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# ACCESS TO PREVENTION AND PUBLIC HEALTH FOR HIGH-RISK POPULATIONS

## HEARING

OF THE

## COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

## UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

ON

EXAMINING ACCESS TO PREVENTION AND PUBLIC HEALTH FOR HIGH-RISK POPULATIONS

JANUARY 27, 2009

Printed for the use of the Committee on Health, Education, Labor, and Pensions



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# ACCESS TO PREVENTION AND PUBLIC HEALTH FOR HIGH-RISK POPULATIONS

**TUESDAY, JANUARY 27, 2009**

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
*Washington, DC.*

The committee met, pursuant to notice, at 9:02 a.m. in Room SR–385, Russell Senate Office Building, Hon. Tom Harkin presiding.

Present: Senators Harkin, Sanders, Casey, and Merkley.

## OPENING STATEMENT OF SENATOR HARKIN

Senator HARKIN. Good morning. The Senate Committee on Health, Education, Labor, and Pensions will come to order.

The committee, as you know, is holding a series of hearings as we gather testimony in helping us craft comprehensive healthcare reform for this year.

This morning, we will be hearing from a distinguished panel of witnesses about access and how we improve access for preventive care and wellness and public health for vulnerable populations—groups that have been traditionally neglected and underserved, including people with disabilities, people who live in rural areas, our senior citizens, children, and especially those who live in poverty.

Last month, looking ahead to this task of drafting this comprehensive reform, Senator Kennedy asked me to chair the Prevention and Public Health Working Group. I am convinced that this has got to be the central focus of any reform legislation because we will never get these costs under control until we place a major new emphasis on wellness and disease prevention, while strengthening America's public health system.

We are in the early weeks of America's great debate about national healthcare reform. I have laid down a public marker of my own, saying that if we pass a bill that greatly extends health insurance coverage but does nothing to create a dramatically stronger prevention and public health infrastructure and agenda, then we will have failed the American people.

Well, I will lay down a second marker this morning. If we fail to seize this unique opportunity to expand access to preventive services and public health for vulnerable, high-risk populations, then that, too, would be a terrible failure.

We must seize this unique moment to rectify some of the most outrageous inequities and pockets of neglect in our healthcare system. It is a matter of simple justice. It is also a matter of basic economics.



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Because when citizens from these vulnerable, high-risk populations show up at the emergency room with late-stage illnesses because of chronic neglect and lack of preventive care, then we all pay, and we all pay more.

I look forward to hearing from our witnesses, getting their best thinking about expanding access to prevention and public health. We have six highly respected witnesses. I will take my opportunity to kind of introduce them all right now, and then I will call upon them individually for their testimony.

Dr. Risa Lavizzo-Mourey is the president and CEO of the Robert Wood Johnson Foundation, a private philanthropic organization whose goal is to improve the health and healthcare of all Americans.

Under Dr. Lavizzo-Mourey's leadership, the Robert Wood Johnson Foundation has targeted a set of high-impact priorities, including improving patient care and strengthening State and local public health systems and halting the rise in child obesity by 2015.

I was also pleased to learn that Dr. Lavizzo-Mourey still practices at a Federally Qualified Community Health Center, the Chandler Clinic, in New Brunswick, NJ.

Dr. David Stevens is director of the Quality Center and associate medical director of the National Association of Community Health Centers, also a research professor in the Department of Health Policy at the George Washington University School of Public Health and Health Services.

Dr. Stevens is also a member of the Commissioned Corps of the U.S. Public Health Service, and he continues to provide clinical care at a Federally Qualified Health Center which serves Prince George's County and Southern Maryland.

Mr. Michael Meit serves as the principal research scientist for NORC, the National Opinion Research Center, at the University of Chicago. At NORC, he is also the deputy director of the NORC Walsh Center for Rural Health Analysis, responsible for NORC projects in the area of rural health, public health, and preparedness.

Mr. Meit recently finished a term on the National Advisory Committee for Rural Health and Human Services, and he currently chairs the National Rural Health Association's Rural Public Health Interest Group.

Dr. Iezzoni is not here right now but I will introduce her anyway.

Dr. Iezzoni is professor of medicine at Harvard Medical School and associate director of the Institute for Health Policy at the Massachusetts General Hospital in Boston. Dr. Iezzoni studies healthcare quality, delivery systems, and policy issues relating to persons with disabilities.

In 2006, she co-authored a book, "More Than Ramps: A Guide to Improving Healthcare Quality and Access for People with Disabilities."

Dr. Robert Butler is president and CEO of the International Longevity Center and professor of geriatrics at the Brookdale Department of Geriatrics and Adult Development at Mount Sinai Medical Center in New York City. Of course, we all know Dr. Butler was the founding director of the National Institute on Aging at the National Institutes of Health.

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Finally, Dr. Joseph Hagan. Dr. Joseph Hagan is a clinical professor of pediatrics at the University of Vermont College of Medicine. It kind of looks like Vermont out there today, now that I think about it.

[Laughter.]

Dr. Hagan has received numerous awards for teaching and for clinical medicine, also served as an advisor to the Vermont Department for Children and Families. He is a fellow of the American Academy of Pediatrics and serves on a number of committees and as liaison to the Centers for Disease Control Task Force on Community Preventive Services for the academy.

Thank you for being here today.

Well, as I have said before that prevention and public health is the missing piece—has been the missing piece in healthcare reform for far too long. We need to guarantee that our most vulnerable, high-risk populations have equal access to preventive services and public health.

This is an extraordinarily important hearing. I appreciate the witnesses for being here. I thank you for your wonderful written statements. They will all be made a part of the record in their entirety.

At the outset, I just want to say two things. First, I hope that we can continue to consult with you as we proceed over the next weeks and months in developing this. I want my staff to be working with you, and to the extent that I can also personally work with each of you, to make sure that what we are talking about this morning doesn't just get left behind, that we fully integrate this into our healthcare reform.

And second, just to say that we had to move the hearing up because the Appropriations Committee meeting is at 10:30 a.m., and I am going to have to leave about that time. If we are not quite finished, I might ask one of my colleagues to take over the chair for the remainder of that hearing if they are not on Appropriations Committee at that time.

We thank you all for being here and for all of your great work in all of these areas of prevention and wellness for so long.

I will start with you, Dr. Lavizzo-Mourey, and we will just go down in that order.

Dr. Butler is just walking in the room. Hi, Bob. How are you? Sorry about the weather out there.

[Laughter.]

Don't tell me you walked?

Dr. BUTLER. Yes.

Senator HARKIN. He walks everywhere. Alright. Bob, I just introduced you, so I am not going to introduce you again.

We will start with Dr. Lavizzo-Mourey. If you could just sort of sum up? I read your summaries also last night. They are great summaries. If you could just give us about 5 minutes of the most important things you think we ought to think about so we can at least have some discussion before 10:30 a.m.

Dr. LAVIZZO-MOUREY. Absolutely. Thank you.

Senator HARKIN. Thank you very much.

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**STATEMENT OF RISA LAVIZZO-MOUREY, M.D., M.B.A., PRESIDENT AND CEO, ROBERT WOOD JOHNSON FOUNDATION, PRINCETON, NJ**

Dr. LAVIZZO-MOUREY. Good morning, and thank you. I want to thank Chairman Kennedy and Ranking Member Enzi and, of course, you, Senator Harkin, for the invitation to speak to the committee on these important issues of prevention and public health among our most vulnerable populations.

As you have already mentioned, in addition to being the CEO of the Robert Wood Johnson Foundation, I have the privilege of working at a community health center. This center provides care to many people who are low-income vulnerable people and have many chronic illnesses.

As I care for these people, I often think to myself wouldn't it have been better if our system had been able to prevent the illnesses that we provide care for at that setting?

Certainly, as Congress considers this important opportunity to expand coverage—and that must be a priority—I am, as you have already mentioned, so thrilled that you are considering other areas, like quality, reducing spending, and improving the capacity of our public health system to make people healthier by focusing on social determinants of health that actually will allow us to prevent disease and promote health.

You have often spoken of "sickcare" and how our system needs to move from a focus on sickcare to healthcare, and I certainly agree with that and applaud you. These challenging times give us an opportunity to take unprecedented steps to invest in more prevention and public health that can help our population stay healthy in the first place.

Now improving health and investing in preventive services makes good fiscal sense. A recent report by Trust for America's Health has found that even small strategic investments in proven community prevention programs can result in dramatic savings.

An investment of as little as $10 per person per year in programs that increase physical activity, improve nutrition, and reduce tobacco use can save $16 billion over 5 years for our country, and that is savings to Medicare, Medicaid, and private payers. Clinical prevention services, such as childhood immunizations, also play a critical role in keeping us healthy.

Disease prevention and health promotion must be a priority, but this is an area that has largely been ignored or chronically underfunded at the Federal, State, and local government levels. As you consider health reform proposals, I urge you to increase stable funding and incentives for both community-based programs and clinical preventive services.

An important first step is being taken now by Congress and the administration under your leadership, Senator Harkin, to increase the investment in prevention in the Economic Recovery and Investment Act, and this unprecedented investment will pay off.

However, there are a tremendous number of promising and successful efforts to improve health and prevent disease in schools, neighborhoods, and workplaces across the country that are reaching the most vulnerable populations where they live, work, learn, and play. I have provided many examples in my written testimony,

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but I would like to just highlight a few for you that show how people are engaging populations at school, in neighborhoods, and where they work.

First, schools. For too many schools, particularly in under resourced communities, recess is a vestige of the past. Yet there is an innovative program called Sports4Kids that is transforming recess across the country using trained, full-time coaches—many of them from Americorps volunteers—who teach kids how to resolve conflicts and engage them in games that everyone can play in.

The kids then return to the classroom more focused, cooperative, and ready to learn. Fights and injuries are reduced, and they have had some good physical activity while out on the playground.

Schools are also a logical place to address the epidemic of childhood obesity, which, as we all know, affects 23 million children and adolescents in our country, nearly a third of the Nation's kids ages 2 to 19. Of course, African-American, Latino, Native American, and Asian-American and Pacific Islander kids living in low-income communities are the hardest hit.

Our foundation is committed to reversing this epidemic by increasing the access to healthy foods and opportunities for physical activity in schools and communities, especially in those with the fewest resources. The Alliance for a Healthier Generation's Healthy Schools Program works to improve nutrition and physical activity as well as staff wellness in schools nationwide.

Senator Harkin, I know that you visited the Oak Street Middle School in Iowa this fall and saw for yourself how they are taking soda out of the vending machines, replacing it with water, offering more fruits and vegetables in the cafeteria, and creating programs where kids can walk during recess and before and after school.

Let me turn to neighborhoods and give you an example there. Neighborhoods and communities also have opportunities to prevent obesity and to help people live healthier lives by providing access to affordable nutritious foods. If they don't have opportunities to these foods or the opportunity to engage in activity, they are more likely to lead unhealthy lives.

Let me just briefly tell you about the Food Trust program that started in Philadelphia and has leveraged their resources from $60 million to $90 million and created over 60 new supermarkets that provide access to food—healthy foods and also play a critical role in developing public-private partnerships.

In closing, let me just say that, as I have said in my written testimony, there are many opportunities for us to invest in worksite wellness programs, some of which, over a 3-year period can save as much as $105 million by reducing absenteeism and healthcare costs.

By supporting policies and programs that keep us healthy in government, in public health system, in business, we can work with faith-based groups to help our populations be healthier. Investing in prevention can save money and reduce the burden of preventable diseases, such as heart disease, cancer, and diabetes.

I believe that we have to reconfigure the way we spend in order to build a culture of wellness in this country by having insurance policies that encourage wellness, urban planning that encourages wellness through sidewalks and the way we zone our communities,

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and by developing more public-private partnerships that provide access to grocery stores, as I have mentioned, and other healthy opportunities.

The Robert Wood Johnson Foundation is committed to working with you, and we stand ready to do all that we can to build this culture of wellness and make progress toward good health for all Americans.

Thank you.

[The prepared statement of Dr. Lavizzo-Mourey follows:]

PREPARED STATEMENT OF RISA LAVIZZO-MOUREY, M.D., M.B.A.

Good morning. Thank you to Chairman Kennedy, Ranking Member Enzi, Senator Harkin and members of the committee for this opportunity to testify about the importance of investing in prevention and public health, particularly in programs that reach the most vulnerable among us. I am Dr. Risa Lavizzo-Mourey, president and CEO of the Robert Wood Johnson Foundation, the Nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans.

I still practice medicine at a federally qualified community health center, the Chandler Clinic, in New Brunswick, NJ, about 25 minutes from the Foundation's headquarters in Princeton. The clinic provides health care to thousands of the area's most vulnerable, low-income or uninsured families, from prenatal care to elder care. Many of my patients have multiple chronic illnesses, and the clinic fills a critical gap in providing them with medical care to treat those illnesses.

But I often think about how our system fails my patients, and how much better off they would be if they had not developed their illnesses—many of them preventable—in the first place. As a physician, I have a place in my heart for the advice that "an apple a day keeps the doctor away." But, as an agent of social change, I am pragmatic enough to see the emptiness of these words if patients cannot find an apple in their home, in their schools or in their corner store.

When I see a patient with diabetes, I can check her feet and examine her eyes. I can monitor her blood pressure and her hemoglobin A1C. I can prescribe medicine to help control her disease. I can counsel her about how important it is that she eat plenty of fruits and vegetables; cut out sugar; reduce salt and fat; maintain a healthy weight and be physically active. But, more often than not, that patient doesn't have access to affordable, nutritious foods; there aren't grocery stores in her neighborhood. She may not be able to exercise because there aren't good sidewalks, or because she doesn't feel safe walking in her neighborhood.

What I can't always do in the clinic is help my patients to *manage* their illnesses very effectively, or keep them from getting sick in the first place, because they're up against a daunting array of problems and challenges in their homes, their neighborhoods, and their schools.

I would argue that, even if my patients had the same health insurance that I have, if they had the same access to high-quality clinical care, their health status would still be unequal, because of these persistent challenges outside of the health care system.

Certainly, as Congress considers opportunities for health reform this year, expanding health care coverage must be a priority. But increasing access to health care alone will not be sufficient. Meaningful health reform must also include efforts to improve the quality, value and equality of care; bring down spending; strengthen the public health system's capacity to protect our health; address the social determinants of health; and prevent disease and promote healthier lifestyles.

THE VALUE OF PREVENTION

Senator Harkin, I've often heard you say that we have a "sickcare system" not a health care system, and I couldn't agree more that it's time to change that. During these challenging times, we also have an unprecedented opportunity for real change, and to invest more in prevention and public health efforts that can reduce illness and disease in the first place and help people stay healthy. Whether or not a person stays well in the first place has little to do with seeing a doctor. Our aim should be to keep as many people healthy and out of the health care system as possible.

Improving preventive services makes good sense for people's health, but it can also make good fiscal sense. A recent report from the Trust for America's Health (TFAH) that the Robert Wood Johnson Foundation and The California Endowment supported found that even a small, strategic investment in proven community-based prevention programs could result in significant savings in health care costs. An in-

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vestment of $10 per person per year in programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save the country—Medicare, Medicaid and private payers—more than $16 billion annually within 5 years. That's a return of $5.60 for every $1 invested.[1]

Clinical preventive services (for example, childhood immunizations; screening for hypertension, diabetes and certain cancers; and counseling smokers to quit) also play a critical role in keeping us healthy, and should be a part of any comprehensive effort to improve the health of all Americans. Many of those services are cost-saving or cost-effective.[2]

Disease prevention and health promotion must be a priority, but this is an area that has been largely ignored and chronically underfunded by Federal, State and local governments. As you consider proposals for health reform, I urge you to increase stable funding and incentives for both community-based programs and clinical preventive services. An important first step is being taken by Congress and the Obama administration—with your leadership, Senator Harkin—in the increased investment in prevention proposed in the Economic Recovery and Investment Act. This would be an unprecedented investment in public health. We must make sure that in the context of health reform, we assure continued funding of these programs.

## PREVENTION PROGRAMS FOR VULNERABLE POPULATIONS

A tremendous range of promising and successful efforts to improve health and prevent disease are taking place in schools, neighborhoods and workplaces across the country, reaching the most vulnerable people where they live, work, learn and play. These are the places where health really happens, more than in hospitals and in clinics. Let me provide some illustrative programs that are improving the health of populations by engaging people at school, in their neighborhoods and at work.

*Schools*

Fifty-six million children attend an elementary or secondary school in the United States,[3] and schools offer a prime opportunity to reach kids where they spend most of their time. The Robert Wood Johnson Foundation has a long history of investing in the expansion of school-based health centers, which now number more than 1,500 across the country and provide critical health and health care services to vulnerable children and, in some cases, their families.

Health care, mental health and dental care are critical services to provide in school-based health clinics to reach children where they spend most of their time, but equally important is making sure that children are engaged in activity during the day that is safe and promotes learning. Recess at school should fulfill this need, but more and more schools are cutting the duration of recess time. We also see racial and ethnic disparities in cuts to recess: 14 percent of elementary schools with a minority enrollment, at least 50 percent do not schedule any recess for first graders; that compares with 2 percent of schools with less than 6 percent minority enrollment.[4] But often, when recess is in place, teachers, principals and schools nurses tell us how much they dread it: recess is when the fights break out; recess is when kids get injured. We've recently invested in an $18-million expansion of an innovative program called Sports4Kids, which is working to transform recess in schools across the country, using trained, full-time site coordinators who serve as coaches during recess and throughout and after the school day. Coaches, many of them AmeriCorps volunteers, teach students simple ways—like Rock/Paper/Scissors—to resolve conflicts and introduce them to games like Four Square and kickball, where everyone gets to play. Kids return to the classroom more focused, cooperative and ready to learn. Fights and injuries on the playground are down.

Schools are also a logical place to address the epidemic of childhood obesity, another important area for focusing on prevention. More than 23 million children and adolescents are obese or overweight—nearly a third of our Nation's kids ages 2 to 19—and African-American, Latino, Native American, Asian-American and Pacific Is-

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[1] Levi J, Segal LM, Juliano C. Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities (2008). Available online at *http://www.rwjf.org/publichealth/product.jsp?id=32711*.

[2] *See* Maciosek MV, Coffield AB, Edwards NM, Flottemesch TJ, Goodman MJ, Solberg LI. "Priorities Among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis." *Am. J. Prev. Med.* vol. 31, no. (1): 52–61. 2006a and National Business Group on Health. A Purchaser's Guide to Clinical Preventive Services: Moving Science into Coverage, 2007.

[3] Upcoming *Statistical Abstract of the United States: 2009*, Table 211. See *http://www.census.gov/compendia/statab/*.

[4] National Center for Education Statistics. *Calories in, Calories Out: Food and Exercise in Public Elementary Schools, 2005*. Fast Response Survey System (FRSS 2005): May 2006.

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lander children living in low-income communities are hit hardest.[5] The Robert Wood Johnson Foundation is investing $500 million over 5 years to reverse the epidemic, focusing on improving access to healthy foods and opportunities for physical activity in schools and communities, especially those with the fewest resources.

For instance, we are the major funder of the Alliance for a Healthier Generation's Healthy Schools Program, which works to improve nutrition, physical activity and staff wellness in schools nationwide. The program currently reaches more than 4,000 schools through in-person and online support—and more than 2 million students in all 50 States—with a particular emphasis on States with the highest rates of childhood obesity. Any school can sign up to join online and take advantage of free resources and tools to help create a healthier environment.

Senator Harkin, I know you're familiar with the program, and that you visited the Oak Street Middle School in Iowa this fall to see the changes, big and small, that the school has made through that program: getting soda out of the vending machines and getting water in; offering more fruits and vegetables in the cafeteria and getting rid of fried foods; and creating programs to encourage students to walk during recess.

The Alliance also has achieved major successes at the national level, such as forging an agreement with top beverage companies that already has resulted in a 58 percent reduction in the number of beverage calories shipped to schools. A similar agreement with snack food companies is helping to get healthier foods that comply with Alliance nutrition standards into schools. These are the kind of broad-scale changes that are needed to help local schools make healthy changes.

NEIGHBORHOODS AND COMMUNITIES

Neighborhoods and communities also present promising opportunities to prevent obesity, for people of all ages. As I said, if people don't have access to nutritious, affordable foods, and if they don't have opportunities to walk and play outside, it severely limits their opportunity to be healthy and to prevent and manage disease.

On average, low-income rural and urban communities have 25 percent fewer supermarkets than their wealthier counterparts. This scarcity of supermarkets coincides with a higher incidence of preventable diseases such as cardiovascular disease, cancer and diabetes. In a study of more than 10,000 people, African-Americans' intake of fruits and vegetables increased 32 percent for each supermarket located in the neighborhood.[6]

In Philadelphia, The Food Trust's Supermarket Campaign is helping to increase the number of supermarkets in low-income neighborhoods, improving access to fresh food and creating new jobs in the community. The initiative brings leaders from the supermarket industry together with public health and economic development professionals to address the barriers to supermarket development, securing public funds for pre-development and capital costs and developing a profitable business model to ensure sustainability. The Food Trust has played a critical role in forming a public-private partnership to support Pennsylvania's Fresh Food Financing Initiative. With $30 million in funding from the Commonwealth of Pennsylvania, this exciting initiative has leveraged an additional $90 million, thus far leading to 1.4 million square feet of new food retail space in 60 projects. The Robert Wood Johnson Foundation is supporting plans to replicate this success in Illinois, Louisiana and New Jersey.

As we consider the importance of taking prevention to where people will most benefit, the kinds of community-based programs that we think will lead to the kinds of cost savings that the TFAH report describes, we are also investing in a new program, called *Healthy Kids, Healthy Communities*. This initiative supports comprehensive approaches to combat childhood obesity in communities across the country. Nine leading sites are now working to increase local opportunities for physical activity and access to healthy, affordable foods for vulnerable children and families.

In Seattle/King County, in my home State of Washington, the Healthy Kids, Healthy Communities partnership focuses on policies that support healthy eating and active living in four public housing sites, linking public housing residents, housing authorities and community organizations to increase opportunities for physical activity and consumption of healthy foods. An additional 60 grants will be awarded for this program by the end of the year, with particular attention to communities in the 15 States with the highest rates of obesity.

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[5] Ogden CL, Carroll MD and Flegal KM. "High Body Mass Index for Age Among U.S. Children and Adolescents, 2003–2006." *Journal of the American Medical Association*, 299(20):2401–2405, 2008.

[6] Morland, K., Wing, S. Diez Roux, A. "The Contextual Effect of the Local Food Environment on Resident's Diets: The Atherosclerosis Risk in Communities Study." American Journal of Public Health; Nov. 2002; 92, 11.

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Although the majority of the Foundation's work to prevent and reduce obesity is focused on children, we also have supported efforts to ensure that older adults get the physical activity they need to stay healthy. A strong body of scientific evidence shows that physical activity can contribute to older adults' improved health and functional ability, as well as reduce chronic illness and disability.[7] Yet only 22 percent of adults 55–64, and 15 percent of adults 65 and older, exercise at least three times a week.[8]

Our *Active for Life* program focuses on delivering research-based physical activity programs to large numbers of mid-life and older adults and works to sustain such programs through existing community institutions, including community or senior centers, recreation centers, public health departments, housing authorities and religious institutions. In Memphis, for example, the Church Health Center collaborates with two community partners—the Metropolitan Inter-Faith Association and New Pathways Community Development Corporation—to provide telephone counseling to motivate older adults participating in the program.

Ensuring that all children get a healthy start in life is probably one of the most important steps toward promoting health that we can take as a nation. The Nurse-Family Partnership—supported by a range of public and private funding sources, including RWJF—works in 28 States to pair young, low-income pregnant women and first-time mothers with nurses who provide home visits during pregnancy and through the child's second birthday. Nurses counsel their clients about the importance of prenatal care, proper diet and avoiding cigarettes, alcohol and illegal drugs and help parents develop skills and strategies for caring for their babies responsibly. In addition, they work with the moms to develop a vision for their own future, including plans to continue their education and find work.

A 15-year study found that participants have positive outcomes in reducing child abuse and neglect, reducing behavior and intellectual problems among children, reducing arrests among children by age 15, and reducing emergency room visits for accidents and poisoning. A 2005 analysis by the RAND Corporation also found a $5.70 return for every dollar invested in the program.[9]

Another community-based prevention program for which we have solid evidence of success is Chicago's CeaseFire program. CeaseFire takes a public health approach to reduce neighborhood violence, working with community-based organizations to develop and implement strategies to prevent and reduce violence, with particular emphasis on shootings and killings. CeaseFire involves outreach workers, faith leaders and other community leaders to change community norms around violence and retaliation. They also hire former offenders who operate as "violence interrupters" and who intervene directly to prevent violent incidents. Public education campaigns round out the intervention to reinforce the message that shootings and violence are not acceptable. One poster used in Chicago shows a child's face, with the tagline "Don't shoot. I want to grow up." It's very powerful, and we have the data to prove it.

An extensive evaluation by the U.S. Department of Justice shows that the program reduces shootings and killings and makes neighborhoods safer. CeaseFire neighborhoods have seen up to a 73 percent reduction in shootings and killings. CeaseFire also provides help for young people to find jobs, educational opportunities and drug counseling. Replication efforts are currently underway in other cities—Baltimore, Pittsburgh, and Kansas City, MO—with plans for expansion to New York, Albany, Rochester and Buffalo.

Homelessness is a growing problem, exacerbated today, of course, by the mortgage finance meltdown. Roughly 70 percent of the chronically homeless in America are burdened with serious health problems, mental health issues, or problems with substance abuse. For many, those concerns are the root causes of their homelessness. Simply providing four walls and a roof only offers a partial solution.

Since 1991, the Corporation for Supportive Housing has been working to respond to the need for housing that's tightly connected to medical and social services to get and keep clients off the streets. The corporation tests the feasibility of supportive housing, raises funds to support its projects, and offers technical assistance to local and State agencies dealing with chronic homelessness. The idea is to create a se-

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[7] For an overview, see RWJF's National Blueprint: Increasing Physical Activity Among Adults Age 50 and Over, March 2001. Available at *http://www.rwjf.org/files/publications/other/Age50BlueprintSinglepages.pdf*.

[8] Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data.* Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007.

[9] Karoly LA, Kilburn MR and Cannon JS. *Early Childhood Interventions: Proven Results, Future Promise.* Santa Monica, CA: RAND, 2005. Available online at *http://www.rand.org/pubs/monographs/2005/RAND__MG341.pdf*.

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cure, inviting environment where formerly homeless tenants feel safe and have a sense of dignity.

Research shows that getting chronically homeless people into supportive housing reduces use of shelters and hospitals, and time spent in jail.[10] Studies also demonstrate the cost-effectiveness of supportive housing. In Los Angeles, for example, where a single day's stay at a mental hospital averages $607, the daily cost of incarceration is $85, and a shelter's daily cost is $37.50. The equivalent cost of supportive housing remains the lowest, at $30. Cost comparison studies in Boston, Chicago, New York and other cities show similar findings.

*Workplaces*

When I talk about non-medical interventions that affect health, I have to mention the Robert Wood Johnson Foundation Commission to Build a Healthier America.[11] The Commission is chaired by Mark McClellan and Alice Rivlin, and is exploring the impact that factors like education, housing, income and race have on health. Over the last year, the Commission has held a series of field hearings: in North Carolina, the focus was on the links between early childhood development and health; in Philadelphia, on the ways that physical and social environments affect health.

In December, a field hearing in Denver focused on the relationship of work and the workplace to health. When I think of health promotion initiatives in the workplace, the first thing that comes to mind is that we know that smoke-free policies improve workers' health. A complete smoking ban in the workplace reduces smoking prevalence among employees by 3.8 percent and daily cigarette consumption by 3.1 cigarettes among employees who continue to smoke.[12] And in New York City, smoking prevalence among adults decreased by 11 percent (approximately 140,000 fewer smokers) from 2002 to 2003 following the implementation of a comprehensive municipal smoke-free law, a cigarette excise tax increase, a media campaign, and a cessation initiative involving the distribution of free nicotine replacement therapy.[13]

We at RWJF are proud to have supported numerous successful smoke-free workplace initiatives. But the Commission's hearing focused more broadly on work and health, and highlighted some promising and creative workplace health initiatives.

On average, American adults spend nearly half of their waking hours at work.[14] Where we work influences our health, not only by exposing us to physical environments and conditions that have health effects, but also by providing a setting where healthy activities and behaviors can be promoted. In addition to features of worksites, the nature of the work we do and how it is organized also can affect our physical and mental health. Work can provide a sense of identity, social status and purpose in life, as well as social support. For most Americans, employment is the primary source of income, giving them the means to live in homes and neighborhoods that promote health and to pursue health-promoting behaviors.

Healthy workers and their families are likely to incur lower medical costs and be more productive, while those with chronic health conditions generate higher costs in terms of health care use, absenteeism, disability and overall reduced productivity.

Workplace-based wellness and health promotion programs are employer initiatives directed at improving the health and well-being of workers and, in some cases, their dependents.[15] Although most workplace-based wellness programs focus primarily on providing traditional health-promotion and disease management programs on site, some model programs integrate on-site elements with health resources outside of the workplace and incorporate these benefits into health insurance plans. While larger worksites offer more health promotion programs, services and screening programs and policies, only 7 percent of employers in 2004 offered a comprehensive worksite health promotion program that incorporated five key elements defined in *Healthy People 2010*: health education, links to related employee

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[10] Culhane DP, Metraux S and Hadley T. "Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing." *Housing Policy Debate*, 13(1): pp. 107–163, 2002.

[11] *See http://www.commissiononhealth.org*.

[12] Fichtenberg CM, Glantz SA. Effect of Smoke-Free Workplaces on Smoking Behaviour: Systematic Review. British Medical Journal. 2002;325:188.

[13] Frieden TR, Mostashari F, Kerker BD, Miller N, Hajat A, Frankel M. Adult Tobacco Use Levels After Intensive Tobacco Control Measures: New York City, 2002–2003. American Journal of Public Health. 2005;95(6):1016–1023.

[14] "Table 1. Time Spent in Primary Activities (1) and Percent of the Civilian Population Engaging in Each Activity, Averages Per Day by Sex, 2007 Annual Averages. *Economic News Release.* Washington, DC: U.S. Department of Labor, Bureau of Labor Statistics, 2007.

[15] Goetzel RZ, Ozminkowski RJ. "The Health and Cost Benefits of Work Site Health-Promotion Programs." *Annual Review of Public Health*, 29: 303–23, 2008.

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services, supportive physical and social environments for health improvement, integration of health promotion into the organization's culture, and employee screenings with adequate treatment and follow up.[16] But in Denver, we heard about some workplace programs with promising and impressive results. The insurance company USAA's Take Care of Your Health program centers around simple health messages to employees and their families that are reinforced by programs at several levels, including individual health risk assessments and campus-wide policies. Wellness programs—ranging from on-site fitness centers and healthier food choices in worksite cafeterias to lifestyle coaching—are integrated with disability management, a consumer-driven health plan and paid time off. Participants have achieved reductions in weight, smoking rates and overall health risk status, and the decrease in participants' workplace absences has saved more than $105 million over 3 years.

CONCLUSION

Whether or not a person stays well in the first place has much to do with his or her daily behaviors and environment. Our aim should be to stop poor health and disease before it starts and keep as many people healthy and out of the health care system as possible. Strategic investment in disease prevention and population health saves lives, strengthens families and communities, makes for more productive workers and reduces health care spending. By supporting policies and programs that keep us healthy, the government, the public health system, businesses, community organizations, schools and faith-based groups can do more to meet our collective responsibility to help citizens lead healthier lives.

Even though America spends more than $2 trillion annually on health care, we do not have the healthiest people. Ninety-five percent of health spending goes toward medical care and biomedical research, and only 5 percent to public health and disease prevention. Yet public health threats like inactivity, obesity and tobacco use are putting millions of adults and children at risk for unprecedented levels of major chronic diseases—many of them preventable. By investing in prevention, we could save money and reduce the burden of preventable diseases such as heart disease, cancer and diabetes.

Right now, America's health care system is set up to focus on treating people once they already have a health problem. We must shift that focus to preventing people from getting sick in the first place, investing in policies and programs that make it easier for all Americans to enjoy the benefits of good health.

I am not here to ask for big new Federal spending. What I believe we need is to reconfigure what we spend to build a "culture of wellness" in this country—ensuring that wellness is a consideration in the insurance policies that employers offer; in urban planning so that sidewalks are safe and inviting; in building more public-private partnerships like the Food Trust so that more people have access to the kind of grocery stores that you and I use.

The good news is that there is a lot of health promotion going on in some communities—and I've told you a lot about those. We need to work together to make sure that programs that are working are available in more communities across this country, especially communities where residents are most disadvantaged and farthest from being as healthy as they could be if they had the opportunity to make healthier choices. We at the Foundation believe that this country can be healthier and we stand ready to work with others who will help create the national "culture of wellness" that can speed our progress toward good health for all. Now more than ever, we have the opportunity for comprehensive, meaningful health reform, and we must take bold steps where we have been timid in our policies to protect and preserve health, to rebuild what we have let crumble in public health, to help our people stay healthy and our businesses stay competitive.

Senator HARKIN. Thank you very much, Doctor.

Now we will go to Dr. Stevens. Dr. Stevens, I have already previously introduced you. Please proceed.

[16] Linnan L, Bowling M, Childress J, et al. "Results of the 2004 National Worksite Health Promotion Survey." *American Journal of Public Health*, 98(8): 1503–9, 2008.

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**STATEMENT OF DAVID M. STEVENS, M.D., DIRECTOR OF THE QUALITY CENTER AND ASSOCIATE MEDICAL DIRECTOR, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, BETHESDA, MD**

Dr. STEVENS. Sure. I want to say good morning to members of the committee, and I, too, would like to thank you, Senator Harkin, and Senator Enzi and Chairman Kennedy for inviting me here today.

It is my privilege to present on behalf of the 18 million Americans currently receiving care at our Nation's community health centers and the countless others from across the country that make up the community health center movement. As the health providers that stand at the nexus of cost, quality, and access, health centers can offer great insights into this committee's efforts.

Given the subject of today's hearings, I just wanted to briefly discuss the patients we serve. Today, health centers nationwide provide primary and preventive care to 18 million people. Seventy-one percent are at or below poverty. Thirty-nine percent are uninsured. Thirty-five percent are on Medicaid, and 64 percent of health center patients are of ethnic minorities, half from rural areas, half from urban, and our patients are also more likely to be disabled than others in other primary care settings.

How well do health centers do in averting disease through primary prevention, which is early detection of disease; through secondary prevention, which is preventing or ameliorating complications of chronic disease; or tertiary prevention?

Research has found that health center patients, both uninsured and Medicaid recipients, receive significantly higher levels of health promotion counseling then their counterparts. This includes higher rates of counseling on physical activity, smoking, and alcohol use, the three top contributors to mortality in our Nation.

A study from GW also documented higher rates of secondary preventive services, such as Pap smear, mammography, and cholesterol testing, than Medicaid or uninsured patients in other settings.

Health centers also excel in tertiary prevention. For example, health center patients with diabetes have improved glucose control, improved cholesterol levels, and greater use of medicines that prevent kidney failure and heart attack.

This excellence in prevention has led to significant overall cost savings. For example, in South Carolina, patients with diabetes enrolled in the State Employees Health Plan treated in non-health center settings were four times more costly than those in the same plan who were treated in community health center. The health center patients also had lower rates of emergency room use and hospitalization.

This excellence in prevention has led to a reduction in health disparities. Nationwide data shows that low-income Hispanic, African-American, and Medicaid female health center patients have a significantly higher likelihood of receiving a mammogram versus their counterparts. Each of these groups of health center patients also surpass the Healthy People 2010 target of 70 percent.

Health centers improve the overall quality of life, which is probably the most important thing, for their patients and communities. In a study of the impact of community health centers, Health Dis-

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parities Collaborative effort on diabetes evidence showed that over a lifetime the incidence of blindness, kidney failure, and coronary artery disease were reduced.

The Health Disparities Collaborative, a health center quality initiative to improve the delivery systems at health centers, does provide a framework for how our Nation could change the healthcare system.

Why are health centers so effective in providing preventive services? Well, first, we firmly believe that health center success is rooted in the FQHC comprehensive primary care model. Essential components of the model include location in high-need area, comprehensive health and enabling services, open to all regardless of ability to pay, control by consumer majority board, and strict performance and accountability requirements.

Another reason is our track record of partnerships with schools, community agencies, and local governments. As Senator Harkin knows from Iowa, where Ted Boesen and the health centers led in the Iowa Collaborative—or they lead because it is still going on—in the Iowa Collaborative Safety Net Provider Network, health centers form effective partnerships with free clinics, rural health clinics, local and State health departments, providers, and other community-based organizations and academia to improve access and the quality of preventive and primary care services.

We believe that health reform must recognize the need for fundamental system change. According to a recent article by Nolte and McKee in Health Affairs, our Nation is last among 19 industrial nations for preventing potentially preventable deaths for people under the age of 75. According to the CDC, we are 29th in the world in infant mortality.

To address these alarming statistics, health reform must enhance the collaboration between public health and comprehensive healthcare modeled by health centers. We should ensure that with the necessary insurance coverage expansions we do not neglect access and the way in which prevention and primary care are delivered.

With our 43-year track record of improving health and enhancing preventive care community by community, we stand ready and willing to engage in this effort, for it, indeed, takes a village to improve our Nation's health status.

Thank you, Senator.

[The prepared statement of Dr. Stevens follows:]

PREPARED STATEMENT OF DAVID STEVENS, M.D.

Good morning, members of the committee. First, I would like to thank the committee for inviting me here today. It is my privilege to present on behalf of the 18 million Americans currently receiving care at our Nation's community health centers, and the countless others from across this country who make up the community health centers movement. As the health providers that stand at the nexus of cost, quality, and access, health centers can offer great insights into this committee's efforts.

Given the subject of today's hearing, let us discuss briefly the patients we serve. Today, health centers nationwide provide primary and preventive care to 18 million patients; 71 percent are at or below poverty, 39 percent are uninsured, and 35 percent are on Medicaid. Sixty-four percent of health center patients are ethnic minorities; half are rural residents, half urban. Our patients are also more likely to be disabled than patients in other primary care settings.

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How well do health centers do in averting disease through primary prevention, early detection of disease through secondary prevention, and preventing or ameliorating complications in patients with chronic disease, or tertiary prevention?

A recent GW analysis found that CHC (Community Health Center) patients, both uninsured and Medicaid recipients, receive significantly higher levels of health promotion counseling than their counter parts. This includes higher rates of counseling on physical activity, smoking and alcohol use—the three top contributors to mortality in our Nation. The study also documented higher rates of secondary prevention services such as Pap smear, mammography, and cholesterol testing than Medicaid or uninsured patients in other settings.

Health centers also excel in tertiary prevention. For example, health center patients with diabetes have improved glucose control, improved cholesterol levels, and greater use of medicine to prevent kidney failure and heart attack.

This excellence in prevention has led to significant overall cost savings.

For example, in South Carolina, diabetic patients enrolled in the State employees' health plan treated in non-CHC settings were four times more costly than those in the same plan who were treated in a community health center. The health center patients also had lower rates of ER use and hospitalization.

This excellence in prevention has led to a reduction in health disparities.

Nationwide data shows that low-income Hispanic, African-American, and Medicaid female health center patients have a significantly higher likelihood of receiving a mammogram versus their counterparts. Each of these groups of health center patients also surpasses the Healthy People 2010 target of 70 percent.

In another example, health center patients on average have lower rates of low-birth weight than their U.S. counterparts, with notably lower rates of low-birth weight for Black, Hispanic, and Asian women.

Health centers improve the overall quality of life for their patients and communities. In a study of the impact of community health centers' Health Disparities Collaborative (HDC) effort on diabetes, evidence showed that over a lifetime, the incidence of blindness, kidney failure, and coronary artery disease were reduced. The Health Disparities Collaboratives, a health center quality initiative to improve the delivery systems at Health Centers provides a framework for how the United States could change the healthcare system.

Why are health centers so effective in providing preventive services?

We firmly believe that health center success is rooted in the FQHC (Federally Qualified Health Center) comprehensive primary care model. Essential components of the model include: location in a high-need area; comprehensive health and enabling services; open to all regardless of ability to pay; control by consumer-majority board; and strict performance and accountability requirements.

Another reason is our track record of partnerships with schools, community agencies and local governments. As Senator Harkin knows from Iowa, where Ted Boesen and the health centers lead in the Iowa Collaborative Safety Net Provider Network, health centers form effective partnerships with free clinics, rural health clinics, local and State health departments, providers, other community-based organizations, and academia, to improve access, and the quality of preventive and primary care services.

Yet, there is still room to do more. A February 2002 NEJM study demonstrated that lifestyle interventions with pre-diabetes patients could reduce the onset of diabetes by 58 percent, while drug therapy could reduce the onset by over 30 percent. When the CDC piloted this on the ground at 5 health centers, it worked. But we need to develop a sustainable way to fund this type of public health/health center collaboration on a larger scale.

We believe that Health Reform must recognize the need for fundamental systemic change. According to a recent article by Nolte and McKay in Health Affairs, our Nation is last place among 19 industrialized Nations in potentially preventable deaths for people under the age of 75. According to the CDC, we are 29th in the world in infant mortality. To address these alarming statistics, health reform must enhance the collaboration between public health and comprehensive primary healthcare modeled by health centers. We should ensure that with the necessary insurance coverage expansions, we do not neglect access and the way in which prevention and primary care are delivered. With our 43 year track record of improving health and enhancing preventative care, community-by-community, we stand ready and willing to engage in this effort, for it indeed takes a village to improve our Nation's health status.

Senator HARKIN. Thank you very much, Dr. Stevens.

There is a question I want to ask you more about and that is why they are so different. Why, why, why? And using that model in other places.

Mr. Meit. Again, looking at rural health, where we have some real problems in rural America.

Mr. MEIT. Yes, absolutely. Thank you very much.

Senator HARKIN. Welcome. Thank you. Please proceed.

**STATEMENT OF MICHAEL MEIT, M.A., M.P.H., PRINCIPAL RESEARCH SCIENTIST FOR NORC AT THE UNIVERSITY OF CHICAGO AND DEPUTY DIRECTOR OF THE NORC WALSH CENTER FOR RURAL HEALTH ANALYSIS, CHICAGO, IL**

Mr. MEIT. I would like to start by thanking the committee for inviting me to provide testimony today.

Today, I am going to talk about the need for public health capacities in rural jurisdictions rather than the need for accessible healthcare services, and I want to begin by emphasizing that access to healthcare services remains a critical challenge throughout the rural United States and one that must not be overlooked.

My intent is not to minimize the issue of access to healthcare services, but rather to demonstrate that the issues that we face today, issues such as increasing concern over infectious disease, increasing prevalence of chronic conditions and preventable conditions, and issues such as emergency preparedness, these issues call for access to a strong public health system throughout our rural communities, in addition to a strong healthcare delivery system.

Public health capacities in rural areas are strained, and they are often nonexistent. This is particularly true in our frontier areas, but also true through much of the United States and throughout rural America.

Why do we need strong public health capacities in rural America? Well, I think if you look at the health data, they speak for themselves.

In August 2001, the CDC released its first-ever report on health status relative to community urbanization levels. I might also add that this is the only time the CDC has done a report looking at health status relative to community urbanization levels. This is the only time they have looked at rural health status specifically.

Specific findings from that report demonstrated a number of disparities in health status between rural and urban Americans, including higher rates of smoking, increased heart disease mortality, higher suicide rates, higher mortality rates from unintentional injury, and lower rates of health insurance coverage.

Recent analyses conducted by NORC at the University of Chicago further show that rural residents are more likely to report their overall health status to be fair or poor and report higher prevalence of chronic preventable conditions, such as hypertension, arthritis, diabetes, and cardiovascular disease. In my written testimony, you will see some of those charts that display that.

At this point, I would like to shift focus from describing the problem to providing some tangible recommendations for improving public health capacities in rural areas. The first of these comes from the National Rural Health Association (NRHA), which in 2004 released a policy statement on rural public health.

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First, the rural public health workforce, most of which has no formal education in public health, needs support through training that is accessible to them in their rural communities. We are talking about distance education and continuing education provided through distance technologies.

There are fewer public health workers per capita in rural America, and they simply cannot get away from their jobs to attend trainings hundreds of miles away.

Second, communication systems and technological capacities within rural public health systems need to be strengthened to be able to effectively deliver health prevention messages, manage public health emergencies, conduct effective disease surveillance, and receive up-to-date health information.

The technological capacities in our rural health departments are not up to par at this point. And again, that is assuming that a community is served by a health department. Many communities, to this day, are not.

And third, greater flexibility is needed in the use of public health resources to respond to local public health priorities. I think this last point is worthy of a bit more attention.

At NORC, we conducted a study on this issue that demonstrated that rural health departments have proportionately less local funding as compared to urban health departments. This means that rural health departments have less funding that they control to respond to locally identified needs.

Allowing greater flexibility in the use of State and Federal funding would make rural agencies more responsive and, I believe, more effective. I think this could be accomplished by tying State and Federal funds to local public health assessments and holding health departments accountable to addressing their locally identified needs.

As the system stands now, local health departments must implement categorically defined programs from State and Federal agencies rather than locally defined priorities.

In addition to the NRHA recommendations, I would like to offer one more. I believe that the CDC, our Nation's premier public health agency, should establish an Office of Rural Public Health dedicated to providing leadership within CDC on rural public health issues. A key deliverable of that office should be an annual report on rural health status.

Recall that CDC has only once conducted a comprehensive report on health status by levels of urbanization, and that report has not been updated since 2001. Unless we have a clear grasp of the issues we face and up-to-date data to support them, we cannot effectively address those issues.

In closing, I would like to make one final point. There is a connectedness between our rural and our urban communities. Rural health is in all of our interests. If our rural communities are not safe and healthy, all of us are placed at increased risk, whether from infectious diseases or food-borne outbreaks that are not identified early or from the tremendous costs of preventable chronic conditions that are borne out by all of us through high insurance premiums and costs to our healthcare systems.

Again, thank you for allowing me to testify today.

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[The prepared statement of Mr. Meit follows:]

PREPARED STATEMENT OF MICHAEL MEIT, M.A., M.P.H.

When the topic of "rural health" is raised, whether by policymakers, the general public, or even public health professionals, the conjured vision is often one of individuals having difficulties accessing healthcare services due to a lack of facilities and/or providers. While the issue of access to care remains a critical challenge throughout rural America, and one that must not be overlooked, we must take a broader view of rural health. It is clear that rural citizens face significant health disparities when compared to the general population and that access to healthcare services, albeit important, is only one of many factors influencing their health. Other factors, such as health behaviors among rural citizens, persistent poverty, disease surveillance challenges created by smaller populations, unique environmental factors, and too many others to list, call for a public health response to addressing rural health concerns.

From a historical perspective, the lack of public health focus in rural jurisdictions is not a surprise. The field of public health emerged in the late 18th century as an urban concern, dealing with issues of sanitation and infectious disease that were common in urban centers. Rural areas, on the other hand, were considered by their very nature to be healthy—clean water and clean air were thought to be curative, and sick urban residents were often sent to the country to recuperate. Only when urban public health issues began to be addressed, and health data started to demonstrate that rural residents were now less healthy than their urban counterparts, did it become evident that public health interventions could also benefit rural citizens. This was articulately stated in 1899 by Pennsylvania Governor Daniel H. Hastings, who reported to the Pennsylvania legislature that it was fiction to assume "that the country districts are naturally so healthy that there is no need for laws to prevent disease."[1] Still, it wasn't until the early 1900s, over 100 years after the development of the first urban health departments, that a second wave of public health capacity development began, this time in rural jurisdictions. Around this same time, however, great advances were also being made in medicine, and the primary focus of rural health activity soon shifted to ensuring access to health care services rather than public health preventive measures. I do not say this to denigrate the importance of providing access to health care services—medical services are clearly a critical component to ensuring healthy rural populations—but rather to demonstrate an imbalance in our rural focus between care and prevention. To ensure a healthy population, both are clearly necessary.

To see the need for public health prevention in rural jurisdictions one must only look at the health data, which speak for themselves. In August, 2001, the National Center for Health Statistics at the Centers for Disease Control and Prevention released the 25th annual statistical report on the Nation's health. This report presented the first look at the Nation's health status relative to community urbanization level. Specific findings demonstrated a number of disparities in health status between rural and non-rural citizens including the following:

- teenagers and adults in rural counties were more likely to smoke;
- residents of rural communities had the fewest dental care visits;
- death rates for working-age adults were highest in the most rural and most urban areas;
- heart disease mortality rates where higher among rural residents;
- suicide rates were higher among rural residents;
- rural areas had a high percentage of residents without health insurance; and
- residents of rural areas had the highest death rates for unintentional injuries in general, and for motor-vehicle injuries specifically.[2]

More recent analyses conducted by NORC at the University of Chicago in 2008 confirm many of the findings from the 2001 CDC report, and demonstrate the ongoing challenges faced by rural residents, who are more likely to report their overall health status to be fair or poor than non-rural residents (Figure 1), and who report prevalence of chronic, preventable conditions to a greater degree than non-rural residents (Figure 2).

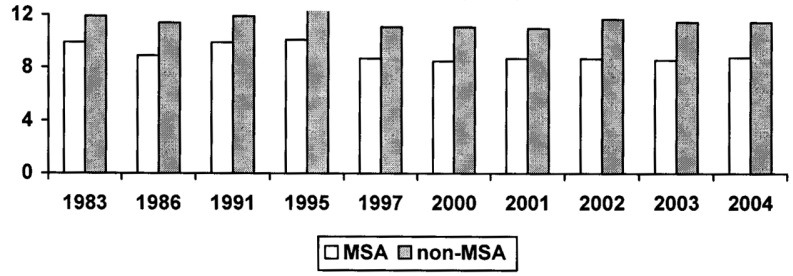
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[1] "Biennial Message, Governor Daniel Hartman Hastings, January 1, 1899," *Pennsylvania Archives*, 4th ser., 12 (Harrisburg, PA, 1902), 315.

[2] *Health, United States, 2001 With Rural and Urban Health Chartbook.* Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Health Statistics; 2001.

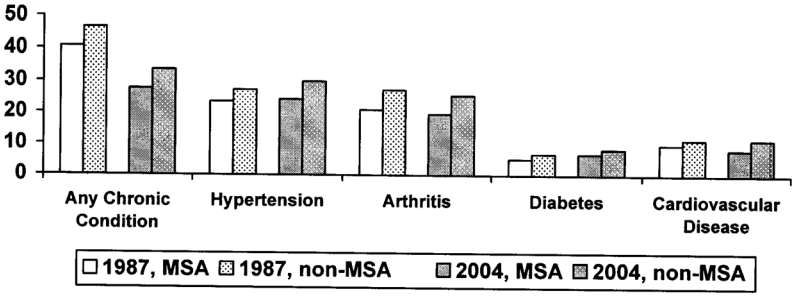
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**Figure 1. Percent Reporting Fair or Poor Health Status**
**Metropolitan Statistical Area (MSA) vs. Non-MSA**




Source: National Health Interview Survey.
All percents are adjusted for differences in age distribution of population.

**Figure 2. Prevalence of Selected Chronic Conditions**
**Metropolitan Statistical Area (MSA) vs. Non-MSA**




Source: 2004 Medical Expenditure Panel Survey, 1987 National Medical Expenditure Survey.

To effectively address these issues, I believe that a robust public health infrastructure is needed that provides services to all citizens in all communities. Public health has been called a system of "organized community efforts aimed at the prevention of disease and promotion of health." Its work is often described as three core functions: ***assessing*** the health needs of a population, ***developing policies*** to meet these needs, and ***assuring*** that services are always available and organized to meet the challenges at the individual and community levels. While aspects of these functions may be delegated to, or voluntarily carried out by, private-sector professionals and organizations, ultimate responsibility and accountability rests with governments at the local, State, and Federal levels. The issues that we face in rural communities clearly require a coordinated response from both our governmental public health system and our private health care delivery system. However, in many rural jurisdictions the governmental public health authority either lacks capacity, or doesn't even exist. Many rural and frontier areas have no local health department at all, and those public health departments that do serve rural areas face significant challenges in recruiting and retaining qualified personnel, especially those with formal public health training such as public health nurses and epidemiologists.

In 2004, the National Rural Health Association (NRHA) took a critical look at the health issues facing rural Americans and the capacities of both the healthcare delivery system and the public health system to address them. The association recognized that the healthcare delivery system alone will not be able to eliminate the

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health disparities faced throughout the rural United States and adopted the following recommendations [3]:

• *All citizens and all communities* should have comparable access to agencies and individuals that assure the provision of the essential public health services. Whether provided locally or on a regional basis, by governmental agencies or the private sector, every citizen has the right to expect access to the full complement of essential public health services in their community.

• Public health is a common good and that there is a governmental responsibility to *assure* access to essential public health services in every community. Regardless of who actually provides the service, there is a governmental responsibility to provide oversight and the governmental public health infrastructure must be strengthened to support this role.

• The rural public health workforce needs support through training and continuing education that is accessible to them in their rural communities, and that is appropriate for their current level of training and experience. A key ingredient to assuring adequate public health services is a competent public health workforce. Whether employed in the public or private sector, public health workers must be well versed in their field.

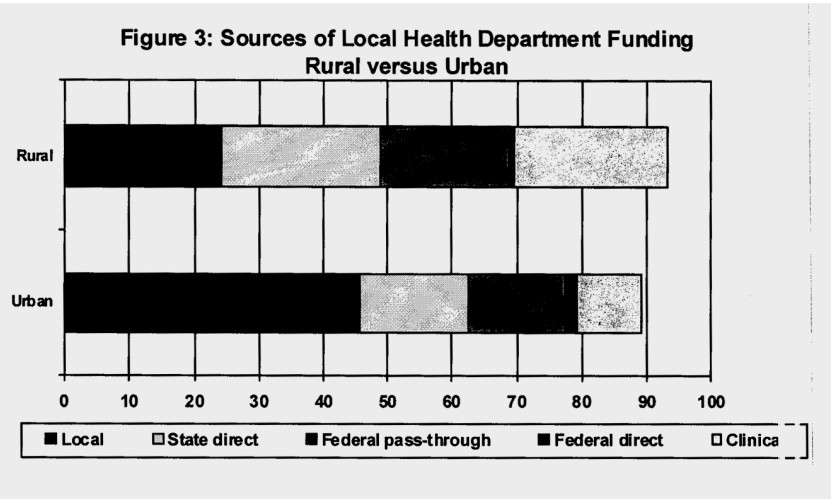
• Communication systems and technological capacities within the rural public health system need to be strengthened. In order to effectively manage public health emergencies, conduct disease surveillance, or simply receive up-to-date public health information, rural public health must have access to advanced communications systems and technologies.

• Greater flexibility is needed in the use of public health resources to respond to local public health priorities. The current public health system is limited by categorical funding which often forces it to address State and Federal priorities rather than local needs. Public health works best when it is responsive to locally identified priorities. Funding streams need to support rather than inhibit this responsiveness.

This last point is worthy of a bit more attention. It is important to note that while local health departments typically receive funding from local tax sources in addition to State funding and Federal pass-through funding, rural health departments (where they exist) rely disproportionately on State and Federal funding as compared to their urban counterparts. Having proportionately less local funding, which the health department has greater control over, means that rural health departments have less capacity to respond to local needs than non-rural health departments. State and Federal funding could be distributed to more effectively allow for local flexibility by tying program activities to local health assessments and holding the health departments accountable to addressing those locally identified needs. As the system works now, health departments are required to implement programs within the categorically funded focus areas, which may or may not correspond to local needs. Figure 3 shows findings from a recent NORC at the University of Chicago study detailing the proportion of rural versus urban local health department funds by source.

[3] NRHA policy statement available online at *http://www.nrharural.org/advocacy/sub/policy briefs/public_hlth.pdf*.

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In addition to the NRHA recommendations, which I believe are all sound, I would like to offer one more that I feel would benefit rural communities in a tangible way. Earlier I discussed the CDC's 2001 report on health status relative to community urbanization levels. These data continue to be the basis for much of our understanding of rural health status, but they are clearly dated. CDC should regularly conduct analyses relative to community urbanization levels. Further, I would recommend that CDC establish an office dedicated to investigating issues of importance to rural public health—a report on rural health status could be an annual deliverable from that office. I think it is notable that the only dedicated office with a rural focus within the Department of Health and Human Services exists within the Health Resources and Services Administration (HRSA). That office does considerable work to ensure access to healthcare services for rural citizens, and its value to improving health in rural communities is immeasurable. A similar dedicated focus at CDC could provide the same kind of dedicated Federal attention for public health and prevention, that HRSA provides for access to health care services.

In closing, I would like to make one final point. This issue of rural health is not just a rural issue. Ensuring the health and well-being of our rural citizens is in the interest of all of us, rural, urban and suburban. We live in a mobile society, and there are strong connections between urban and rural communities, including familial relationships, agricultural production and delivery, and commerce. We need a strong system in place in our rural communities that both ensures access to quality health services *and* a strong public health infrastructure that delivers important health messages to its citizens, identifies and mitigates the effects of infectious diseases and foodborne outbreaks, and helps to respond effectively to emergencies such as natural disasters and infectious disease outbreaks. In the end, it is important to recognize that the health of all of us depends upon all of our communities having effective health care delivery and public health capacities.

Senator HARKIN. Thank you very much, Mr. Meit.

Dr. Iezzoni is on her way here. I know she has entered the building. We will just move ahead.

Dr. Butler, I introduced you before here, but a longtime friend, founder of our National Institute on Aging at NIH, and the foremost expert on the problems of aging. Of course, what we are looking at here is preventive healthcare and wellness and how we get that to our elderly population. I, of course, read your testimony last night.

Welcome again to this committee. You have been here many times in the past and I appreciate your being here again this morning.



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**STATEMENT OF ROBERT BUTLER, M.D., PRESIDENT AND CEO, INTERNATIONAL LONGEVITY CENTER—USA, NEW YORK, NY**

Dr. BUTLER. It is a pleasure to be here. I want to speak from the perspective of gerontologists and geriatricians and in the context of the country, the United States, that actually over the last years has dropped from 11th place in life expectancy to 42d place in life expectancy. It is very serious.

People not only want to live long, but they want to remain in good health. We pretty much know what the necessary ingredients are, but it is very difficult to live up to those requirements. I would like to identify seven key features of healthy aging.

One is an appropriate low-calorie diet with seven to nine fruits and vegetables each day, multivitamins with particular attention to vitamin C, which requires, in turn, exposure to sunlight in order to activate vitamin D.

Second is the vast importance of physical activity, not just aerobics four or five times a week, but muscle strengthening, particularly of the quadriceps or the thigh muscle because it is the number-one predictor of frailty in old age. Just doing squats makes an enormous difference.

Falls are the No. 12 cause of death in people over 65 years of age, and obviously, balance and muscle are crucial, as are flexibility and posture.

Third is obviously smoking cessation.

Fourth is the very moderate use of alcohol, the equivalent of no more than one glass of wine per day.

Fifth, and the most difficult of all, managing stress through meditation, yoga, visualization, mini vacations, appropriate sleep.

Sixth, and then a couple that are not often mentioned. Building a strong support system and a social network of friends and relationships. This may be one reason women outlive men by over 5 years because they seem more gifted at dealing with intimacy issues of grief and problems than we men are.

Seventh, is a sense of purpose. We discovered this in the 1950s in our work at the National Institutes of Health that people who had a purpose in life, something to get up for in the morning, actually not only live longer, but they live better.

It is not a bad idea for older people, particularly in these times, to continue to work. After all, we are living longer. We really should work longer. It would make a huge difference in the Social Security system as we discovered in hearings, in such a hearing as this some many years ago.

Of course, people should be providing active help and resources to other people. Think of all the scientists, engineers, mathematicians who could be contributing tremendously to after-school enrichment programs for kids in a country that is number 18 in science and math literacy.

We know that perhaps no more than 25 percent of our health and longevity depends upon genes. That is power. That means 75 percent of it is up to us.

Now in order to assist people to maintain healthy aging by undertaking the activities I described, how can we help them? Some help, of course, could be derived from the doctor-patient relationship. The truth is today doctors have about 12 minutes per patient.

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We have to turn to a larger message. We have to be much more concerned with the public health system.

Doctors today are primarily engaged in a sickness system, not a healthcare system. Doctors and hospitals do not have incentives to maintain health. They, in fact, have incentives through profit through disease. I say this as a physician.

I believe we have to expand our efforts at prevention through a broad public health perspective. For example, there are some 15,000 senior centers throughout the United States. These are community facilities—5,000 of which receive some support from our Administration on Aging.

The utilization rate, however, is not what it should be. Relatively few people attend these senior centers. They need to be dramatically transformed.

First, they should be health promotion centers themselves, promoting exercise, squats, and the like. They should also be dedicated to deriving from such older persons more direct purpose of activities that would be constructive for society.

Now taxation and education were very effective in the 50 percent reduction of smokers in the United States since 1964. On the other hand, alcohol in America is marked by a significant number of hard-core alcoholics affecting one out of every four American families.

We are not being adequately attentive to the problems of alcoholism in America. It accounts for most abuse within families, contributes significantly, about 20 percent of all the highway fatalities and other accidents. At times, people get misdiagnosed as Alzheimer's disease when they have alcoholic dementia.

Alcohol taxes used to constitute a significant part of Federal revenue. In fact, there has only been a few increases in liquor taxes since the 1950s. This is an issue that I think should be revisited by Congress if we are going to have a serious health promotion effort in this country.

Now I would like to call upon all citizens of America, including our new President, the President's Council on Physical Fitness and Sports, U.S. Preventive Task Force, and other appropriate organizations, to help sponsor a national walking movement where friends, neighbors, and families could walk together. This is not expensive. It doesn't require membership in a health club.

Of course, healthy aging is a life course issue. It is not something you simply introduce at 50, 60, or beyond. A few years ago, several of us wrote a widely quoted paper in the New England Journal of Medicine on the problem of obesity in America and the prospect that we could lose 3 to 5 years of the 30 years of additional years of life that we had gained in the 20th century.

Further, we said, for the first time in our history, our children might not live as long as their parents. It is, indeed, dreadful to see 10-year-old children with obesity and old-age type 2 diabetes. A national walking movement is simple, but an important way to deal with the problem of obesity.

Finally, and to repeat, it is urgent to realize the cost of failed health promotion and disease prevention. We must now go beyond the doctor-patient relationship to achieve the goals of healthy

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aging, which requires, of course, healthy living throughout life. It is never too late to start and always too soon to stop.

On another occasion, I might speak of a new paradigm derived from recent remarkable advances and understanding of the basic biology of aging. For it is now possible to slow aging while simultaneously delaying the onset of diseases associated with aging. That is a big step forward.

Thank you.

[The prepared statement of Dr. Butler follows:]

PREPARED STATEMENT OF ROBERT BUTLER, M.D.

HEALTHY AGING

People not only want to live long, but to remain in good health. We pretty much know what the necessary ingredients are, but it is very difficult to live up to the requirements.

The seven key features of healthy aging are:

1. Appropriate low caloric diet with 7–9 fruits and vegetables each day, multivitamins in particular vitamin D (with sunlight to activate vitamin D).
2. Physical activity including: (1) aerobics, that is reasonably strenuous walk 5 days a week, (2) muscle strengthening, particularly of the quadriceps or thigh muscle, through squats. It is known that the quadriceps is the primary predictor of frailty in old age. Falls is the No. 12 cause of death for people over 65 and muscle strength and balance are critical, (3) Balance, (4) Flexibility, and (5) Posture.
3. Smoking Cessation
4. Moderate use of alcohol, the equivalent of no more than one glass of wine per day.
5. Managing stress, most difficult of all efforts through meditation, yoga, visualization, mini vacations and appropriate sleep.
6. Building a strong support system and social network of friends and relationships. This may be one reason why women outlive men, because they have a stronger capacity for dealing with intimacy.
7. A sense of purpose—something to get up for in the morning. We discovered in studies we did at the National Institutes of Health back in the 1950s and 1960s that those individuals that had something to get up for in the morning, something purposeful, lived longer and better.

Since people are living longer, they should work longer for health reasons and to reduce Social Security costs. Older persons should also actively volunteer, providing services to others.

We know that perhaps no more than 25 percent of our health and longevity depends upon genes. Thus some 75 percent is up to us. This offers us a lot of power, but also entails genuine responsibility and self care.

In order to assist people to maintain healthy aging by undertaking the activities described, how can we help them? Some help of course, can be derived from the doctor-patient relationship. But doctors today have no more than 12 minutes on average to spend with their patients. Fundamentally, we have a sickness system, not a health system. In general, neither doctors nor hospitals have incentives to maintain health—they profit through disease.

I believe we have to expand our efforts in prevention, through a broad public health perspective. For example, there are some 15,000 senior centers throughout the United States. These are community facilities, 5,000 of which receive some support from our Administration on Aging. The utilization rate is not what it should be. Senior centers need to be modernized in at least two respects, both of which are supportive of healthy aging. One is senior centers should promote exercise, diet, etc. Two, closely related to purpose, older people should be encouraged to contribute more directly to the community. These modernizations of senior centers would help maintain healthy aging.

Taxation and education were very effective in the 50 percent reduction of smokers in the United States since 1964. On the other hand, alcohol in America is marked by a significant number of hard core alcoholics affecting one of every four American families, accounting for most domestic abuse and a significant contribution to highway fatalities and other accidents. Alcohol taxes used to constitute a significant part of Federal revenue. In fact, there have been only a few increases in liquor taxes since 1950. This is an issue that should be revisited by Congress.

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I call upon citizens of America, the President's Council on Physical Fitness and Sports, the U.S. Prevention Task Forces and other appropriate organizations to help sponsor a national walking movement where friends, neighbors, and families could walk together. This is not expensive and it does not require membership in a health club.

Of course, healthy aging is a life course issue, it is not something you simply introduce at 50, 60 or beyond. A few years ago, several of us wrote a widely quoted paper in the New England Journal of Medicine on the problem of obesity in America and the prospect that we might lose 3 to 5 years of life expectancy from the 30 additional years of life we gained in the 20th Century. Further, for the first time in our history, our children might not live as long as their parents. It is quite terrible to see 10-year old children who are obese and who already have type 2 old-age diabetes.

A national walking movement is a simple, but an important step in dealing with the problem of obesity.

Finally, and to repeat, it is urgent to realize the cost of failed health promotion and disease prevention. We must now go beyond the doctor-patient relationship to achieve the goals of healthy aging which requires healthy living throughout life. It is never too late to start and always to soon to stop.

Senator HARKIN. Thank you very much, Dr. Butler. It is good to see you again.

I see Dr. Iezzoni is here, but I will go ahead with Dr. Hagan, and then we will finish up with you.

Dr. Hagan, again, welcome. If you could summarize your statement, we would certainly appreciate it.

**STATEMENT OF JOSEPH F. HAGAN, JR., M.D., F.A.A.P., CLINICAL PROFESSOR OF PEDIATRICS, UNIVERSITY OF VERMONT COLLEGE OF MEDICINE, BURLINGTON, VT**

Dr. HAGAN. Thank you.

Good morning. It is my honor to represent the American Academy of Pediatrics (AAP) at today's hearing.

Senator Harkin, thank you for this opportunity. I do apologize for the Vermont weather. I don't think you should blame Senator Sanders. I take full responsibility for bringing the snow with me.

[Laughter.]

Senator HARKIN. All right.

Dr. HAGAN. Preventive healthcare is a fundamental investment in the health of all children and adults. In pediatrics, preventive healthcare is vital as it has lifelong impact. In the design of any healthcare system, inadequate attention to preventive care mortgages future health and welfare not only of children, but of society itself.

Pediatric preventive healthcare is fundamentally different from adult preventive health. We recommend that all children receive regular well-child care visits based on the American Academy of Pediatrics Bright Futures recommendations for preventive pediatric healthcare.

In addition to receiving immunizations and important screenings, children are tracked for appropriate growth and developmental milestones. There is no comparable analog in adult health for this schedule of regular preventive visits or for tracking growth parameters, such as physical growth, body mass index, and developmental achievement.

The AAP has focused on developing effective systems of pediatric healthcare. We wish to recommend three successful models for pro-

moting child health—the medical home, Bright Futures, and EPSDT (Early and Periodic Screening, Detection, and Treatment).

In a medical home, care is delivered—or directed by competent, well-trained physicians who provide primary care, managing all aspects of pediatric care—preventive, acute, and chronic. A medical home delivers care that is accessible. It is continuous and comprehensive. It is family centered. It is coordinated, compassionate, and culturally effective.

A high-performing healthcare system requires medical homes that promote system-wide quality with optimal health outcomes, family satisfaction, and value.

Bright Futures is a national standard for the components of quality well-child care. Bright Futures serves as a comprehensive guide to health promotion and guidance for preventive care to be used by all healthcare professionals caring for children and adolescents. I am honored to have served as co-editor of these guidelines.

This national initiative is funded by HRSA's Maternal and Child Health Bureau and is developed and implemented and supported by multidisciplinary experts from national organizations and agencies.

Community health centers, which provide important access to care for children, are increasingly using Bright Futures to guide well-child care. Many States have used Bright Futures to inform their Medicaid and State Child Health Insurance Programs.

For example, the State of Iowa has used Bright Futures to update and benchmark its EPSDT measures and the EPSDT health program. In the private sector, the National Business Group on Health used Bright Futures as its model in crafting and testing its model benefits package for maternal and child health.

Now, since 1967, the Medicaid program has required that all States provide medically necessary care to children under the EPSDT standard. EPSDT should serve as the fundamental principle for any benefits package for children under healthcare reform, and the Bright Futures guidelines should be the standard for well-child care under EPSDT.

Now, in addition to these positive models for the care of children, the academy has also studied other models that have been less successful. We urge you not to place significant reliance on the following models when developing a comprehensive healthcare reform package.

Retail-based clinics fail to provide a medical home that can offer consistent and comprehensive care to children and are unequipped to provide virtually any form of pediatric or adult preventive healthcare.

Health savings accounts typically fail to promote child health by not requiring first dollar coverage for most pediatric well-child or preventive care.

Some have suggested using the Federal Employees Health Benefits Program Basic Option under Blue Cross Blue Shield as the basic benefits package under healthcare reform. The academy considers this benefit package to be inadequate, particularly for children with special healthcare needs. A more appropriate private sector model can be found in the National Business Group's model benefits package.

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And finally, the U.S. Preventive Services Task Force provides an excellent evidence base for the determination of appropriate screening in adult preventive health services, but it has made few recommendations that apply to children and adolescents. Bright Futures would be a more appropriate set of guidelines for use in pediatric preventive care.

The academy commends you, Mr. Chairman, for calling attention to the preventive healthcare needs of children. We look forward to working with Congress to craft a healthcare reform package that moves our healthcare system further towards promotion of health and wellness, particularly for children and youth.

I appreciate this opportunity to testify. I would be honored to work with you in the future and will be pleased to answer any questions.

Thank you.

[The prepared statement of Dr. Hagan follows:]

PREPARED STATEMENT OF JOSEPH F. HAGAN, JR., M.D., F.A.A.P.

Good morning. I appreciate this opportunity to testify today before the Committee on Health, Education, Labor, and Pensions on access to preventive health care for children. My name is Joseph F. Hagan, Jr., M.D., F.A.A.P., and I am proud to represent the American Academy of Pediatrics (AAP), a non-profit professional organization of 60,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. I am a pediatrician in private practice in Burlington, Vermont and Clinical Professor in Pediatrics at the University of Vermont College of Medicine and the Vermont Children's Hospital. I served as co-chair of the Bright Futures Steering Committee, and I co-edited the *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents 3rd edition*—the national standard of well-child care for children. I have also authored chapters on preventive care in two of the three major pediatric textbooks.

Preventive health care is a fundamental investment in the health of all children and adults. In pediatrics, preventive health is vital because it can have lifelong impacts. Inadequate attention to preventive care in the design of any health care system mortgages the future health and welfare not only of children, but of society itself. Research across a broad range of interventions has shown that preventive health and wellness for children consistently produces a high return on investment.[1] Three key principles govern pediatric preventive care: (1) Prevention works, (2) Families matter, and (3) Health promotion is everybody's business.

PEDIATRICS IS A PREVENTIVE MODEL OF CARE

Pediatrics *is* preventive care. The entire model of pediatric health care focuses around promoting optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. Pediatric preventive care can be seen as a set of concentric circles, with the child at its heart:

*Prevention works*: Primary prevention involves the prevention of disease or illness before it occurs. In pediatrics, the well-known schedule of immunizations is proven to protect children against a wide range of previously deadly illnesses like polio and rubella. Other examples of primary prevention include health promotion and anticipatory guidance for the development of healthy lifestyles, such as good nutrition and regular physical activity.

Another core principle of pediatrics is secondary prevention, which is early screening for a wide range of conditions that can lead to poor health. Newborn screening programs can identify metabolic conditions whose ill effects can be averted or mitigated with changes in diet or other interventions. Toddlers are screened for healthy development so that developmental delays can be detected and treatments provided early, when they can be most effective. Children are screened routinely for problems with vision or hearing that can profoundly impact healthy development. Lead screening can identify children who are being exposed to dangerous lead levels in their environment.

[1] Bibliography of studies assembled by the Partnership for America's Economic Success available at *http://www.partnershipforsuccess.org/index.php?id=15&MenuSect=3#benefits*.

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In order for preventive care to be comprehensive and consistent, it must be delivered in a medical home. The medical home is defined as medical care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.[2] The medical home allows for the delivery of quality pediatric preventive care in a manner that avoids duplication of efforts and provides appropriate follow-up or interventions.

*Families matter*: A successful system of care for infants, children and adolescents is family-centered. In most cases, pediatric care involves treating not only the child, but also providing guidance to the family as a whole. Parents and caregivers may require guidance on issues related to appropriate expectations for different stages of child development, proper nutrition, or violence in the home. Focusing on the family's growth, development and concerns in parallel with the growth and development of the child is a central activity in pediatric care.

*Health promotion is everybody's business*: Communities can have a significant impact on the health and well-being of residents. Families benefit from a broad range of community-based services, including mental health services, education services and services for children and youth with special health care needs. Child care and schools play a vital role in promoting the health of children, including health education programs, food services, and promotion of physical activity. Access to green spaces and recreational areas provides opportunities for play and exercise. These programs and services, coupled with primary care provided in a medical home, constitute a community-based system of care and are central to promoting family well-being. The AAP is expanding its Federal advocacy efforts to highlight the preventive health aspects of issues including transportation policy, education policy, energy policy and climate change, and Federal nutrition programs.

By placing health promotion, anticipatory guidance, and family engagement at the heart of all care, pediatric health care in the medical home can serve as a model for transforming our health care system.

### CHILDREN HAVE DIFFERENT PREVENTIVE HEALTH CARE NEEDS

Pediatric preventive health care is fundamentally different from adult preventive health. It is recommended that all children receive regular well-child care visits based on the AAP/Bright Futures Recommendations for Preventive Pediatric Health Care, also known as the Periodicity Schedule, which sets out a series of examinations at specific developmental stages.[3] In addition to receiving immunizations and important screenings, children are tracked for appropriate growth and developmental milestones. There is no comparable analog in adult health for this schedule of regular preventive visits to the physician, or for tracking growth parameters such as head circumference and Body Mass Index.

Successful pediatric preventive care is dependent entirely upon partnership with the family to provide the elements necessary for health promotion. Most children have no responsibility for and indeed no control over most aspects of their own health, including access to care, appropriate nutrition, shelter, cleanliness, or nurturing. Pediatric preventive health efforts must focus, therefore, on education and engagement of parents and caregivers, with emphasis gradually shifting to the child's own responsibility for good health as he or she grows up. Health professionals who have pediatric patients with special health care needs must seek to understand the family's composition and social circumstances and the impact the special needs have on family functioning.

### ALL CHILDREN NEED PEDIATRIC-SPECIFIC MODELS OF PREVENTIVE CARE

In recent decades, the American Academy of Pediatrics has focused on developing and studying effective systems of pediatric health care. We are proud to describe successful models for promoting child health.

*The Medical Home*: In a medical home, care is delivered or directed by competent, well-trained physicians who provide primary care, managing and facilitating all aspects of pediatric care: preventive, acute and chronic. The Academy has led the development of a body of literature surrounding the medical home, including dozens of studies that examine the impact of care coordination on patient outcomes. The U.S. Department of Health and Human Services' *Healthy People 2010* goals and objectives state that "all children with special health care needs will receive regular ongoing comprehensive care within a medical home," and multiple Federal programs require that all children have access to an ongoing source of health care. A high

[2] American Academy of Pediatrics Medical Home Initiatives for Children With Special Needs Project Advisory Committee. The Medical Home. *Pediatrics*, Vol. 110 No. 1 July 2002.

[3] For more information on Bright Futures, see *http://brightfutures.aap.org/*.

performance health care system requires medical homes that promote system-wide quality with optimal health outcomes, family satisfaction, and value.

*Bright Futures*: *Bright Futures*: *Guidelines for Health Supervision of Infants, Children and Adolescents* is the national standard for quality well-child care, serving as a comprehensive guide to pediatric health promotion and guidance on preventive care for use by all health professionals.[4] The Guidelines address the care needs of all children and adolescents, including children and youth with special health care needs and children from families with diverse cultural and ethnic backgrounds. Bright Futures recognizes that effective health promotion and disease prevention require coordinated efforts among medical and nonmedical professionals and agencies, including public health, social services, mental health, home health, parents, caregivers, families and many other members of the broader community. This national initiative is funded by the Health Resources and Services Administration's Maternal and Child Health Bureau and developed, implemented and supported by multidisciplinary experts, national organizations, and agencies addressing child and adolescent health issues.

Pediatricians and other child health care providers should follow Bright Futures Guidelines for pediatric well-child care at all preventive care visits as prescribed by the AAP/Bright Futures Periodicity Schedule. One of the great strengths of Bright Futures is its adaptability to any setting or provider model; it can be used in whole or in part, by physicians, nurses, or other health care professionals, and in delivery settings ranging from clinics to school-based health centers. Many States have used Bright Futures to inform their Medicaid and State Child Health Insurance Program well-child care standards; for example, the State of Iowa uses Bright Futures to update and benchmark its EPSDT health program.[5] Oklahoma uses Bright Futures family tip sheets as a resource for anticipatory guidance and follows the well-child screening guidelines. Massachusetts has included Bright Futures as a reference for the delivery of comprehensive care in Medicaid, public health programs, and school-based health centers. The National Business Group on Health used Bright Futures as its model in crafting its Model Benefits Package for Maternal and Child Health.[6]

*Early and Periodic Screening, Detection, and Treatment (EPSDT)*: Since 1967, the Medicaid program has required States to provide all medically necessary care to children under the EPSDT standard. EPSDT directs States to cover not only appropriate screening of children, but the treatment necessary to address any conditions or needs identified. EPSDT should serve as the fundamental principle for any benefits package for children under health care reform. Bright Futures Guidelines should be the standard of well-child care within EPSDT.

In addition to promoting these positive models of care for children, the Academy has also studied other models that are less successful. We urge you not to place significant reliance on these models when developing a comprehensive health care reform package:

*Retail-based Clinics (RBCs)*: RBCs fail to provide a medical home that can offer consistent, comprehensive care to children. With their focus on providing care for adults and episodes of illness, RBCs are unequipped to provide well-child care, anticipatory guidance, or virtually any form of pediatric preventive health care. They are in direct opposition to the fundamentals of preventive care because they fragment the care delivery process. In fact, they can be a disruptive influence on the continuous engagement and follow-up of families and their children.[7]

*Health Savings Accounts (HSAs)*: HSAs fail to promote child health by not requiring first-dollar coverage for most pediatric well-child or preventive care. By requiring families to pay out-of-pocket for virtually all care except catastrophic needs, HSAs can present a serious barrier for families to pursue pediatric preventive care according to the Periodicity Schedule as well as timely illness care. HSAs are particularly unsuitable for families with children with special health care needs. The ongoing health care needs of these children quickly drain these accounts and par-

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[4] Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents. 3rd Ed. American Academy of Pediatrics, 2008.

[5] For more information on Iowa's use of Bright Futures in its EPSDT program, see *http://www.iowaepsdt.org/EPSDTNews/2007/Winter07/IdentifyDevelConcerns.htm*.

[6] National Business Group on Health. Investing in Maternal and Child Health. Available at *http://www.businessgrouphealth.org/healthtopics/maternalchild/investing/docs/mch_toolkit.pdf*.

[7] Retail-Based Clinic Policy Work Group. AAP Principles Concerning Retail-Based Clinics. *Pediatrics*, Vol. 118 No. 6, December 2006.

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ents find themselves unable to access the critically needed services for this vulnerable population of children.[8]

*Federal Employees Health Benefits Program (FEHBP) Basic Option*: Some have recommended using the FEBHP Basic Option under Blue Cross Blue Shield as the basic benefits package under health care reform. The Academy considers this benefits package to be inadequate, particularly for children with special health care needs and complex conditions.[9] A more appropriate pediatric private sector model can be found in the National Business Group on Health's Model Benefits Package for Maternal and Child Health, which recognizes the importance of Bright Futures and associated preventive care. In addition, the AAP makes recommendations for the full scope of health care benefits for children birth through age 21.[10]

*Recommendations of the U.S. Preventive Services Task Force (USPSTF)*: While the USPSTF provides an excellent basis for the determination of appropriate screening for adult preventive health services, USPSTF has made few recommendations that apply to children and adolescents. Most of these findings related to children and adolescents result in a classification of "I" for insufficient evidence. In some cases, the USPSTF finds that there **is** enough evidence to recommend a preventive service or counseling for **adults**, but not enough evidence to recommend the same service for children and youth.[11]

Bright Futures would be a more appropriate set of guidelines to use for pediatric preventive care than the recommendations of the USPSTF. *The Bright Futures Guidelines* made extensive use of the USPSTF guidelines that existed and is transparent in its use of other available evidence. However, performing only the handful of current USPSTF-recommended pediatric preventive care screenings would lead to missed opportunities in disease prevention, disease detection and necessary early intervention.

### MORE RESEARCH IS NEEDED TO BUILD THE EVIDENCE BASE FOR PEDIATRIC PREVENTIVE CARE

Health supervision of an individual child is a complex package of services that is provided over the child's lifetime. It includes not only preventive and screening interventions that are recommended for all children, but also addresses the particular needs of that child in the context of family and community. Studying the outcomes over a child's lifetime of health supervision at this level of integration can be a daunting task.

For many interventions that are commonly performed in child or adolescent care, no, or few, properly constructed studies have been done that link that intervention with intended health outcomes. Absent evidence does not demonstrate a lack of usefulness, however. The lack of evidence most often simply reflects a lack of study. Filling in the gaps in evidence is highly desirable, and additional research is strongly encouraged.[12]

The American Academy of Pediatrics commends you, Mr. Chairman, for holding this hearing today to call attention to the preventive health care needs of children. As you study the entire health care system and address the need to assure every person achieves the best possible outcome, please remember that quality, comprehensive preventive child health services are essential to any effort to prevent morbidity and cost in the adult population. Any successful effort to reform our health care system must recognize the interdependence of initiatives on preventive care, health information technology, and quality improvement to achieve the desired goals. We look forward to working with Congress to craft a health care reform package that moves our health care system further toward promotion of health and wellness, particularly for children and youth. I appreciate this opportunity to testify, I would be honored to work with you in the future and I will be pleased to answer any questions you may have.

Senator HARKIN. Thank you very much, Dr. Hagan.

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[8] American Academy of Pediatrics Committee on Child Health Financing. High-Deductible Health Plans and the New Risks of Consumer-Driven Health Insurance Products. *Pediatrics*, Vol. 119 No. 3, March 2007.

[9] National Health Policy Forum. EPSDT: Medicaid's Critical But Controversial Benefits Program for Children. Issues Brief No. 819, November 20, 2006. Available at *http://www.nhpf.org/library/issue-briefs/IB819_EPSDT_11-20-06.pdf*.

[10] American Academy of Pediatrics Committee on Child Health Financing. Scope of Health Care Benefits for Children from Birth to Age 21. *Pediatrics*, Vol. 117 No. 3, March 2006.

[11] For more information on the U.S. Preventive Services Task Force and its recommendations, see *http://www.ahrq.gov/clinic/uspstfix.htm*.

[12] Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents. 3rd Ed. "Rationale and Evidence." American Academy of Pediatrics, 2008.

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I don't mean to play favorites here, but of all the things we are thinking about in prevention and in wellness, you have really got to start with kids really early on because that determines everything later on. We have really got to focus on—sorry, Dr. Butler, I know aging and——

[Laughter.]

Dr. BUTLER. Oh, I agree. You have to start with kids.

Senator HARKIN. You have got to get these kids early on.

Dr. Iezzoni, thanks for being here. Sorry for all the snow and everything out there, but——

Dr. IEZZONI. I think you are sending it out my way later today.

Senator HARKIN. I introduced you earlier. I said Dr. Iezzoni is a professor of medicine at Harvard Medical School, associate director of the Institute for Health Policy at the Massachusetts General Hospital in Boston. Has published and spoken widely on risk adjustment and, again, has been a member of the Institute of Medicine and the National Academy of Sciences, focusing on prevention and wellness as it pertains to people with disabilities, which is a particular focus of mine, as you probably know.

Thanks for being here, Dr. Iezzoni.

**STATEMENT OF LISA I. IEZZONI, M.D., M.SC., PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL AND ASSOCIATE DIRECTOR OF THE INSTITUTE FOR HEALTH POLICY AT THE MASSACHUSETTS GENERAL HOSPITAL, BOSTON, MA**

Dr. IEZZONI. Thank you very much, Senator, for having me here. I appreciate that.

I would like to make four points in my brief comments this morning. The first is that 40 million to 50 million Americans live with disabilities, and they face the same risk of developing preventable acute and chronic health conditions as do other people.

In fact, because of their underlying health conditions, some individuals with disabilities might have higher risks than other people of developing certain types of preventable health problems.

Second, individuals with disabilities experience high rates of disadvantages relating to their personal, social, economic, and environmental determinants of health, as recognized by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020.

Compared with nondisabled individuals, people with disabilities are much more likely to have low levels of education, lower levels of employment, higher rates of poverty. Twenty-five percent of working-age adults with disabilities live in poverty, compared with 9 percent of other working-age individuals.

Problems finding safe, accessible, and affordable housing. Higher rates of depression, anxiety, and stress. Thirty-four percent of persons with major difficulties walking report being frequently depressed or anxious, compared with 3 percent of those without disabilities.

Higher likelihood of being victims of crime or domestic violence. Higher rates of being overweight and obese, and higher rates of tobacco use.

However, individuals with disabilities can be unaware of their health risks and the need for screening and preventive services.

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Some persons engage in magical thinking, the notion that because they have a serious health problem that nothing more can go wrong with their health. Therefore, they do not seek the preventive services——

Senator HARKIN. True.

Dr. IEZZONI [continuing]. That one should recommend. These disadvantages heighten the risk that persons with disabilities may not achieve the national health goals envisioned by the Healthy People 2020 Advisory Committee, which is for every American to live long and healthy lives.

Surveys, in fact, find that adults reporting disabilities are 30 percent more likely than nondisabled respondents to report being in fair or poor health.

Third, persons with disabilities face major externally imposed barriers to obtaining their healthcare services and public health intervention. Frankly, discriminatory and stigmatizing societal attitudes are still at play.

A survey of Los Angeles County residents with sensory or physical disabilities found that 18 percent of persons reporting severe disabilities describe being treated unfairly by their healthcare provider because of their disability.

Smokers with major difficulties walking are 20 percent less likely than other smokers to be asked about their smoking histories by their physicians during routine annual checkups. Recommendations from several groups about distributing ventilators and other scarce resources during influenza pandemics categorically exclude individuals with disabilities from obtaining those resources.

*Physical access barriers*. The survey of Los Angeles County residents found that 31 percent of people with severe physical or sensory disabilities reported physical barriers to getting into their healthcare provider.

Many factors might explain lower rates of screening and preventive service use among persons with disabilities, including competing health demands and patient preferences. Nonetheless, equipment inaccessibility likely contributes to lower rates of service use.

Persons who cannot stand to be weighed report not knowing their weight. Some with spinal cord injury joke about weighing the same as they did the day they were injured because they haven't been weighed since then.

Women with spinal cord injury who became pregnant described being weighed during prenatal care visits on laundry or freight scales in hospital basements or loading docks.

Women with major difficulties walking are 40 percent less likely than other women to get Pap smears. Some women with major mobility problems report never having had a Pap smear because they cannot get onto the fixed-height examination table in their physician's office.

Women with major difficulties walking are 30 percent less likely than other women to get mammograms. Although wheelchair-accessible mammography equipment does exist, many facilities have not yet installed those machines.

*Communication barriers*. Inaccessible communication poses barriers for persons who are deaf or hard of hearing, blind or low vi-

sion, individuals with speech impairments, and persons with cognitive and developmental disabilities.

According to the Nutrition Labeling and Education Act of 1994 requirements, nutrition labeling on packaged food can use print as small as 8-point type. Nutrition labels provide critical guidance for consumers concerned about purchasing healthy foods. However, the type size on these labels is too small for people with low vision to read at the grocery store.

Women who are deaf or hard of hearing are 20 percent less likely than other women to get mammograms. The reasons for this are unclear, but one factor likely relates to communication barriers. Unless a sign language interpreter accompanies them, they may be unable to follow instructions from the mammography technician, who disappears behind a protective radiation shield while taking the image.

Without being able to see the technician, the woman may be unaware of when to hold her breath to avoid motion artifact when the equipment generates the mammogram image and might have a bad experience obtaining the test.

*Financial barriers*. Although people with disabilities are more likely than others to have social safety net health insurance, there are many who are still uninsured. In particular, individuals with disabilities in States with restrictive Medicaid coverage policies have high rates of being uninsured.

In the South, for example, 39 percent of low-income workers reporting disabilities lack health insurance. The nationwide uninsurance figure for this population subgroup is 24 percent.

Fourth, and finally, the *public policy implications*. Now these problems have been noticed before. In 2000, Healthy People 2010 cautioned that, "As a potentially underserved group, people with disabilities would be expected to experience disadvantages in health and well-being compared with the general population."

On July 26, 2005, the 15th anniversary of the ADA being signed, the U.S. Surgeon General issued a call to action, warning that people with disabilities can lack equal access to healthcare. Nevertheless, more efforts are needed to eliminate barriers to public health and preventive services faced by persons with disabilities.

According to the Institute of Medicine report entitled, "The Future of Disability in America," the number of Americans with disabilities will likely grow substantially in coming decades. Improving access to health promotion and disease prevention, programs for people with disabilities should be a national public health priority.

Thank you.

[The prepared statement of Dr. Iezzoni follows:]

PREPARED STATEMENT OF LISA I. IEZZONI, M.D., M.SC.

In the United States, 40 to 54 million persons have disabilities. They face the same risks of developing preventable acute and chronic health conditions as do other people. Disabilities are diverse, but many are caused by serious medical conditions that leave persons with a narrow margin of health. Thus, depending on their underlying health conditions, some individuals with disabilities might have higher risks than other people of developing certain preventable health problems.

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DETERMINANTS OF HEALTH

Rates of disabilities vary across demographic subgroups within the U.S. population. Disability rates rise with increasing age: 6 percent among persons ages 5–15 years; 7 percent for ages 16–20; 13 percent for ages 21–64; 30 percent for ages 65–74; and 53 percent for ages 75 and older.[1] Across the population age 5 and older, females (16 percent) have slightly higher rates of disabilities than males (14 percent). Among adults in different racial and ethnic groups, American Indian or Alaskan Native populations report the highest disability rates (30 percent), compared with 21 percent for black persons, 20 percent for white persons, 17 percent for Hispanic individuals and for Native Hawaiian and other Pacific Islanders, and 12 percent for Asians.[2]

Many persons with disabilities confront sociodemographic disadvantages and have other attributes that heighten their risks for preventable health problems. Compared with nondisabled individuals, persons with disabilities are much more likely to have[3]:

- Lower levels of education: among adults with disabilities, 30 percent have less than a high school education, compared with 17 percent among those without disabilities.
- Lower rates of employment: 37 percent of working-age adults with disabilities are employed, compared with 80 percent of nondisabled working-age adults.[4]
- Higher rates of poverty: 25 percent of working-age adults with disabilities live in poverty compared with 9 percent of other working-age adults.[5]
- Problems finding safe, accessible, and affordable housing: for example, 20 percent of persons with major difficulties walking have trouble using the bathrooms in their homes because of physical barriers[6]; a study of 14 federally funded public housing facilities in the Kansas City area found that 14 percent–29 percent did not comply with various Federal disability access regulations[7]; and a survey of Los Angeles County residents with disabilities found that 25 percent need home modifications but do not have them.[8]
- Higher rates of depression, anxiety, strong fears, and stress: for example, 34 percent of persons with major difficulties walking report being frequently depressed or anxious, compared with 3 percent among those without disabilities.
- Higher likelihood of being victims of crimes or domestic violence although, as the U.S. Department of Justice acknowledges, statistics for this population are hard to acquire: persons with certain types of disabilities may be unable to file reports; others who are abused physically and psychologically by caregivers fear losing essential assistance with activities of daily living.[9]

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[1] W Erickson and C Lee. 2007 *Disability Status Report: United States*. Ithaca, NY: Cornell University Rehabilitation Research and Training Center on Disability Demographics and Statistics, 2008. The population prevalence figures come from the 2007 American Community Survey.

[2] LA Wolf, BS Armour, and VA Campbell. Racial/Ethnic Disparities in Self-Rated Health Status Among Adults With and Without Disabilities—United States, 2004–2006. *Morbidity and Mortality Weekly Report* 2008;57(39):1069–1073. Figures come from respondents age greater than or equal to 18 years to the Behavioral Risk Factor Surveillance System surveys.

[3] LI Iezzoni and BL O'Day. *More Than Ramps: A Guide to Improving Health Care Quality and Access for People with Disabilities*. New York: Oxford University Press, 2006. Unless otherwise noted, the statistics listed below this paragraph come from various national health surveys but may not represent exactly circumstances in 2009.

[4] Erickson and Lee, 2008. The employment figures come from the 2007 American Community Survey.

[5] Ibid. The poverty figures come from the 2007 American Community Survey. Among disability categories, persons with "mental" disabilities had the highest poverty rate (32 percent) and those with "sensory" disabilities the lowest poverty rate (22 percent).

[6] LI Iezzoni. *When Walking Fails: Mobility Problems of Adults with Chronic Conditions*. Berkeley: University of California Press, 2003: p. 88. This figure comes from the 1994–1995 National Health Interview Survey Disability Supplement. Despite its age, this survey continues to offer the most comprehensive information available about the lives of Americans with disabilities.

[7] K Froehlich-Grobe, G Regan, JY Reese-Smith, KM Heinrich, and RE Lee. Physical Access in Urban Public Housing Facilities, *Disability and Health Journal*. 2008;1:25–29.

[8] E Bancroft, A Lightstone, and P Simon. Environmental Barriers to Health Care Among Persons with Disabilities—Los Angeles County, CA, 2002–2003. *Mortality and Morbidity Weekly Report*. 2006;55(48):1300–1303. The survey involved only 1,333 persons reporting physical or sensory disabilities.

[9] U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime. The OVC worked with the National Organization for Victim Assistance on a project *Working with Crime Victims with Disabilities*, which explored these issues. *www.ojp.gov/ovc/publications/factshts/disable.htm*.

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• Higher rates of being overweight and obese: for example, 27 percent of adults with major physical and sensory impairments are obese, compared with 19 percent among those without major impairments.
• Higher rates of tobacco use: for example, 47 percent of adults with major difficulties walking use tobacco, compared with 26 percent of nondisabled adults.

In addition, interviews with individuals with disabilities find they can be unaware of their health risks and need for screening and preventive services. Some persons describe "magical thinking"—the belief that because they already have one significant impairment nothing more can go wrong with their health.[10] They therefore do not seek or receive routine screening services, such as those recommended by the U.S. Preventive Services Task Force (USPSTF).

Thus, individuals with disabilities experience high rates of disadvantages relating to the personal, social, economic, and environmental determinants of health as recognized by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020.[11] These disadvantages heighten the risks that persons with disabilities will not achieve the national health goal envisioned by the committee, of living long and healthy lives. Not surprisingly, surveys find that adults reporting disabilities are 30 percent more likely than nondisabled respondents to report being in fair or poor health.[12] These health disparities are particularly marked for certain population subgroups: for example, 33 percent more black respondents with disabilities than black respondents without disabilities report fair or poor health, as do 38 percent more disabled American Indian/Alaskan Natives than their nondisabled counterparts.

### BARRIERS TO PUBLIC HEALTH AND HEALTH PROMOTION SERVICES

Persons with disabilities face several major externally imposed barriers to accessing health care services and public health interventions.

### DISCRIMINATORY AND STIGMATIZING SOCIETAL ATTITUDES

Despite significant gains in civil rights and greater participation in daily community life, persons with disabilities continue to confront discriminatory and stigmatizing attitudes. These attitudes may possibly extend to health care settings. For instance [13]:

• Smokers with major difficulties walking are 20 percent less likely than other smokers to be asked about their smoking histories by their physicians during routine annual check-ups. However, scientific evidence suggests that when physicians ask about patients' smoking histories, even this simple act can encourage attempts to quit smoking. Some persons with walking difficulties may have limited lung capacity, increasing their risks of respiratory infections and other pulmonary complications. Ceasing smoking is therefore critical in this population.
• Women of child-bearing age with major difficulties walking are 70 percent less likely than other women to be asked about contraception during routine physician office visits. However, if these women are sexually active, they face risks of unintended pregnancy. They may also have heightened risks of complications (such as deep vein thrombosis) from hormonal contraceptives or have trouble with manual dexterity, making barrier contraceptives less feasible. Therefore, safely and effectively preventing unintended pregnancy can require consultation with their physicians.

Stigmatizing attitudes could contribute to these findings. For instance, physicians may choose not to discuss smoking with disabled patients under the distorted belief that smoking brings consolation to otherwise unhappy lives. Physicians may not discuss contraception with disabled women under another erroneous belief that they are not sexually active and at risk of unintended pregnancy. In a survey of Los Angeles County residents with sensory or physical disabilities, 13 percent reported being treated unfairly at their health care provider's office because of their dis-

[10] Iezzoni and O'Day, 2006.
[11] Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. *Phase I Report. Recommendations for the Framework and Format of Healthy People 2020*. October 28, 2008. This committee, which operates under FACA rules, is chaired by Dr. Jonathan Fielding, Director of Public Health and Health Officer, Los Angeles County, and it has 13 members. I am a committee member.
[12] Wolf, Armour, and Campbell, 2008. Figures come from respondents age greater than or equal to 18 years to the Behavioral Risk Factor Surveillance System surveys.
[13] Iezzoni and O'Day, 2006.

ability; 18 percent of persons reporting severe disabilities described unfair treatment.[14]

One particularly worrisome issue involves distribution of scarce resources during public health emergencies, such as provision of mechanical ventilators during a pandemic influenza outbreak. While the U.S. Department of Health and Human Services acknowledges that such shortages will likely occur in the event of an influenza epidemic, DHHS has offered little guidance on how to allocate scarce resources. Other groups have provided recommendations for distributing ventilators and other scarce resources, some categorically excluding individuals with disabilities.[15] It is critical to conduct an open and transparent debate with the public and government officials about allocation guidelines before a pandemic public health emergency occurs.

PHYSICAL ACCESS BARRIERS

Little systematic information is available about the accessibility of health care facilities. A survey of Los Angeles County residents with physical or sensory disabilities found that 22 percent had difficulty accessing their health care provider's office; non-Hispanic black respondents and persons with severe disabilities reported the highest rates of physical barriers (33 percent and 31 percent, respectively).[16] Plentiful anecdotal reports suggest that basic equipment required for routine health and screening services is frequently physically inaccessible, including:

- Weight scales;
- Examination tables; and
- Mammography machines.

Many factors may explain lower rates of screening and preventive service use among persons with disabilities, including competing health demands and patient preferences. Nonetheless, equipment inaccessibility likely contributes to lower levels of service use among persons with disabilities as suggested by the following examples [17]:

• Persons who cannot stand to be weighed report not knowing their weight. Some with spinal cord injuries (SCI) joke about weighing the same as the day they were injured because they have not been weighed since. Women with SCI who become pregnant describe being weighed during prenatal care visits on laundry or freight scales in hospital basements or loading docks.

• Women with major difficulties walking are 40 percent less likely than other women to get Pap smears, which are recommended with Grade A evidence by the USPSTF to prevent cervical cancer deaths.[18] Some women with major mobility problems report never having had a Pap smear because they cannot get onto the fixed-height examination table in their physicians' office.

• Women with major difficulties walking are 30 percent less likely than other women to get mammograms, which are recommended by the USPSTF every 1 to 2 years for women age 40 and older (Grade B evidence). Although wheelchair accessible mammography equipment does exist, many facilities have not yet acquired these machines. Women with major walking difficulties report being unable to obtain adequate images or having such unpleasant initial experiences that they do not return for their periodic screening.

COMMUNICATION BARRIERS

Inaccessible communication poses barriers for persons who are deaf or hard of hearing, blind or low vision, individuals with speech impairments, and persons with cognitive and developmental disabilities. Persons may not receive the information they need to manage their health in formats that they can access or understand. In addition, failures of information transfer during screening or preventive services can compromise clinical procedures. These communication barriers are diverse. Several examples include the following:

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[14] Bancroft, Lightstone, and Simon, 2006.

[15] DB White, MH Katz, JM Luce, and B Lo. Who Should Receive Life Support During a Public Health Emergency? Using Ethical Principles to Improve Allocation Decisions. *Annals of Internal Medicine*. 2009;150:132–138.

[16] Bancroft, Lightstone, and Simon, 2006.

[17] Ibid.

[18] U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services*, 2008. *www.ahrq.gov*.

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• According to the Nutrition Labeling and Education Act 1994 requirements, nutrition labeling on packaged foods can use print as small as 8-point type.[19] Footnotes and caloric conversion information can be as small at 6-point type. Nutritional labels provide critical guidance for consumers concerned about purchasing healthy foods. However, the type size on these labels is too small for persons with low vision to read, and information is not readily available in other formats (e.g., Braille). Although nutritional information on specific products may be available through other sources (e.g., manufacturer Web sites), consumers need information at the time of purchase.

• Women who are deaf or hard of hearing are 20 percent less likely than other women to obtain mammograms. The reasons for this are unclear, but two factors might contribute. Some persons who are deaf and use American Sign Language (ASL) as their primary language report that they have little knowledge about routine preventive health services, such as information frequently provided through Public Service Announcements (PSAs). They do not listen to radio and watch limited television, needing closed captioning to access auditory television content. With English as their second language, they also may not routinely read magazines or newspapers and see print PSAs. Second, some women who communicate using ASL describe difficult situations in mammography suites. Unless an ASL interpreter accompanies them, they may be unable to follow instructions from the mammography technician, who disappears behind a protective radiation shield when taking the image. Without being able to see the technician, the woman may be unaware of when to hold her breath (to avoid motion artifact while the equipment generates the mammogram image). A simple system of readily visible light cues could rectify this situation (e.g., a red light for holding breath; a green light for breathing normally).

• Ineffective communication between patients and physicians may generate fears and anxieties that are long-lasting, compromising future care. Some persons who are deaf report physicians being unwilling to hire ASL interpreters for routine office visits, preferring instead to communicate by note-writing. One young woman described being unaware what was going to happen when she had her first Pap smear. The physician failed to explain the procedure (e.g., insertion of the speculum), producing such profound distress that the woman insists she will not return again for subsequent screening. Although the Americans with Disabilities Act requires effective communication during clinical encounters, a Catch–22 confounds this mandate. Physicians are prohibited from charging patients for the costs of the ASL or other sign language interpreters, and interpreter fees often exceed reimbursement for the services. Thus, despite the legal mandate, physicians have a financial disincentive to hire sign language interpreters.

### FINANCIAL ACCESS BARRIERS

Although persons with disabilities are more likely than others to have "social safety net" health insurance, some are uninsured. In particular, individuals with disabilities in States with restrictive Medicaid coverage policies have high rates of being uninsured. In the South, for example, 39 percent of low-income workers reporting disabilities lack health insurance (the nationwide uninsurance figure for this population subgroup is 24 percent).[20] Without health insurance coverage, persons may lack access to critical screening and preventive health services.

### PUBLIC POLICY IMPLICATIONS

Public health officials have recognized the barriers experienced by persons with disabilities.

• In 2000, *Healthy People 2010*, cautioned that "as a potentially underserved group, people with disabilities would be expected to experience disadvantages in health and well-being compared with the general population."

• On July 26, 2005, the U.S. Surgeon General issued a *Call to Action* warning that people with disabilities can lack equal access to health care.

Nevertheless, more efforts are needed to eliminate barriers to public health and preventive services faced by persons with disabilities. According to the Institute of Medicine report, *The Future of Disability in America*, the number of Americans with

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[19] U.S. Food and Drug Administration, Office of Regulatory Affairs. *Guide to Nutrition Labeling and Education Act Requirements, August 1994. www.fda.gov/ora/inspect_ref/igs/nleatxt.html.* Print must be in easy to read type styles, with nutrition facts in bold face: 21 CFR 101.9(d).

[20] These unpublished figures come from our ongoing analyses of the 2000–2005 Medical Expenditure Panel Survey, produced by the Agency for Healthcare Research and Quality.

disabilities will likely rise substantially in coming decades.[21] Aging "baby boomers" will fuel much of this growth, with this enormous cohort entering age ranges with greatest disease and disability risks. Although rates of some serious limitations among elderly persons have declined, sobering reports warn of higher rates of potentially impairing conditions among children and working age adults. Much of this growing risk relates to preventable health conditions, such as those caused by overweight and obesity. Improving access to health promotion and disease prevention programs for persons with disabilities should be a national public health priority.

Senator HARKIN. Thank you, Dr. Iezzoni.

Very good. I appreciate it. Thanks for being here today.

Well, thank you all very much for being here, but more than that, as I said earlier, thank you for your almost lifetime of involvement in preventive healthcare and prevention. I think you can see from the testimony here that we have everything, well, from early childhood to rural populations, disadvantaged, low income, people with disabilities.

We have a broad spectrum of people out there that if they are not getting adequate access to the sickcare system that we have today, if we are really going to change this system and make it more preventive and wellness-based, public health-based, if we just move the present system that way, they are going to be left behind, too.

So, again, your testimonies are great. I just had this sense that we really need to put this together in a form, and my staff is working on that—Jenelle and Lee, others are working on this—to put together a package that would span this spectrum here that we have today of how we change some of these policies to reach out.

You know, people say, "Well, it will cost money." Well, it may cost money, sure. But, it is going to, as you point out, save us a lot of money early on and also later on.

In terms of people with disabilities, you know, you mentioned the unemployment. Perhaps one of the most perplexing and just—I don't know the right word—just confounding, perplexing, and irritating and dismal figures that I have seen since the passage of the ADA, Americans with Disabilities Act, is that people with disabilities are unemployed at the rate of 63 percent.

About 63 percent of people with disabilities are unemployed, who want to work and could work, but they are unemployed—63 percent. We are worried now about 7 percent unemployment among the general population.

So, again, you know, this part of our society—and I know from all my work in this area that if you are talking about exercise and you are talking about diets and you are talking about nutrition, they are just totally left out of the picture. Totally left out.

With that, I mean, and with more of a full integration, people can work. They can get the jobs and everything.

I didn't mean to go on like that. This is one thing that we really need your help on how we put this together. And as I said early on, I hope we can continue to rely upon your expertise as we move ahead on this.

There is one question I want to ask of all of you, though, before I turn to Senator Merkley. Do you have to leave pretty soon?

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[21] Institute of Medicine Committee on Disability in America. Field MJ, Jette AM, eds. *The Future of Disability in America*. Washington, DC: National Academies Press, 2007.

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I will tell you what. I will save my question. I will turn to Senator Merkley. Go ahead for any statements you want to make or any questions. Go ahead, Jeff, and then I will come back. I have more time.

Senator MERKLEY. Thank you very much, Mr. Chair.

No statement, but a couple of questions.

The first is I believe, Dr. Hagan, you referred to the model of retail-based clinics being a model that doesn't work well. Can you expand a little bit? We have our rural health clinics and our school-based clinics and our Federally Qualified Health Centers, and I am not familiar with your commentary on retail-based clinics. If you can just give a little sense of that.

Dr. HAGAN. I am relieved because I hesitate to hear retail-based clinics in the same sentence as Federally Qualified Health Centers. Retail-based clinics have been—are just as they say. They are open in your local Wal-Mart or your local drug store. They often employ a nurse or a nurse practitioner to provide walk-in episodic care.

Now it may or may not be a good place to go for a sore throat, but it certainly is not a medical home. When the retail establishment closes, so does the health center. When you need help after hours, you go to the emergency room. I mean, that is a very expensive nonsystem of care.

It has become prevalent in many parts of the country, thankfully not yet in New England.

Senator MERKLEY. Thank you very much.

Second question I wanted to ask for whoever would like to respond to it is many of you have talked about clinics and the role of primary care physicians. The demographics, I believe, of the number of primary care physicians is not encouraging, in part because so many doctors are reaching retirement age in general and in part because of the financial incentive for folks to move from primary care into specialties.

As we look at that curve ahead of us in which so many more citizens are aging and needing additional healthcare, yet so many physicians are retiring and those who aren't retiring are in referring specialties, how do we address this? How do we particularly address it in the context of physician services in rural areas?

Dr. STEVENS. Senator Merkley, if I could say a few words about that? First of all, I think your observation is quite accurate. I made comparisons to other countries, and those countries had at least 50 percent of their clinicians who are in primary care and we have only about a third. There is a direct relationship between our primary care infrastructure and our ability to deliver wellness and also, Dr. Hagan, in terms of a system where there is a medical home.

Two things, in other countries and our country. One is, is to have policies that influence the distribution of primary care physicians and that encourage clinicians to go into primary care.

One of the programs that we have now that has been quite successful—in fact, I was in it—is the National Health Service Corps, for example, where there are incentives and there is support for physicians who go into primary care. You know better than I do in terms of the debt and the other issues—in fact, in Great Britain,

in the United Kingdom, primary care physicians are paid more than they are in the United States.

We need to have policies and encourage people to go into primary care, so they know they can get a good living. And secondly, we need to encourage people like the National Health Service Corps and other programs to go into areas where there is a greater need for them.

Dr. LAVIZZO-MOUREY. Thank you for that question. I certainly agree with Dr. Stevens about the incentives for going into primary care among physicians. I think we have to also recognize that much of healthcare is practiced in teams, and particularly teams that pair physicians with nurse practitioners and other healthcare providers can provide healthcare at the primary care level that has been demonstrated to be equivalent to that provided by physicians alone.

I think as we consider how we are going to meet the workforce demands of the future, we need to think not only about primary care physicians, but teams of healthcare providers that can provide those services both in urban and rural settings.

Dr. BUTLER. I think it is ironic that at the moment the country is growing older, we not only have a growing shortage of primary care physicians, but nurses. From 1985–89, when I served on the Physician Payment Review Commission, working for Congress, we tried to address the reimbursement issue, which so favors the procedural specialties rather than the primary medicine. And that is a tough one.

Somebody is going to have to deal with it because as long as we have perverse incentives in favor of procedures, we are not going to have primary care medicine.

Dr. HAGAN. I practice primary care pediatrics in a small practice. I am not going to whine about the fact that surgeons make more than I do. I will point out that our medical students at the University of Vermont College of Medicine, which is not a terribly expensive medical school, are graduating with incredible debt load.

Now, we may be able, as experienced adults, to think that over the years, $300,000 is not a huge number. But someone who is in——

Senator SANDERS. I think it is a huge number.

Dr. HAGAN. I do. I think it is a huge number, Senator. Thank you.

That is what two of my medical students that I have as freshmen in my clinic are facing. As they are making their decisions about residency and about what they expect to earn first year out, they are drawn to orthopedics. They are drawn to other specialties that are going to have them feel more competent to address this huge debt load.

I think if we don't address the debt load on our students, we are not going to be able to draw them into primary care. I am troubled by that.

Mr. MEIT. I agree with everything I have heard. I would add that, in addition to doctors and nurses, we also must remember that it takes a lot of other people to run healthcare facilities, and we also have shortages of other health professions, including allied

health professionals. That is an opportunity for rural communities to provide jobs for local citizens within their community.

One of the interesting demographics of rural America right now is that it is disproportionately older. The reason that rural America is disproportionately older is that the youth are leaving rural America. This provides job opportunities for youth to keep them within their communities, and I think that is another tremendous opportunity that we shouldn't miss.

Dr. STEVENS. Senator Merkley, there is one other thing. There is another solution. There is a university called A.T. Still University, which is an osteopathic school.

Senator HARKIN. Where?

Dr. STEVENS. In Arizona. They have, first of all, re-designed medical education. After the first year, students are educated actually in community health centers across the country, and they are chosen on the basis of mission, about wanting to go into primary care and wanting to go back to underserved communities. There is also a dental school there.

I think we also have to look into how we can design the medical school experience to encourage the right kinds of folks to go into primary care and to get them engaged early into what it is like working in different communities.

Senator HARKIN. What is the name of the school? I didn't hear——

Dr. STEVENS. A.T. Still.

Dr. BUTLER. One of the reasons the European medical practices are more predominantly primary—sorry. My fault.

Dr. STEVENS. A.T. Still. I will give it to you afterwards.

Senator HARKIN. Dr. Butler.

Dr. BUTLER. I was just going to indicate that we have to remember Europe has a very different culture. In France, for example, medical school is free. The prospects of more people going into primary care medicine is very different, where they do not have $40,000 to $50,000 a year in many medical schools today in America to pay your tuition and have on average $140,000 worth of debt when you leave.

It is an extraordinarily different culture, and it is worth noting this distinction.

Senator MERKLEY. Mr. Chair, thank you very much.

Senator HARKIN. Thanks, Senator Merkley.

A little follow-up question on that. Well, my question was about incentives, but you kind of all addressed yourselves to what incentives we put into it.

The one on medical school, on helping medical students who want to go into primary care, forgiving their debts, loans, and stuff so that they have that incentive I think is something that we have to look at.

The other thing that has bothered me for some time now is that—we have one, two, three, four, five doctors here—I have come to know that in medical school, that you go through all this medical schooling and you get precious few courses in prevention and wellness. Has that been your history?

I mean, how can we change that? How do we get more courses where students have to take courses in health and wellness and prevention and primary care?

Dr. Hagan.

Dr. HAGAN. Go ahead.

Dr. BUTLER. I was going to say there is a chicken and egg problem, too. You have to have well-trained teachers. Teachers come first. If we don't have the teachers that are dedicated to the concepts of health promotion and disease prevention, we have a problem.

We have to start to make sure we get well-trained teachers. Similarly, in geriatrics and other neglected fields.

Senator HARKIN. Dr. Hagan.

Dr. HAGAN. I think the trend is changing. Certainly there is more preventive health being taught in all medical schools. It is required by the accreditation organizations.

Certainly in primary care there is much more training in preventive healthcare. That is what Bright Futures is about. It is about prevention. I think that HRSA was wise in the use of those limited funds to focus on prevention.

I think that it is probably not enough yet, but it is a whole lot more than when I was a medical student at Georgetown.

Senator HARKIN. Any other observations on that at all before I turn to "Senator Community Health Center?"

[Laughter.]

Senator Sanders.

Senator SANDERS. I accept that title.

[Laughter.]

There are worse titles. I have been called worse.

First of all, I apologize for being late, Senator Harkin. Everything I have heard in the last 10 minutes is like music to my ears. This is exactly what we should be discussing, and I know these are the issues you have been leading on for a very long time. I think we are now at the moment in history where we may get to implement some of these ideas.

Let me just ask the panel—Senator Harkin and I are working together, along with a number of other Senators, on a number of issues—would you agree that it makes sense and in the long run saves money if we greatly expand the number of community health centers so that everybody in this country has access to a doctor, a dentist, mental health counseling, and low-cost prescription drugs?

That we keep people out of emergency rooms, we get people before they become very ill and end up in a hospital. Does that investment make sense to all of you?

Senator HARKIN. Well, you have two that work in community health centers.

Dr. STEVENS. All I can say is "Amen."

Senator SANDERS. What we are working on is the quadrupling of community health centers over a 5-year period from an investment of $2 billion to $8 billion and providing a community health center to every underserved area in America. We think what the studies show is that you actually save substantial sums of money in doing that by keeping people healthy rather than having them end up in the hospital.

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Does that make sense to everybody in this room? OK.

Let me ask you another question that was touched on a moment ago, all right. Senator Harkin and I and others are also working on this issue that Dr. Hagan talked about that I am sure you all talked about earlier. When people graduate from medical school $200,000 or $300,000 in debt, they are going to go to specialties to pay off their debt.

What we are trying to do, and I think you will see immediately in this stimulus package—by the way, a significant increase in funding for the National Health Service Corps. Can you talk about the National Health Service Corps and your support or lack of support for it?

Does it make sense to you to provide debt forgiveness and scholarships for those people who want to serve in underserved areas in primary healthcare? Does that make sense to you all?

Dr. STEVENS. Yes. I was in the National Health Service Corps, and I served in the South Bronx. All I can say is, I agree totally with you.

Senator SANDERS. One of the areas, when we talk sometimes about community health centers—Senator Harkin is from Iowa. I am from Vermont. Sometimes people think, well, this is just for urban areas. Believe me, it is not. Rural America faces enormous problems.

In our State, we have expanded community health centers from 2 to 7 in the last 5 years, which have had a very, very positive impact. We have a number of more to go. You are all in support of greatly expanding funding for the National Health Service Corps and getting doctors out into underserved areas.

What about, I didn't know if you went into dental care at all? Is that something that——

Dr. HAGAN. Senator, before we leave the National Health Service Corps, my only concern with that is, obviously, it should be expanded as to anybody who wants to use that for their debt recovery. That would be good. But, I think there should be other models as well.

We do need pediatricians and internists in community health centers. We need them in rural areas, but we need them in Burlington. You know, it is a long time to get a well visit for an adult in our own town.

The National Health Service Corps is not going to deliver people immediately and everywhere. I think it is a strong model, but I think it should not be perhaps the only model.

Senator SANDERS. You know, I read something. I don't know, Tom, if you are aware of this. That if we were not importing thousands of physicians from India and countries which themselves are in desperate need of doctors, if we were not dependent on foreign doctors, our entire primary healthcare system would collapse.

Is that something, the idea that in the United States of America, we are not educating doctors that we need is incomprehensible. Is that something that——

Mr. MEIT. Yes, and I think that is particularly true in rural areas.

Senator SANDERS. Say a word about—I am sorry.

Senator HARKIN. Dr. Iezzoni.

Dr. IEZZONI. Risa, you go first, and then I will.

Dr. LAVIZZO-MOUREY. Very quickly, Senator, I just wanted to mention that in addition to providing access to care, health centers also provide access to high-quality care for chronic illness. A very powerful study has shown that Federally Qualified Health Centers provide a system of care that allows for better outcomes in diabetes care, better outcomes in other chronic illnesses because they use a system that also integrates the community and supportive environments within the community.

There are two reasons to support health centers, not only the access that they provide to primary care services, but they do a great job of providing high-quality care.

Senator SANDERS. Well, the bottom line, Doctor, is when you have a physician who you trust and see on a regular basis, things are going to happen that doesn't happen when you are just bumping into an emergency room.

Dr. LAVIZZO-MOUREY. It is that combination of the trusted medical home, but also a system that allows for measurement of quality and improvement of quality, particularly in chronic care.

Senator HARKIN. Yes, Dr. Iezzoni.

Dr. IEZZONI. I certainly support dealing with the debt that medical students are faced with. However, I think that there is another issue that is preventing medical students from going into primary care, and that is what they see their mentors' lives being like. The students look at the work life of the primary care practitioners that they are basically apprenticed to, and they decide, "I cannot do that."

I am from ground zero on healthcare reform, Massachusetts. I do not have a primary care doctor. My last primary care doctor, I saw her in December. She said she was leaving practice because she just can't take it anymore, and she wants to figure out how to reform the entire healthcare system.

My primary care doctor before that, who just resigned from primary care a year ago, became a hospitalist, hospital-based medicine doctor. I actually am a professor of medicine at Harvard Medical School, and I do not know where I am going to get a primary care doctor.

Actually, a very senior physician who I know was in a similar situation, called up Gary Gottlieb, the president of the Brigham & Women's Hospital, who managed to get him a doctor in the women's healthcare program because he knew a woman in the women's healthcare program and got a doctor for this man.

It has really gotten to that point. I think that a lot of people want to go into primary care because they want to give the best care possible to the kind of underserved population that a number of us have been talking about this morning.

With the ENM codes giving X dollars of reimbursement for the routine kind of visit, they simply do not have the time to provide the kind of quality of care that they want to provide as a primary care doctor. And so, their work lives become intractable.

The medical students see that, and I, frankly, think that that is one of the contributions to people not going into primary care.

Senator SANDERS. Very good point.

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Senator HARKIN. That is a great point. I can tell you in my experience in Iowa, I have a number of cases of primary care doctors, most of whom have come from Des Moines University's osteopathic teaching hospital in Des Moines, and they do a lot in primary care. They have gone out to places like Mason City and Charles City. I just happened to think of a couple of places where we had primary care doctors, and they lasted about, oh, 2, 3 years, something like that.

They were getting married. They started having children of their own, and they had no time with their families. They couldn't take a vacation. They were on call 24 hours a day, 7 days a week, middle of the night, middle of the day. After a while, you just burn out.

And they just can't take it anymore. I have seen this. I have seen it happen in my State.

Dr. STEVENS. Senator Harkin.

Senator HARKIN. Yes.

Dr. STEVENS. This is building on what was just said, is we know a lot more about how to organize a practice, and teams were mentioned and how effective they can be and the use of data and having the right systems. We are not trained in medical school or, quite frankly, even nursing school about those.

What we found in the health center program is having an infrastructure where we had support or people who could help us do that——

Senator HARKIN. Sure, I see what you are saying.

Dr. STEVENS [continuing]. And I would say, maybe we are talking about 2 to 3 percent of this whole budget, it was extremely important in order to learn about how to organize a practice, what to do with your quality outcomes, how to keep on improving, not rest on your laurels, and also how to build staff experience as well as patient experience in the practice.

Senator HARKIN. I think that is a great point because the cases I mentioned that I know I have in my head are all primary care doctors that were just kind of in a small practice of their own. They didn't have the infrastructure to support them, that type of thing, which you do in the community health center type system.

That is an interesting, interesting point.

Dr. Hagan.

Dr. HAGAN. Thank you. I think that that is very much embodied in the medical home model. I think that community health centers are excellent medical homes. There are other good medical homes, too.

The current funding for Bright Futures from HRSA is actually about implementing these services, looking at implementing preventive care services in practices in many different styles. Community health centers like yours, private practices like my own certainly can be held to a bar for good quality preventive services.

One must learn to develop partnerships and teamwork, not just with allied health professionals and the very valuable nurses on our staff, but also with families. Our focus now within the academy is to teach our fellows how to do that and how to raise that bar. It is a barrier.

Senator HARKIN. Mr. Meit, I am going to get to you next. How much—if you don't know right now, maybe my staff can find out.

How much are we funding through HRSA that we are funding to Bright Futures? I have no idea.

Dr. HAGAN. When the grant started, it was a 5- or 6-year period, and it was, I believe, $5 million to bring together the tremendous number of experts who wrote it and then a smaller amount in that $5 million to actually implement it. That is the process that we are in now.

We had about 50 experts contribute to the writing, and we had over 1,000 reviewers. It is a large project.

Senator HARKIN. Thank you very much.

Mr. Meit.

Mr. MEIT. I would like to make two points. Senator Sanders, you mentioned oral healthcare. I want to make sure that that is an issue that isn't neglected because it is another critical issue in terms of prevention within all communities, in particular within rural communities, which is my focus.

There is an undeniable link between chronic preventable disease and oral health. I think that needs to be stated. In addition, what I think is often neglected more is there is a link between oral health and economic viability within communities.

There was an interesting study in West Virginia, where they did a study of welfare recipients. It was a welfare-to-work study. It was done probably 6 or 7 years ago. The second most common reason that people stated, self-report, that they stated for not being able to get a job was oral aesthetics.

No. 1, was they had medical conditions that they couldn't get a job. No. 2, was oral aesthetics. Their teeth looked bad, and no one would hire them. That is a particularly striking issue.

The other thing I would like to say is I am a firm believer in community health centers. I agree that we need more primary care physicians. I also want to make sure that we don't forget about strengthening the public health infrastructure as we have those capacities.

The healthcare delivery system and public health infrastructure need to work hand-in-hand in creating healthy communities and preventing disease, and we can't build one and forget about the other because we clearly need both in our rural communities and our urban communities throughout the United States.

Dr. HAGAN. Senator Harkin, may I correct my——

Senator SANDERS. If I could just comment on Mr. Meit? You have made a very interesting point. If we want to get people to work—and I can tell you, and Dr. Hagan will acknowledge this, that in my State, you have many people who have dental health problems that can lead to tooth loss.

The truth is when you walk in to get a job and you smile and you have no teeth in your mouth, it is kind of a badge of poverty. It is a badge of failure, and you are not going to get that job, everything being equal. It is hard to. Then you stay low income, and you don't pay taxes and everything else.

You know that—you do know, of course, that Medicaid does not pay for dentures. Medicaid does not pay for glasses. Medicaid does not pay for hearing aids in the United States of America in the year 2009.

You tied that to an economic issue, which is interesting. I hadn't thought about it in that way.

Mr. MEIT. The jobs that people are likely to get at that level are jobs where they may be a cashier. They are public jobs where they are going to be very visible.

It is interesting to me that the thought of being able to buy somebody a pair of dentures, and that is the ticket for them to get off of welfare, it is a very low-cost approach that could be very effective.

Senator SANDERS. It is interesting.

Dr. HAGAN. Yes, we also recognize, Senator, that the transmission of the bacteria that lead to a dental illness is vertical and that mothers often transfer it to their children before 6 months of age. Before 6 months of age. It will repeat itself generation to generation.

Oral health risk assessments are very much part of pediatric preventive care now, beginning at 6 months with anticipatory guidance with things directed to parents beforehand.

Now if I may correct my dollar statement? It is $1 million total. It was $700,000 for the writing, and $300,000 implementation, and I realized that I pulled that number out of the wrong hat.

But, the oral health approach, we are indebted to the pediatric dentists who really helped us recognize that this is a major health problem for children and not simply a long-term problem in terms of the long-term effects, but an acute problem as well.

Dr. LAVIZZO-MOUREY. I would like to just underscore Mr. Meit's comments about the public health system and have us think more about the preventive services that are encouraged by public health systems. We have spoken a lot about primary care and physicians' offices and screening, and those are all extremely valuable. I remind you that that is a small fraction of where we spend our lives.

Mostly, we are in school or we are going to work or we are out walking or we are living our lives. The policies that will encourage health in those areas are the ones that are really going to dramatically improve the health of the country.

As Dr. Butler suggested, that will encourage us to walk more, policies that will encourage our children to eat healthier foods, to have access to healthy foods, and to exercise in their communities, those things that will help us live long, as Dr. Butler underscored, are the same kinds of programs and policies that will help our children begin a healthy life.

If I could just underscore one that really makes a difference? That is a program that focuses on young women when they are pregnant, before they even become mothers, a nurse-family partnership that brings a nurse into the home of a young woman for 2 years.

Studies have shown that if you follow those kids out 15 years, they have less drug abuse. They have a greater chance of staying in school. Their mothers stay in school. Early on, they use less emergency room care. It is a cost benefit all the way around.

Senator SANDERS. Tom, can I——

Senator HARKIN. Yes. Go ahead.

Senator SANDERS. OK. You touched on the word "schools." I, again, apologize for being late. I couldn't be at two places at the

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same time. I will give you an example of something about school-based healthcare.

In both Bennington and in Burlington, we managed to get dental chairs in the school, which has had a profound impact on pediatric dentistry in terms of caring for a lot of low-income kids. It has worked phenomenally well in both Bennington and in Burlington.

What do you guys think about school-based healthcare and dental care in general? Putting dentists in schools, perhaps physicians once in a while in schools, does that make sense?

Dr. LAVIZZO-MOUREY. I would just comment very briefly, since our foundation funded a program that put 1,500 school-based clinics around the country. And two outcomes I would underscore.

One, the need for dental care and putting dental chairs within schools dramatically improved access to care and the outcomes related to it. Also mental health services, those are the two services that are most in need and where children getting those services in the school are tremendously beneficial.

Senator SANDERS. You have studies which show that these have been successful?

Dr. LAVIZZO-MOUREY. Yes, and we can get those to you.

Dr. STEVENS. Many health centers, as you know, have school health programs as part of their work.

Senator SANDERS. In fact, in Burlington, that is what we are doing. The community health centers linking up.

Dr. STEVENS. We get the family involved, and that is very important.

Dr. BUTLER. As a geriatrician, I would like to speak up for pediatrics.

[Laughter.]

Most of the diseases of old age have their beginnings at the beginning of life. I am not just talking about genetic conditions with which one might be born, but the environmental conditions in which children grow up, the extent to which behavioral and lifestyle factors come into being.

Osteoporosis, which we think of as a bone disease of old age—if bone was laid down during pubescence and adolescence with adequate vitamin D and calcium, and in the absence of further alcoholism or smoking, chances of having osteoporosis is going to be dramatically reduced. It is as though that bone laid down during the pubescence and adolescence is critical.

Sadly, in our toxic food environment, sometimes we will see fatty plaques, atherosclerotic plaques in toddlers in this culture. So, again—and that is, of course, the underlying base. It is hard to see stroke and so forth. I just want to put in a real strong plea that as a geriatrician, it makes a difference.

When I first got into this field, in 1955, half of our older patients had no teeth at all. There has been a dramatic improvement, thankfully, and I lay that to the door of the excellent work of pediatricians.

Dr. HAGAN. Thank you for that.

[Laughter.]

Dr. BUTLER. Do the same for me sometime.

Dr. HAGAN. Absolutely, and I push calcium to my pre-adolescents and adolescents every day.

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Senator, I can't say enough good about school-based health centers. I think about where do kids spend most of their time? It is tough to navigate childhood and adolescence, and it is tough to be healthy during those periods of time. Anything we can do to improve their health, I welcome the work of my colleagues.

Amy Mellencamp, principal of Burlington High School, was one of our experts. Amy was a huge help to the adolescent panel in helping suggest what should be in the things that physicians talk to adolescents about so that we can be in parallel with what schools are passionate about.

Absolutely, we are in favor of that.

Dr. BUTLER. We haven't touched on it much, but we really do have to deal with overweight and obesity. I know the Robert Wood Johnson Foundation most certainly is. It is a terrible problem. It is very disheartening to see a 10-year-old child overweight with old age, not dying of old age, but old-age diabetes in this culture.

How we alter the food habits, how we—maybe we have to make the lunch hour with kids a nutritional teaching experience rather than just pizzas and hamburgers. There has got to be some way we can interrupt this unfortunate cycle, which is going to lead to not just the obesity of children, but to a very deficient old age.

Senator HARKIN. Well, let me just say, Bob, that one of the things we have to reauthorize this year is the Child Nutrition Act. That is the school lunch, school breakfast, and the WIC program.

Dr. BUTLER. Yes.

Senator HARKIN. I think we have an opportunity—at least I hope we do—of really making some changes in the kind of foods our kids eat in school, what they are served both in the lunch and the breakfast program, and the snacks, vegetables, fresh vegetables and fruits for a snack program. And getting the soft drinks and candies and stuff out of the vending machines.

We have an opportunity to do that this year. I hope that, again, we can be talking to you and our friends in the American Academy of Pediatrics also about their support and suggestions for how we change that. But, you are right. We have got to get better food for our kids in school.

The other thing is the exercise, and who mentioned that? One of your testimonies talked about recess and, yes, that was you, Dr. Lavizzo-Mourey. Yes, about how we have to structure better exercise programs in our schools. I have seen them. Some schools do them. I mean, there are models out there for what we can do, but it is just sort of hit or miss, here and there.

I have said it to former Secretary Spellings a number of times, and I have said it to our new Secretary Duncan that we have No Child Left Behind in reading and in math, but how about no child left behind in terms of their health, just their basic health in school.

It seems to me that is also an important function for our schools. Anyway, I just wanted to mention the reauthorization of the child nutrition bill this year that we really have to focus on.

I guess in listening to all of you, I have got a new idea, Bernie.

Senator SANDERS. We are in trouble.

[Laughter.]

Senator HARKIN. I have got a new idea. That is to marry the public health system with our community health centers. Because I was hearing about, talking about community health centers, they do a great job in Iowa, but someone said don't forget about the public health sector. I am thinking to myself, "Why can't the two be joined at the hip somehow?"

So that we have a public health input in through our community health centers, and then we also use the community health centers to back up, supplement our public health system. Somehow it seems to me that could be done.

Mr. MEIT. We were talking about that at the beginning of this session, in fact.

Senator HARKIN. Yes, we were.

Mr. MEIT. I think that is something that should be explored.

Senator HARKIN. Yes.

Mr. MEIT. Again, I had mentioned that the public health infrastructure in many rural areas is lacking or nonexistent.

Senator HARKIN. Right.

Mr. MEIT. We have a very patchwork public health system around the country. The community health center system is very strong and growing. That may be the foundation upon which we could build a stronger public health system. I think it is very worthy of exploring. I think there are some models out there where public health and community health centers have collaborated very effectively, and they could be the models for that.

Integrating the public health workforce into the health centers I think is a phenomenal idea. It is an approach that I think could be very productive being able to capture the epidemiological data within the community. I think there are a lot of synergies there that I think could be very beneficial.

Senator HARKIN. I have got to think more about that.

Dr. HAGAN. Senator Sanders, you will remember when our first community health centers were founded in Northeast Kingdom 15, 20 years ago, when Madeleine Kunin was our governor. The Vermont Department of Health was very much a partner in that formation.

Our immunization system is one of the best in the country because of the public-private partnership that really supports that connection between public health and the health delivery systems.

Senator SANDERS. Actually, the gentleman who helped found that system is sitting behind me right now and now works on my staff.

Dr. HAGAN. I know that.

[Laughter.]

Well, the other thing is that——

Senator HARKIN. Bob.

Dr. BUTLER. Senator Harkin and Senator Sanders, a bit of a challenge that might be worth looking at with this change of administration is that the Departments of Agriculture and Health and Human Services are not really in alignment when it comes to nutrition.

Senator HARKIN. That is very true.

Dr. BUTLER. Many of the things that the Department of Agriculture advance, understandably in representing the needs of farmers, are fructose and so forth. Whereas the very kinds of things

that are not advantageous to the American diet, which may be promoted by the Department of Health and Human Services, are not in league.

I don't know quite how you magically deal with that, but there may be some ways of kind of accommodating and coming to terms with the discrepancies between the two departments.

Senator SANDERS. You are probably talking to the right guy, who is chairman of the Agriculture and Health and Human Services.

Dr. BUTLER. I thought I could pick on Tom.

Senator HARKIN. Well, 2 or 3 years ago I tried in the committee—I wasn't chairman at that time—an amendment to have every school in the country that participates in the lunch program, which is about every school, to develop a wellness policy.

Now every school in America has developed a wellness policy. The problem is I wanted it to be a wellness policy based upon the recommendations of the Institute of Medicine. I lost that. I am coming back this year.

Dr. BUTLER. Good. Come back.

Dr. STEVENS. I think another characteristic that makes health centers an important partner for public health, it is the only system I know where the care is based on the community needs assessment of the health needs of the community. It is a perfect marriage between public health and primary care.

Senator HARKIN. Yes.

Dr. STEVENS. Second, and I can follow up with your staff, there are two really good examples. One was around immunizations, and one was around chronic care where we worked very—we have a model for that, how we worked with local public health and with the CDC. We have some ideas about how to do it.

And third, it might be weird from a guy who worked in the South Bronx, but the Extension Service in Agriculture is also a vehicle in terms of extension agents that can be doing health prevention messages right there on the front line. I think that is also a potential.

Senator HARKIN. I never thought about that.

Mr. MEIT. And that is being done. I had previously been in Pennsylvania, and in Pennsylvania, the Cooperative Extension is very involved in health education throughout the State, and that is how a lot of health education happens in rural jurisdictions.

Pennsylvania doesn't have a strong public health infrastructure in the rural jurisdictions. They have tried to identify other partners, and some of those partners have been Cooperative Extension, and they have been a very good partner.

I think the only other thing I would add, I really like this idea of a marriage between public health and community health centers. It just needs to be about more than just access, though.

One of public health's core functions is to ensure access to healthcare services. That is a core role of the community health centers. It needs to go wider and deeper than that so that the community health centers get involved in all aspects of public health, delivering broad messages to the community, conducting disease surveillance, helping to implement community policies.

It is not just about making sure that everyone has accessible healthcare services. That is critical, but it goes wider and deeper than that.

Senator HARKIN. Dr. Mourey.

Dr. LAVIZZO-MOUREY. I agree. One of the things that we are learning about improving the quality of public health services is that there is a tremendous variation in the quality of services across the country.

Senator HARKIN. Yes.

Dr. LAVIZZO-MOUREY. The public health professionals themselves are calling for greater accreditation standards and improvement of those standards as time goes on to ensure that whether it is a community health center that is delivering the services or a public health department or at the county or State level, we are ensuring that the level of standards and the quality of public health being delivered is what it should be across the country.

We know that the return on investment for delivering public health as opposed to medical care is tremendous. We have got to make sure that public health is being delivered, whether it is in a community health center or in some other venue.

Senator HARKIN. Dr. Iezzoni, I have been thinking. I mentioned earlier about the training of doctors in medical schools on prevention programs and approaches. Another thing that is lacking is for doctors and nurses and other health professionals to get adequate training in dealing with people with disabilities. They just have not——

Dr. IEZZONI. OK. I will go anywhere at any time to talk to medical students about this, and you are absolutely right. They don't hear about it at all.

Senator HARKIN. They don't.

Dr. IEZZONI. No. On Tuesday, I was teaching the second-year Harvard medical students in their Patient-Doctor II course, and I told them this will be the only hour in your 4 years at Harvard Medical School that you will hear about disability.

Apparently, when I left the room, which I had to do because I had a van scheduled—and when you are disabled and the van is there, you have to leave—they sat around for a half an hour and talked to the course director and said absolutely that is true. They will not hear about this topic again.

Now you had mentioned earlier about how do you get preventive services onto the agenda of medical schools? This is the phrase that I hear repeatedly, at least at Harvard, from the curriculum people. "The real estate is really tight here." There are tons of people jockeying for space on the real estate, i.e., the curriculum at the medical school.

There are the genomics people. There are the new imaging people. There is just so much fund of knowledge that today's medical student needs to become aware that the kind of push-pull among different groups trying to get a hold of the students' attention is just really kind of dramatic at medical schools.

And so, you are absolutely right. They do not hear about disabilities. They do not also hear the more general topic of functional assessments, which is the more general topic.

Senator HARKIN. Yes, right.

Dr. IEZZONI. Yes.

Dr. HAGAN. In way of counterpoint, and I agree completely, I think efforts are certainly being taken in many medical schools. At

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the University of Vermont, our first-year students have a mandatory course called Medical Student Leadership Groups, where they meet every week and they talk about doctoring, not just about medicine.

The most popular week that I have with my preceptees is when the parent of a child with special healthcare needs comes in to talk about what it is like to have a disabled child. As your students' response was, it is dramatic. That is always the week that they highlight most in the course.

I can't speak for what happens in medicine, but I can say that when our students come into pediatrics, wherever they are rotated, whether it is on the floor or in the clinic, they are seeing children with special healthcare needs.

The model is the medical home model. The model is care management. The model is working collaboratively. It is a whole lot better than when I was trained, and it is not—I mean, UVM isn't Harvard. I agree. I think that there is room in the real estate, and I think it has to do with when we teach them genomics and we teach them radiology, how do we integrate that into the care of patients?

Dr. IEZZONI. Oh, I agree. I can only speak to where I am and what I know the most about. I do hear about programs around the country in other places, the University of Florida and the University of Pennsylvania in Philadelphia, have, again, an hour on it. You know, an hour.

I think it is wonderful that the parent with the kid comes, and I agree that that would be a very evocative something that the students will probably remember all their entire lives. I remember that from my medical school days of a given patient that I will remember now 30 years later.

But, I just think that the kind of continuity of looking across the lifespan at functioning, the fact that disability is not a minority issue. It is something that we all will face at some point in our lives. Kind of the lifespan context of that, I think, has not really been conveyed in medical schools in the way that might be most powerfully done.

Senator HARKIN. Again, a lot of times when we talk about people with disabilities, we think of someone that uses a wheelchair or has a physical disability. How about people with intellectual disabilities?

Senator SANDERS. Or mental health issues?

Senator HARKIN. Or mental health disabilities, kind of two other groups that have trouble accessing and getting adequate primary care in our system.

And again, I have talked to dentists—I don't know why I focus on dentists, but they just don't have any training at all in how to deal especially with kids that have intellectual disabilities, a Down Syndrome kid or something like that, and how you deal with them. They don't know.

Dr. HAGAN. The pediatric dentists, the Board of Pediatric Dentists are actually trained. How well I don't know, but I think the children certainly in Burlington are well served with special needs kids because we have a core of pediatric dentists there.

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But, I think you are right. I think it is broader than just the so-called obvious disabilities. We know that one in five children from the beginning of middle school to the end of high school will have a diagnosable mental health condition. They are underserved. They have a chronic problem for a period of time.

Senator HARKIN. Yes. Well, we just had that in a hearing the other day about that, about how—first of all, a lot of physical ailments that we have in our society are traceable back to mental illnesses that people have. Those mental illnesses kind of go back a lot of times, back to youth, back to grade school, high school.

When they don't get treated early on, they fester, and they grow and they fester. They get worse and worse as they get to 18, 19, 20, 22 years old. Now they have physical ailments as a result of that. And so, you are right on point on getting more mental health in pediatrics, for kids in school, in high school.

Some of these kids come from tough homes, tough neighborhoods. They have tough lives. Yet they are trying to struggle with it and cope with it, and they have absolutely no help or support whatsoever in that. That is just another area that we have got to think about in terms of primary care.

Dr. LAVIZZO-MOUREY. And frankly, prevention. One of the programs that has been very exciting for us is one that actually trains people in schools—teachers, counselors, and the like—families, and people in communities to recognize the symptoms of serious mental illness before it becomes a full-blown psychotic event and to begin to structure the environment in a way that you can actually prevent some of these terribly debilitating and lifelong problems.

Having the services in the schools to treat is important. Even more important, I think, is beginning to train people to recognize these symptoms before they become psychotic problems or real disabilities.

Senator HARKIN. You know, everybody talks about change. We have got to change this, and there is a lot of talk about change. There is one thing that hasn't changed in several hundred years, 300 years, I don't know. The concept of school, that a classroom is a bunch of kids sitting out there and a teacher up in front. It has been that way forever. Is that the best model? Is that the only model?

You know, it used to be that kids with disabilities were shunted aside, were not incorporated. Many sent to special schools, schools for the deaf, schools for the blind, schools for this, schools for that. Now we are trying to integrate them. Maybe we have got to change the way we think about the classroom.

Since society is evolving, maybe we have got to think about that classroom as not just a teacher who is teaching a subject to the kids, but there is a teacher teaching a subject. There is a child psychologist dealing with kids and their emotional and mental health problems. There is a nutritionist/dietician dealing with their food intake and what they eat.

There is a Physical Ed teacher teaching them how to exercise and how to be healthy. Maybe this whole concept of one teacher sitting in front of all of those kids is old. Maybe we have to change the way we think about a classroom in America today and how kids

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are educated since they do spend so much of their daily lives in school.

Again, I don't want to fall in the trap of saying, "When I was young, things were great," you know? That is a definite sign of old age when you start talking about that.

[Laughter.]

It is true. When I was young in school, I mean we did exercise. We had an hour a day—a half hour at lunch, 15 minutes in the morning, 15 minutes in the afternoon. We had to leave the building. We had to go outside. Well, maybe if it was 20 below, maybe we didn't. But most of the time we had to.

We had that, and we had everybody exercise, girls and boys together. I mean, we had softball teams that were made up of girls and boys together. I see today that doesn't happen anymore.

And in terms of nutritious meals and stuff, I think our meals were much more nutritious. I was in grade school when the school lunch program started, and I can remember as a kid thinking this is great. This is really something getting fresh, just getting fruit and vegetables and high protein, good quality meats, things like that. Now it is all junk food.

I don't know why I got off on that tangent, but just the idea that schools need to be more than just that one teacher teaching a bunch of kids. Anyway, that is just my thought for the day. I don't know if it is worth anything or not.

Did you have anything else?

Senator SANDERS. Well, I just wanted to pick up on Dr. Iezzoni's point about medical curriculum, and it just occurs to me, my thought of the day, is that a society which ignores, to a significant degree, primary care, by definition, the medical schools are going to go where the money is. If the money is in high-tech tertiary care, that is where they are going to train the physicians.

Meanwhile, 50 million Americans don't have access to any doctor at all, and schools don't have access to nutritionists, et cetera, et cetera.

I think what we are really looking at is a revolution, which will eventually filter down to the medical schools as well, when we begin to say that long term, as Tom just indicated, we have got to pay attention to the kids. We have got to make sure that we do a much better job in terms of nutrition, in terms of exercise, and keeping people healthy.

I think once we make that revolution, which probably will start here, it will filter down to the medical schools because that is where people will be working in those areas. Does that make sense to you?

Dr. IEZZONI. I would like that to happen.

[Laughter.]

Senator HARKIN. I have to go. Do you want to stay any longer or not? I have to go to an Appropriations Committee. I already announced it.

Senator SANDERS. Senator Harkin has to go and has asked me if we want to prolong the meeting. Are there any other issues that have not been discussed that you would like to bring public? If there are, I am happy to stay. If not, no. Or do you think we have covered the terrain?

Senator HARKIN. I thought this was a great discussion.

Senator SANDERS. I agree.

Senator HARKIN. Of course, this was right up my alley. Why wouldn't I think it would be a great discussion? You are all really experts in your fields, and you are all on the right track on this.

Again, I just want to ask all of you to be available to our staff for further input and consultation as we move ahead.

Thank you all very much. I know some of you came a great distance in bad weather, and I appreciate it very much.

Senator SANDERS. Thank you all very much.

Senator HARKIN. Thank you. The committee will stand adjourned.

[Additional material follows.]

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## ADDITIONAL MATERIAL

### PREPARED STATEMENT OF SENATOR KENNEDY

Millions of Americans are struggling today with the burden of rising health costs and inadequate health insurance. Our health is affected not only by our access to affordable care but also by our living conditions, healthy foods and safe environments. Children, seniors and persons with disabilities often have the most pressing health needs but also face the greatest barriers to health. It's estimated that at least 40 million Americans live with some level of disability, including 6 percent of children nationwide. Overall, American children lag behind almost all industrialized nations on key health indicators for children.

Increased risk for poor health may result from chronic illness, age, lack of insurance, or poverty. By 2030, one in every five Americans will be aged 65 and older. Although physical activity has multiple proven health benefits, only 21 percent of adults age 65 and older engage in regular leisure-time physical activities. Programs that increase seniors' knowledge of the health benefits of physical activity and help them include it in their daily lives have been shown to work and need to be strengthened.

In the years ahead, the increasing number of older Americans and their growing diversity will create unprecedented demands on public health, aging services, and the Nation's health care system. As our country ages, greater investments in prevention efforts are essential not only to protect the health and quality of life for older adults, but also to control the costs of health care.

Individuals have the responsibility to eat well and stay active, but Federal programs can remove obstacles that make it difficult for individuals to make healthy choices. This point is especially true for high-risk persons. People with disabilities face significant barriers in obtaining preventive services, with only 48 percent reporting access to local health facilities and wellness programs. These barriers may include lack of transportation and affordable housing, higher rates of unemployment, and inadequate knowledge of the health risks they face.

Initiatives such as the Making Healthy Connections Program in Boston address the specific needs of young people with disabilities as they move into adulthood and develop greater independence. In partnership with Boston Medical Center, the program educates youths and parents on how to obtain adult health services and develop independent living skills. Topics covered include personal care assistance, preparing for jobs and college, assistive technology and transportation options. This type of comprehensive care model will strengthen the connection between health services and other community resources, and reduce health costs by increasing access to care and preventing chronic disease. By adopting successful models of care for those with complex health issues, we can improve the health of millions of Americans.

A key factor for successful programs for high-risk populations is to meet people where they live, work and play, in places such as schools and community health centers. Prevention efforts focused on children are essential, since health risks accumulate a person's lifespan.

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An impressive example is "Shape Up Somerville: Eat Smart Play Hard" a CDC-funded environmental approach to obesity prevention targeting 1st–3rd graders in Somerville, MA. Parents, local restaurants and after-school programs are each involved in increasing physical activity, and spreading healthy eating messages. It's clear that congressional action on health reform must encourage such successful initiatives for high-risk communities that cut across traditionally disjointed systems of care and services.

Those at highest risk have the most to gain from effective public health and preventive clinical programs, and the most to lose if these programs are not a central part of health reform. By investing in proven preventive services and proven public health programs, we can reduce health care costs by increasing longevity, improving quality of life, and preventing chronic disease.

An annual investment of $10 a person each year in effective community-based programs to increase physical activity, improve nutrition, and reduce tobacco use could save the country more than $16 billion annually within 5 years and would be of particular benefit to those at the highest risk of poor health outcomes.

I commend Senator Harkin for highlighting the issues of high risk populations and emphasizing that effective strategies to reduce the risk of disease must be a central part of health reform. I look forward to the testimony of today's witnesses, and I wish I could be there for this important hearing.

## PREPARED STATEMENT OF SENATOR COBURN

The Federal Government is engaged in extensive efforts to promote prevention and wellness, particularly for high-risk populations, and we must continue to examine ways in which our prevention dollars can be spent more effectively. The Centers for Disease Control and Prevention (CDC), the Nation's prevention agency, has an $8.8 billion budget to address infectious and chronic disease prevention, and the National Institutes of Health (NIH) spends $6.74 billion. The Substance Abuse and Mental Health Services Administration (SAMSHA) spends about $1.8 billion on prevention and treatment, and the Health Resources and Services Administration (HRSA) spends roughly $809 million primarily for underserved populations. For elderly Americans, the Administration on Aging spends $779 million for nutrition and preventive health services.

I appreciate the opportunity to hear from today's witnesses about how our health care system can better allocate resources to help those in need, and I look forward to working with my colleagues to change the paradigm in health care to prevention. The most effective way to achieve prevention is for individuals to have "skin in the game." Our current health care system insulates individuals from the costs of their health care. We must realign incentives so that individuals see cause and effect from their lifestyle decisions. Rather than naively expand costly government programs and slap on onerous new mandates, we must emphasize the need for personal responsibility. In promoting behavior change, there are also appropriate roles for the Federal Government, States, and the private sector. The Federal Government doesn't need to implement a

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one-size-fits all solution for prevention—or in any other component of health care reform.

Access points for underserved communities, such as community health centers, are helpful safety nets for many across the country but are not the solution to our larger health care problems. Instead, we must pursue fundamental reforms of our health care system that allow market forces to make health care more affordable and tailored to each individual's needs. Our health care system should work for every patient, every time.

[Whereupon, at 10:46 a.m., the hearing was adjourned.]

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