public health.

3378 Mr. {Pallone.} Okay. Thank you. Mr. Deal.

3379 Mr. {Deal.} Thank you. Dr. Spivak, I was intrigued by
3380 your testimony as to what your group is doing. It is
3381 apparently very impressive results that you are achieving.
3382 And I notice that you mentioned the Tufts Health Plan
3383 Medicare Preferred. I assume that is a Medicare Advantage
3384 program, is that correct?

3385 Dr. {Spivak.} That is correct. It is a Medicare
3386 Advantage HMO product, so it is different than the Medicare
3387 Advantage fee for service products in that the patients
3388 choose a primary care physician and choose a network, so it
3389 allows us to get information about them because we know who
3390 their primary care doctor is and who is responsible for their
3391 care, so it give us access to claims data about their
3392 pharmacy utilization, what prescriptions they are really
3393 filling, and gives us easier access to if they go out of our
3394 network getting information about their care as well.

3395 Mr. {Deal.} Obviously, you are aware that much of the

3396 movement about Medicare Advantage is to do away with those
3397 kind of programs. If Medicare Advantage is basically
3398 abolished then your network that you have established would
3399 virtually disappear because--and you wouldn't have the
3400 flexibility that you have described in the way you outreach
3401 now, is that right?

3402 Dr. {Spivak.} That is correct. And it is one of the
3403 problems that we see if Medicare Advantage goes away that the
3404 fee for service medicine just doesn't allow us to give the
3405 infrastructure and the support that we need to do this kind
3406 of care. The medical home concept that people are talking
3407 about goes a little bit towards it but it really doesn't go
3408 far enough in the current models to provide the extensive
3409 programs that we have today.

3410 Mr. {Deal.} Dr. Herrick, following on that same line of
3411 questioning from your printed testimony excerpts you say
3412 government insurers should also allow doctors and hospitals
3413 to repackage and re-price their services under government
3414 health care payment systems allowing them to gain financially
3415 providing better care. You go on to say entrepreneurs can
3416 solve many of the health care problems that critics condemn.
3417 One of the concerns I have is that if we move into a system
3418 that is as rigid as our current systems are in basically a
3419 fee for service format, I think we bill rigidity into the

3420 system and we don't allow any room for entrepreneur or even
3421 for those providers who want to do things in a little
3422 different way. Is that the point you were trying to make?

3423 Mr. {Herrick.} Well, the point I was trying to make is
3424 under the current system it is a very rigid system.
3425 Basically Medicare and Medicaid tend to pay by task. We are
3426 not paid for results, we are not paid for outcomes. In a
3427 sense, if you have pay for performance often times it is the
3428 payers of health care trying to tell the purveyors of health
3429 care, the providers of health care, how to practice medicine.
3430 It is the doctors and hospitals that know the most about how
3431 to practice medicine. Let them propose novel solutions. Let
3432 them experiment. And if they can find a way that has higher
3433 quality and lower cost let them suggest ways of getting paid.

3434 For example, I gave some anecdotes about how the chronic
3435 disease management firms talk to you on the phone. They
3436 might e-mail you to tell you, you forgot to take a certain
3437 blood glucose test, but Medicare will not pay for those, will
3438 not reimburse for that type of advice, neither will Medicare,
3439 but yet these are very innovative type of arrangements.
3440 Tele-medicine is a very efficient way to prod people into
3441 compliance. We need to have ways of reimbursing physicians
3442 for doing those very novel ideas.

3443 Mr. {Deal.} Dr. Satcher, once again, I compliment you

3444 for all the good work you are doing and for things that you
3445 are continuing to promote. The Alzheimer's research is
3446 particularly important. But I think as we look at children,
3447 which has I think been one of your focuses as well in your
3448 testimony here today as Georgia has its peach care component
3449 of our S-Chip program isn't it important that we give some
3450 flexibility to the way that program works so that, for
3451 example, there can be coordination between community health
3452 centers that may be providing part of the care between
3453 primary physicians that may become a medical home and then
3454 the traditional providers of health care. I have a sense
3455 that we don't have that kind of coordination of care that is
3456 allowed under our current silos in which we deliver health
3457 care. Do you agree or disagree?

3458 Dr. {Satcher.} Oh, I agree. This was about
3459 Alzheimer's. One of our major recommendations, in fact, a
3460 second recommendation is for enhancing community
3461 collaborative care using electronic health records but tying
3462 people together all the way from family members who take care
3463 of relatives when they are ill with Alzheimer's, tying them
3464 together with physicians and other health care providers so
3465 the community collaborative system of care is one that I
3466 think is very important at every level.

3467 Mr. {Deal.} I have to keep shielding my eyes to see the

3468 clock up there. I think I am over and exhausted my time.

3469 Thank you all for being here.

3470 Mr. {Pallone.} Ms. Christensen.

3471 Ms. {Christensen.} Thank you, Mr. Chairman. And I want
3472 to thank the panelists for their patience. I know you have
3473 had a long week. Dr. Howard, you say in your testimony that
3474 we need a public health work force to deliver the basic
3475 package. Would you elaborate on the components and the
3476 characteristics that you see being needed in that work force?

3477 Ms. {Howard.} Thank you. That is a great question. I
3478 think one thing we haven't talked about today is the nursing
3479 public health work force. We haven't talked enough about
3480 nurses, and nurses are a critical component of our public
3481 health system, and we are facing a very dire shortage of
3482 nurses in New Jersey but nationally. So that is just one
3483 example of where we are facing a shortage. We are also
3484 facing in New Jersey, and I know this is true nationally and
3485 in our urban areas, a shortage of other practitioners as
3486 well. And access to dental care is restricted, so we have a
3487 number of practice areas where there is a real shortage. I
3488 am pleased that in the recovery act there was funding for
3489 development of the work force, and I think that will go a
3490 long way.

3491 But I encourage you all as you think about reforms to

3492 think about that, and I think one of the lessons learned from
3493 Massachusetts was that even having universal health insurance
3494 was not good enough. People can't see a provider. And then
3495 from my own perspective also states are unfortunately having
3496 to make lots of cuts in programs, and we are cutting staff in
3497 vital programs because of the economy, so it is hitting us on
3498 all fronts.

3499 Ms. {Christensen.} Thank you. Dr. Satcher, references
3500 have been made to 2010 and I guess it is now 2020 goals. I
3501 think we started at 2000 goals, then to 2010, and now to
3502 2020. Why do you think we have not been doing better
3503 achieving our 2010 goals, and if you could also in your
3504 answer comment on the importance of diversity in the work
3505 force?

3506 Dr. {Satcher.} Healthy People started, as you know, in
3507 1980 with Healthy People 90, and then we had Healthy People
3508 2000, so you are right. It has been around. And we have had
3509 goals for each decade, and the idea is that we maintain those
3510 goals until we achieve them. I think there are several
3511 issues related to the achievement of 2010 goals, and one, of
3512 course, is we did not anticipate that we would have 8 million
3513 more people uninsured than we had in the year 2000. We also,
3514 as you know, have not put in place the kind of system we have
3515 been discussing here this morning that are going to really be

3516 critical for the elimination of disparities in health, and
3517 they have got to be programs that target all of the
3518 determinants of health, which is why I took time to mention
3519 those determinants again.

3520 So I think a real commitment to eliminating disparities
3521 in health is a commitment to a public health approach to
3522 health care delivery in this country. I also think that the
3523 whole issue of cultural diversity is critical. The Institute
3524 of Medicine in its 2003 report following our having set the
3525 goal of eliminating disparities pointed out that the absence
3526 of cultural diversity in health care was a very dangerous
3527 situation. They gave examples from several areas including
3528 mental health. When the people providing the care don't
3529 understand the language or the culture of the people they are
3530 taking care of, and I know that Congressman Gingrey mentioned
3531 that this morning.

3532 But it was very clear from that report that it did, in
3533 fact, damage health care when the providers didn't understand
3534 the culture, not just the language, but the culture of the
3535 patients they were taking care of, so I have seen some good
3536 examples of programs now where they try to integrate the
3537 community into the system of care. We don't have enough
3538 African American physicians or Hispanic physicians or Native
3539 American physicians to do that or nurses. That is what I was

3540 getting to that we have to look beyond just the physicians if
3541 we are going to have that kind of diversity. And we can make
3542 progress down the line with community health workers, nurses,
3543 and others, and that is what some programs are now doing,
3544 programs that take care of southeast Asians, Native
3545 Americans, African Americans.

3546 Ms. {Christensen.} Dr. Levi, I was going to ask you how
3547 much the public health trust fund--what was your estimate,
3548 but you gave me that. We also have been talking about a
3549 health disparity elimination trust fund or a health equity
3550 trust fund, so I was really interested in that. I wonder if
3551 you would want to comment on community health centers and
3552 their role. One easy area to get funding for in the Congress
3553 has always been community health centers, but I find that we
3554 only think about the community health centers and not all of
3555 the things that community health centers need. Do you
3556 understand my question? Can you speak to that?

3557 Mr. {Levi.} I think I do, and I think it is partly
3558 again to be thinking about what needs to surround the primary
3559 care system in order for it to be effective. And the kinds
3560 of community prevention programs that we were talking about
3561 really the things that can make a difference to--a community
3562 health center doctor can write a prescription, so to speak,
3563 for a person to go out and get more exercise.

3564 Ms. {Christensen.} If you have the staff.

3565 Mr. {Levi.} Assuming you have the staff. Making
3566 certain assumptions. If you have the staff and someone
3567 needs--the prescription is get more exercise and eat
3568 healthier, but you live in a community where it is not safe
3569 to walk, where there aren't sidewalks, there aren't
3570 opportunities to exercise, and where healthy food isn't
3571 accessible, then you are not going to have a successful
3572 intervention there. So for the community health center to be
3573 effective the people who are served by that health center
3574 need to live in a healthier community, and that has to be
3575 built into what we think about in health reform, and find a
3576 way to bring these together.

3577 The return on investment that I spoke about in my
3578 testimony was thinking about doing these interventions truly
3579 on a population level, the entire country. Is we target it
3580 to high risk communities where there is a high prevalence of
3581 these conditions the return on investment would be even
3582 greater. And we are talking about flexibility in the
3583 Medicaid program and the Medicare program. Some flexibility,
3584 we would love to see as an opportunity for Medicare and
3585 Medicaid dollars to do work in a community. So we know
3586 people who are on Medicare and obese have much higher costs
3587 than people who are not. So let us target people 55 to 64 in

3588 their communities with proven evidence based interventions,
3589 spend some Medicare dollars up front to get them healthier as
3590 they are entering the Medicare program.

3591 As I was going around the country talking about this
3592 report, I met with some Medicaid plans, some Medicaid
3593 managed-care plans, and they were frustrated that they didn't
3594 have the flexibility, for example, to go into their catchment
3595 area and give everyone a pedometer. They were absolutely
3596 convinced that if they did that, they would save money but
3597 that was not an allowable cost because they would also be
3598 reaching non-Medicaid beneficiaries which only emphasizes the
3599 point that we have to surround whatever is this reformed
3600 health care system with true community level interventions.

3601 Ms. {Christensen.} Mr. Chairman, I plan to introduce a
3602 health empowerment zone bill that I hope will do that, and we
3603 invite you to look at it when we do.

3604 Mr. {Levi.} Great. Thank you.

3605 Mr. {Pallone.} Thank you. Mr. Gingrey.

3606 Mr. {Gingrey.} Mr. Chairman, I want to remind that I
3607 waived my opening statement so hopefully I will have time to
3608 ask two questions. Dr. Spivak, I think Ranking Member Deal
3609 may have addressed this a little bit a moment ago in regard
3610 to this independent physician association that you run in
3611 Massachusetts and the success rate that you think it has. It

3612 is a Medicare Advantage plan as I understand your testimony,
3613 is that correct?

3614 Dr. {Spivak.} We also do the similar management for
3615 commercial products with Tufts Health Plan, Blue Cross and
3616 Harford Pilgrim, so we have about 50,000 commercial lives as
3617 well.

3618 Mr. {Gingrey.} Right, but this plan that you have with
3619 Tufts Medical Center is a Medicare Advantage, and as you
3620 described it, and that was always--has always been my
3621 understanding of what a Medicare Plus Choice and not Medicare
3622 Advantage Plan does in contrast to the Medicare fee for
3623 service where it is just kind of episodic care, in fact,
3624 until we made some recent changes in the law even a routine
3625 physical examination was not covered and now it is only
3626 covered at the entry into Medicare exam, and yet what the
3627 Administration is proposing in the 2010 budget is to really
3628 cut significantly the funding to Medicare Advantage, I would
3629 say almost to the bone, and take some of that money at least
3630 to create this escrow account to help pay for health care
3631 reform which would then go toward creating more payment to
3632 primary care physicians to man a medical home, to incentivize
3633 them by additional payments for wellness.

3634 It seems like it is the very same thing that Medicare
3635 Advantage was designed to do, and I realize that maybe we are

3636 paying a little bit too much, 115 percent or whatever it is,
3637 and maybe some cuts could and should be made, but it is like
3638 just scoring in esthetic way and saying, well, this compared
3639 to Medicare fee for service is too expensive, but if you look
3640 at it over a 10 or 20 or a lifetime period of those Medicare
3641 patients who receive their care through that type with an
3642 emphasis on prevention and wellness, at the end of the day if
3643 you score esthetically or dynamic then the savings, I think,
3644 would be there. If you would quickly comment on that for us,
3645 then I will go to Dr. Satcher.

3646 Dr. {Spivak.} I think that one of the things that was
3647 not talked about today is that the public health crisis that
3648 we face is also the aging population, and as our population
3649 ages they are going to need more and more help with their
3650 health care. I think that the Medicare Advantage programs
3651 allow physicians to work with health plans and with hospitals
3652 in a way that forms a network that will give much more
3653 support to the elderly than any type of traditional fee for
3654 service medicine can, and in the long run will keep costs
3655 down. I think we have looked at alternative methods of
3656 paying doctors. Paper performance does not seem to--it may
3657 improve quality a little bit but it doesn't seem to cut costs
3658 down.

3659 All of the programs in public health that we have talked

3660 about are critical but at the end of the day when patients
3661 are sick, they need a model of health care that will support
3662 them. I really believe groups like mine provide the model.

3663 Mr. {Gingrey.} Reclaiming my time, I believe that too,
3664 and I hope we are not about to throw the baby out with the
3665 bath water, as they expression goes. I really feel that if
3666 we had continued in a cost effective way to let Medicare
3667 Advantage provide care for right now 10 million Medicare
3668 recipients have chosen that over fee for service, and then to
3669 incentivize people through the tax code maybe or through ha
3670 reduction in Medicare Part B premium, if they executed a
3671 living will advance directive that is actually on line as we
3672 get this fully integrated electronic medical system to cut
3673 down on those costs and let them say what they want at the
3674 end of life. But thank you so much for that.

3675 Dr. Satcher, I want to thank you again for your service
3676 to our country and the time you have spent in government and
3677 outside government and what you are doing now at Morehouse
3678 School of Medicine. It is great to see you again. You
3679 stated in your testimony that half of health outcomes come as
3680 the result of human behavior and that we must provide
3681 incentives and rewards for healthy lifestyles. I agree
3682 completely. Do you think that businesses that have
3683 implemented programs that let us say reward smoking

3684 cessation, a healthy diet, regular exercise are an effective
3685 way to better the public health and what kind of benefits
3686 come from these types of programs and cost savings associated
3687 with this type of program. I would imagine it is pretty
3688 significant.

3689 Dr. {Satcher.} Yes, I do think that businesses that
3690 invest in, for example, work site wellness programs, we have
3691 been working with the Technology Association of Georgia, and
3692 we have been looking at data from many of those businesses.
3693 And it is clear that they can show that for every dollar
3694 invested in wellness, in some cases they save \$4, in mental
3695 health I think it is a little bit more than that. They save
3696 by investing. Now they save it by preventing illness in the
3697 population that they would have to pay for but they also save
3698 it by preventing absenteeism from work and they save it by
3699 enhanced productivity.

3700 I would be happy to submit to you data from several of
3701 those companies as opposed to naming them because I am on the
3702 board of one of those companies, so it wouldn't be fair. But
3703 clearly there is data showing that investment in work site
3704 wellness programs saves money in terms of how much we pay for
3705 care and how much we pay for absenteeism and lost
3706 productivity when people become sick.

3707 Mr. {Pallone.} I am going to try to wrap up because--

3708 Mr. {Gingrey.} Dr. Satcher, thank you, Dr. Spivak,
3709 thank you, and thank you, Mr. Chairman, for your indulgence.
3710 I yield back.

3711 Mr. {Pallone.} And we are going to end with Mr. Engel
3712 because otherwise you would have to wait another half hour or
3713 an hour for us to come back again because there are more
3714 votes. Mr. Engel.

3715 Mr. {Engel.} Thank you, Mr. Chairman. I am going to
3716 try to give the abbreviated version of questions. Let me ask
3717 Dr. Levi about HIV prevalence in the United States. We found
3718 out last year it was higher than we had thought much to our
3719 dismay and that the global HIV prevention working group which
3720 is comprised of 50 leading public health experts and others
3721 released a study last summer called behavioral change in HIV
3722 prevention, and in the study essentially what they came to
3723 conclusion is they said prevention efforts to be successful
3724 will be unsustainable unless there is a comprehensive
3725 evidence-based approach employed that targets behavior social
3726 norms and other underlying drivers in the HIV AIDS epidemic.

3727 So, Dr. Levi, could you please discuss the contributions
3728 the guide to community preventive services has made with
3729 regards to reviewing HIV behavioral and social interventions
3730 at the community level and where is our research lacking and
3731 how much do you believe that increased funding would enable

3732 the guide to better assist HIV prevention efforts?

3733 Mr. {Levi.} Overall, the guide has been chronically
3734 underfunded and so it is unfair to judge the guide on what it
3735 has covered and not covered. But one of the things I think
3736 we need to be careful about is that there are actually within
3737 CDC several efforts, for example, in addition to the
3738 community guide in identifying successful interventions. And
3739 within the HIV AIDS division of the CDC, they have developed
3740 a compendium of what they consider to be approved community-
3741 based interventions and successful prevention program from
3742 which grantees can choose as they decide to spend federal
3743 dollars, so there are multiple ways of approaching it.

3744 I think the real challenge that we have around HIV
3745 prevention in this country, and this is something I have been
3746 working on since the beginning of the epidemic, is that we
3747 haven't fully committed the resources to the kinds of
3748 community change that is necessary to implement the policies
3749 that we know work so we have had restrictions, frankly, on
3750 use of needle exchange, use of federal funds for needle
3751 exchange programs. That is an evidence-based approach and
3752 countries that adopted it early on in the epidemic, they have
3753 not had the same kind of epidemic as they did, you know,
3754 among injection drug users, not just for HIV but also for
3755 transmission of hepatitis which has resulted in tremendous

3756 cost savings in those countries.

3757 We have not had that benefit of that because we failed
3758 to adopt evidence-based practices. In terms of community
3759 change, I think it really does again come back to community
3760 level interventions that reach the multiple communities that
3761 are affected by the epidemic. It is not a one size fits all
3762 effort. It is not just going to be promoting use of commons
3763 or promoting safe sex or promoting abstinence. It is going
3764 to be what works in a particular community and what brings
3765 people together to feel empowered to adopt the norm changes
3766 that need to happen. That is much more complex than the
3767 programs we have been willing to talk about until now, but
3768 that is what it is going to take in the same way, as we have
3769 been talking about earlier, there isn't a one size fits all
3770 for obesity. There isn't a one size fits all for physical
3771 activity. There isn't going to be one size fits all for HIV.
3772 And I don't think that we have been willing to invest in
3773 those affected communities enough to empower them and give
3774 them the resources.

3775 Mr. {Engel.} Let me ask you one final question on
3776 another topic. Health insurance pays for many clinical
3777 preventive services like immunizations and screening tests
3778 such as mammograms but important community level prevention
3779 services such as fluoridation of water or lead abatement in

3780 buildings are not reimbursed by health insurance, so it means
3781 that federal, state, and local agencies that provide these
3782 services rely on our annual appropriations process to fund
3783 these important activities. I would like you to explain what
3784 kind of challenges that poses and in your testimony you
3785 mentioned there was a need for reliable funding source for
3786 public health activities. What would that funding stream
3787 look like?

3788 Mr. {Levi.} Well, you are absolutely right. The
3789 dependence on the fluctuations in the annual appropriations
3790 cycle has meant, and Commissioner Howard could probably speak
3791 to this better, meant that there isn't a reliable source of
3792 revenue and therefore not a predictable source of funding and
3793 it is very hard to plan to build programs and to build
3794 capacity, and so what we have been seeing, we have seen it in
3795 many areas, we have seen it in chronic diseases. We have
3796 seen it most evidently, I think, on the preparedness side
3797 where there is an initial major investment state staff up
3798 using those dollars and then the dollars start withering away
3799 literally, I mean 25 percent cut since the peak.

3800 And so it is hard to keep staff. It is hard to retain
3801 staff. And, in fact, you know, at a time when we are seeing
3802 whole generation of public health workers retiring and we
3803 need to fill back fill, we don't have the resources and the

3804 stability of resources to make sure that we have a new work
3805 force coming in and that this is a viable occupation for
3806 people to enter. To resolve that, we think there ought to be
3807 the equivalent of a trust fund. If we are going to guarantee
3808 funding for health care, we should also be guaranteeing
3809 funding for public health. So there is a reliable mechanism
3810 that states can depend on, the CDC can depend on, and we can
3811 make the investments that over time will indeed pay off.

3812 Mr. {Pallone.} We are going to have to--I think we only
3813 got a couple minutes.

3814 Mr. {Engel.} Okay. I was going to ask the commissioner
3815 if she agreed.

3816 Ms. {Howard.} I do.

3817 Mr. {Engel.} Thank you.

3818 Mr. {Pallone.} Thank you, Eliot. I hate to rush, but I
3819 don't want you to have to wait another hour for us to come
3820 back because we have another series of votes. So thank you
3821 very much. This has been very helpful. We want to stress
3822 the public component of this health care reform. You may get
3823 additional questions in writing within the next 10 days from
3824 some of us to respond to, and hopefully you will respond to
3825 them. But, again, thank you for all your input and what you
3826 do. And without further adieu, the subcommittee hearing is
3827 adjourned.

3828 [Whereupon, at 2:35 p.m., the subcommittee was
3829 adjourned.]