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PREVENTION AND PUBLIC HEALTH: THE KEY TO TRANSFORMING OUR SICKCARE SYSTEM

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

ON

EXAMINING DISEASE PREVENTION AND PUBLIC HEALTH, FOCUSING ON TRANSFORMING THE HEALTH CARE SYSTEM

DECEMBER 10, 2008

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WEDNESDAY, DECEMBER 10, 2008

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

The committee met, pursuant to notice, at 10:09 a.m. in Room SD-192, Dirksen Senate Office Building, Hon. Tom Harkin, presiding.

Present: Senators Harkin, Dodd, Reed, Sanders, and Coburn.

OPENING STATEMENT OF SENATOR HARKIN

Senator HARKIN. Good morning. I would like to thank everyone for coming this morning to discuss why a new emphasis on prevention and strengthening our public health system are critical to transforming America's healthcare system.

I especially want to thank Senators Kennedy, Enzi, and Coburn for giving us the opportunity to come together this morning.

When we look at our healthcare system nationwide, we see a system that I say is fundamentally broken. It squanders countless of hundreds of billions of dollars. It underserves some 45 million Americans because they don't have health insurance, lags behind many other countries in the use of information technologies and other systems that can reduce errors and improve quality.

We need to fundamentally change this system. We need to get healthcare costs under control. This will not happen, however, unless we place a major new emphasis on wellness and disease prevention while strengthening America's public health system.

To be honest about it, I have often said we don't have a healthcare system in America. We have a "sickcare" system. If you are sick, you get care, some way or another—through insurance, Medicare, Medicaid, community health centers, emergency rooms, charity, one way or the other.

The problem is that this approach is about patching things up after the fact. We spend untold hundreds of billions on pills and surgery and hospitalization and disability. We spend peanuts—I am told about 3 percent of our healthcare dollars—for prevention.

There are huge untapped opportunities in the area of prevention, wellness, and public health. We think about the status quo, we spend a staggering $2 trillion annually on healthcare, more than any other Nation in the world. Yet the World Health Organization ranks U.S. healthcare only 37th among nations. Out of 21 industri-

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alized nations, we are 20th in the quality of healthcare for our children.

When I look at these statistics, it seems as though we have lost our capacity to be shocked or outraged. Just how much evidence do we need that America's approach to healthcare, I should say sickcare, is simply not working?

It is not enough to talk about how to extend insurance coverage and how to pay the bills, as important as those things are. If all we are going to do is figure out a better way to pay the bills for the current broken, unsustainable system, then I think we are sunk.

Indeed, I want to lay down a marker right here at the outset of this forthcoming great debate about healthcare reform, and this is my marker. 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.

It simply makes no sense to legislate broader access to a healthcare system that costs too much and delivers too little, largely because it neglects prevention and public health. We need to craft a bill that mobilizes our society to prevent unnecessary diseases and conditions, things like obesity and type 2 diabetes, heart disease, mental health conditions, and some forms of cancer.

A robust emphasis on wellness is about saving lives, saving trips to the hospital, saving money. It is the only way—I repeat, the only way—we are ever going to get a grip on skyrocketing costs. There are tremendous opportunities here, both in terms of cost savings and in terms of helping people to live healthier and happier and more productive lives.

That is a whole other area that I am not going to get into right now, but it has something to do with people's productivity also. And I think we are going to hear from some businesses on that.

So, to that end, I look forward to hearing from our witnesses in this, sort of our kickoff hearing on this. To date, prevention and public health have been the missing pieces in our national conversation about healthcare reform. It is time to make them the centerpiece of the conversation, not an asterisk, not a footnote, but the actual centerpiece of our healthcare reform debate.

And with that, I will yield to my friend and colleague from Oklahoma, Senator Coburn.

STATEMENT OF SENATOR COBURN

Senator COBURN. Thank you, Senator Harkin.

Much of what you just said I adamantly agree with. We have to change the paradigm on health in this country. Seventy-five percent of all the dollars we spend on healthcare are for five preventable chronic diseases, two of which I have. I wish I would have prevented them.

Nevertheless, how we do that is important. We had asked that Dr. Cooper from Texas be a witness. We were not allowed to do that. He has made great strides in prevention in this country, one of the leaders in prevention.

One of the things that he has gotten instituted in the State of Texas is physical exercise again in the schools. If we talk about

problems in terms of prevention, childhood diabetes and obesity is a totally preventable disease, and type 2.

Obesity leads to increased risk of cancer, leads to increased risk of hypertension, coronary vascular disease as well as peripheral vascular disease. It leads to all sorts of other types of complications.

We have to change the paradigm, and I look forward to the debate this year. I think the Government is not the best place to provide healthcare, but I am anticipating a great debate on how we solve our Nation's problem.

This is a great country to get sick in because we do a great job once you are sick. We don't do a good job preventing you from getting sick. And so, I will join my colleagues in looking forward to changing the paradigm.

But I would also caution that, oftentimes, we are not the best at actually performing the procedures. We are good at messaging them. And we spend billions of dollars right now in this country on prevention, through NIH, which was just reformed and is much more streamlined; CDC, which needs to be reformed so that the prevention dollars—we say it is CDC. It is really CDCP. And we have dropped the emphasis of "prevention" from CDC.

When we look at the total, which is about $15 billion a year minimal that is being spent supposedly on prevention in this country, we don't have any metrics. We don't have any metrics to measure whether we are successful.

I visualize a time when every American—either through their schools, public service or coordinated efforts through public health and the private health in this country—where every American is educated to the degree they need to be on the risks of the behaviors and the lifestyle choices that they make. We do a poor job on that.

We know when we start prevention screening that we have good results, whether it is with Pap smears or mammograms or colon screening, or other tests. What we know is we make a big difference in terms of productivity, in terms of decreasing the cost. More importantly, we ought to be about decreasing the things that cause the disease in the first place, not in preventing the advanced disease.

I look forward to hearing from our witnesses. I appreciate the opportunity to be here with you, Senator Harkin. And my hope is, is that as we start this debate, we will have a vigorous debate about what gets us the most efficient and the best message on prevention.

Americans are not stupid. If we teach and put out there the information they need with which to make decisions, they will make good decisions, and we know that in a lot of areas. It is if we try to mandate it and run it, which I think Government has not proven to be great at, I don't think we will see the kind of results than if we do it through an encouraging and economic incentive- based system.

I thank you again for the hearing. I look forward to it.

Senator HARKIN. Thank you, Senator Coburn.

Senator Sanders.

STATEMENT OF SENATOR SANDERS

Senator SANDERS. Thank you very much, Senator Harkin. And thank you very much for the work that you have done over the years in this particular area.

I don't think there is anybody in the Congress who has been stronger in understanding that the key to healthcare reform has to be disease prevention, (A), in keeping people healthy and in saving us hundreds of billions of dollars. So thank you for what you have done.

In my view, we are living in a non-healthcare system, which is disintegrating. It is beyond comprehension that in this great country, 47 million Americans have zero health insurance. Even more are underinsured, with high deductibles and copayments.

In the midst of that nonsystem, what is even worse, even in more dire circumstances, is the disastrous efforts that we make in terms of primary healthcare. Today, we are looking at some 56 million Americans in medically underserved areas throughout this country who do not have access to a doctor and, in many cases, to a dentist as well.

The issue of the crisis of primary healthcare is an issue that we, as a Nation, must begin to address. There are approximately 20,000 Americans who die every single year because they can't find a doctor.

I have talked to physicians in the State of Vermont who, when people walk in, the doctor says, "Why didn't you come in 6 months ago when your condition was treatable? We can't treat you now." People die because of that. And people say, "Well, I don't have any health insurance." "I don't want charity." "I couldn't find a doctor." "I thought it would get better."

People are dying. People are becoming much sicker than they should be. And then the cost is that people end up in the emergency room. People end up in the hospital because they do not have access to a doctor when they should have access.

I think the issue of disease prevention and primary healthcare has to be at the top of any list in terms of healthcare reform. Now that is the bad news. Let me give you some good news—what we are doing is, in fact, very, very good.

There is a program that started many, many years ago led by Senator Kennedy, Senator Harkin, and many others called the Federally Qualified Community Health Centers. There are about 1,100 of them all over America.

What these centers do in an extremely cost-effective way is they say if you have Medicaid, come in. If you have Medicare, come on in. If you have private insurance, come in. If you have no health insurance, we are going to treat you on a sliding-scale basis. You make $30,000 a year, maybe it costs you $10 to come in.

The results have been enormously impressive. Widespread support for this program from conservatives, progressives, Republicans, Democrats, President Bush. We have 1,100 of these centers. In my State, we went from 2 to 7 in the last 6 years with tremendous gains in terms of disease prevention.

My hope is that in the coming years, we will expand that program so that every medically underserved area in this country will

have a Federally Qualified Community Health Center, affordable primary healthcare, dental care, mental health counseling, and low-cost prescription drugs.

Now, in picking up on Senator Harkin's point and Senator Coburn's point, let me give you an example of what happens when people have access to a community health center as opposed to when they do not. What community health centers stress is just the point that Senator Coburn made. We all know that if people have physical activity, they are much more likely to stay healthy.

Community health centers stress that point. The results are there to be seen. Of the people who go to the health centers, 63.7 percent get information about physical activity as opposed to 39.4 percent of adults who don't.

In terms of smoking, the idea that in my State—it breaks my heart to see young kids, girls now more than boys, who are smoking. When you go to a community health center, you are educated. A doctor sits down and talks to you about the stupidity of smoking and what it does for cancer, what it does for heart disease in general.

The results are very, very clear. Low-income people who walk into a community health center will end up smoking less, and that is true with drugs and with abuse of alcohol as well.

We have a real crisis among African-American women in terms of low-weight babies. Again, the result is in that when people have a regular physician—they are treated on a regular basis—their prenatal care is much better, and the results in terms of not having a low-weight baby is much better with access to a community health center.

There was a study in South Carolina recently. We talked about diabetes, obesity, and again, the results are the same. Common sense suggests that when you have access to a regular physician who cares for you, who treats you on a regular basis, whom you trust, you will get better healthcare in general, and you will do a better job in preventing disease.

So, I would hope, Senator Harkin, that in the stimulus bill and within the next couple of years that what we will do is make sure that every American has access to primary healthcare. I think the evidence is overwhelming that Federally Qualified Community Health Centers are the most cost-effective way of delivering that. And I hope in a bipartisan way that we can work together on that.

So thank you very much, Senator Harkin.

[The prepared statement of Senator Sanders follows:]

PREPARED STATEMENT OF SENATOR SANDERS

America's health care system is badly in need of an overhaul. It is shameful that the richest country in the history of the world does not guarantee health care as a right to all citizens. Nowhere is this failure more apparent than in the provision of basic public health and preventive care. While the United States spends more than any other country on health care, most of it is spent on treating diseases that could have been prevented. Various estimates indicate that only 2–4 percent of health care spending is for prevention and public health in America. The result is that we lag far behind other developed countries on key health status measures.

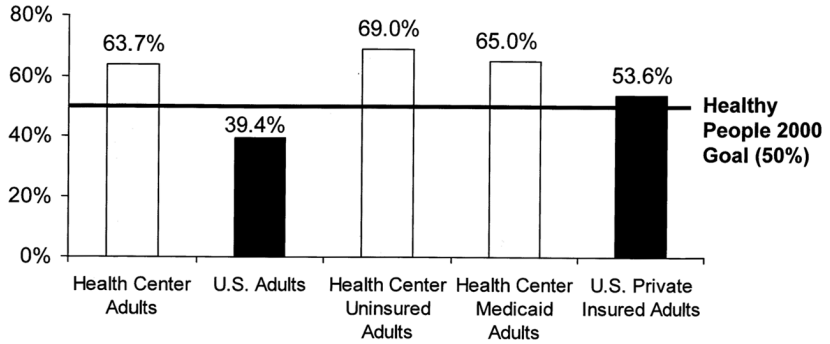
Rather than concentrate on this failure, I know that Senator Harkin is interested in positive solutions. While overall the health care system is failing us, we do have one part of it that has been in place for a long time and that has done a good job in primary care and prevention.

The Community Health Center program provides a model for the impact that a concentration on prevention can have in improving health and reducing costs. I believe we need to do much more to make sure all Americans have access to community health centers, and I look forward to hearing from our panelists regarding their place in a national prevention strategy. A look at just a few indicators shows why I believe community health centers play a vital role in prevention for our most vulnerable citizens.

Two of our biggest public health problems relate to the obesity epidemic and tobacco use. They are responsible for most of the chronic disease and preventable deaths in this country. If we could get people moving more and smoking less, we could prevent a huge number of chronic illnesses, including heart disease and cancers. We also know that people are likely to change their behaviors and adopt a healthier lifestyle if they discuss it with their physician. Community health centers invest in this effort. Here are just two examples:

Figure 4.6

'Amount of Physical Activity' Discussed with Adults



Source: Leiyu Shi, "The Role Of Health Centers In Improving Health Care Access, Quality, And Outcome For The Nation's Uninsured." Testimony At Energy and Commerce Committee, Subcommittee on Oversight and Investigations Congressional Hearing "A Review Of Community Health Centers: Issues And Opportunities." Washington, DC. May 25, 2005. Based on Community Health Center User Survey, 2002; and National Health Interview Survey, 2002.

• **Physical Activity**—Providers in health centers are more likely to discuss the amount of physical activity with their patients than those in other health care settings. About two thirds of health center patients have had discussions about physical activity, which exceeds the Healthy People 2000 goals. Only 40 percent of all adults seen elsewhere have had these discussions.

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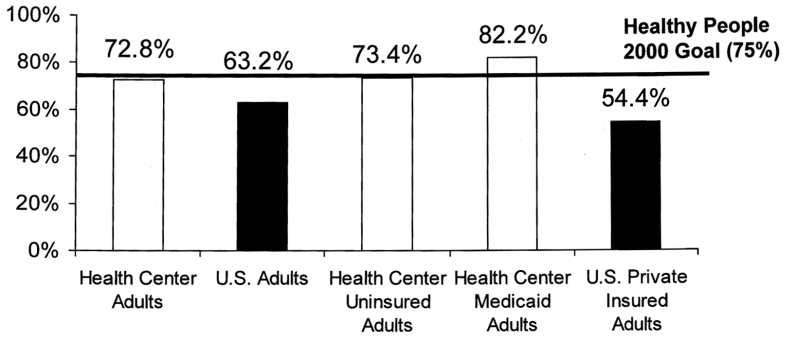
Figure 4.7

'Whether Smokes/Uses Tobacco' Discussed with Adults



Source: Leiyu Shi, "The Role Of Health Centers In Improving Health Care Access, Quality, And Outcome For The Nation's Uninsured." Testimony At Energy and Commerce Committee, Subcommittee on Oversight and Investigations Congressional Hearing "A Review Of Community Health Centers: Issues And Opportunities." Washington, DC. May 25, 2005. Based on Community Health Center User Survey, 2002; and National Health Interview Survey, 2002.

• **Tobacco Use**—Four out of every five Medicaid patients in health care centers and nearly three quarters of all patients going to health care centers have had their tobacco use discussed with them, compared to only about half of insured adults who don't use health centers.

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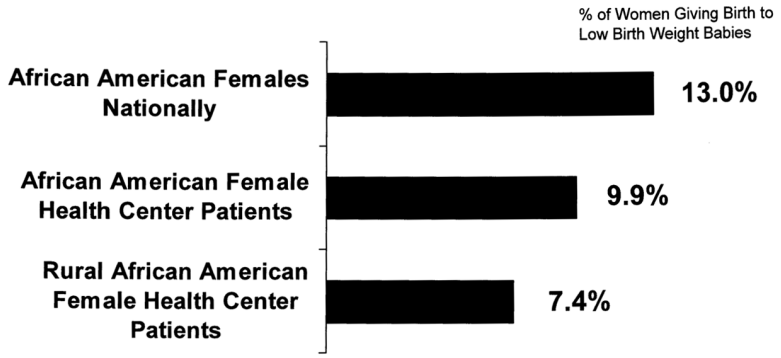
Figure 5.6

Health Centers Decrease the Rate of Low Birth Weight Babies



Source: Politzer, R., et al. "Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care." 2001. *Medical Care Research and Review* 58(2):234-248.

• Another important component of prevention is assuring early prenatal care to reduce the incidence of low-birth weight babies. Low-birth weight babies have more health problems at birth and as they grow. **Low-birth Weight**—We usually think that minorities in rural America have less access to health care.

Yet significantly, rural African-American women going to health centers have a rate of low-birth weight babies significantly lower than the national average for African-American women, and better than the overall national rate.

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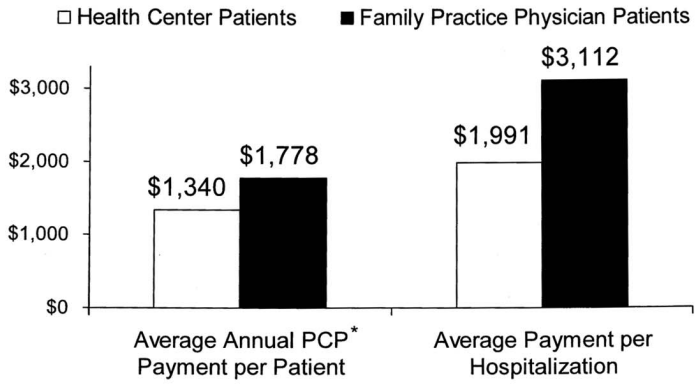
Figure 6.3

South Carolina Case Study: Costs Associated with Treating Medicaid Diabetic Patients, 2000-2003



* Primary Care Physician
Source: South Carolina Budget and Control Board, 2004.

• In addition to primary prevention, managing chronic diseases is an important secondary prevention strategy. Early and consistent intervention will pay dividends in enhancing health and reducing costs, given our chronic illness epidemic. Health centers have been developing strong care management programs. **Diabetes**—A study of health centers in South Carolina found that costs of physician care and hospitalization for diabetic Medicaid patients were substantially less for patients who use health centers.

Besides fully investing in community health centers, there are several other important prevention initiatives that I believe will be indispensable as we move forward. Let me highlight just a few.

• We need to invest in disease registries to give epidemiologists the information needed to figure out the determinants of disease and how to correct them. Without such registries, it's like driving without a roadmap or a destination.

• We need to fully fund CDC nutrition and physical activity grants to States. Increasing physical activity and eating right are the two keys to obesity prevention. Several States, including Vermont, recently lost programs because of funding cuts.

• Oral health is an all-too-often neglected part of prevention efforts. I believe that dental clinics in the schools make sense, where screenings can be provided for our kids to educate them on how to keep their mouths healthy and to provide them with sealants to prevent cavities.

• And finally, Medicare and Medicaid need to be reformed to put more emphasis on preventive care. Coverage for preventive services has too often been neglected in our public programs.

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For one example, I understand that Medicare won't reimburse for smoking cessation methods and programs until after a doctor has diagnosed a respiratory illness. That isn't prevention and it just doesn't make sense.

Let me conclude by returning to my earlier point on the value of assuring good primary care as a major prevention strategy. My home State of Vermont was recently cited as the healthiest in America. The report noted that a key element in this result is the adequate and well-distributed supply of primary care physicians throughout the State. I believe that contributing to this is that our most underserved areas are served by community health centers which invest in prevention.

So, while we have much to do, we do have solutions and I look forward to hearing from our panelists about more of them. Thank you.

Senator HARKIN. Thank you very much, Senator Sanders.

I might just say that the Chairman of the committee, Senator Kennedy, had asked me to chair the Working Group on Prevention, Wellness, and Public Health. I take that seriously. This is the beginning of that process, just for general knowledge purposes. We will be focusing on this strongly in this month and next month as we move ahead.

I look forward to working with the Senator on this aspect of healthcare reform. And I appreciate what you have to say about community health centers because we have them in Iowa, too. They do a great job in my State of Iowa.

Senator Reed.

Senator REED. Mr. Chairman, I want to commend you for holding this hearing. It is absolutely important in terms of not only health, but also in affording healthcare going forward.

So thank you, Mr. Chairman.

Senator HARKIN. Thank you very much.

Again, I thank all of my witnesses. I will just ask consent that the hearing record be left open for 10 days.

We are joined by an outstanding panel of witnesses. I thank all of you for taking your time to be here. We will have our first panel, and then we will move on to the second panel.

Our first panel would be Don Wright. Dr. Don Wright is the principal deputy assistant secretary for health at the Department of Health and Human Services, where he acts as an advisor to the assistant secretary for health on matters involving our public health and science.

His responsibilities include the planning and execution of public health policy as it relates to disease prevention, health promotion, women's and minority health, the fight against HIV/AIDS, blood safety, pandemic influenza planning.

Dr. Wright received his undergraduate degree from Texas Tech University, his medical degree from the University of Texas, and completed his family medicine residency training at Baylor. In addition to his medical degree, Dr. Wright holds a Master of Public Health from the Medical College of Wisconsin, board certified in both family medicine and preventive medicine, and is a fellow of the American College of Occupational and Environmental Medicine and the American Academy of Family Physicians.

So, again, Dr. Wright, thank you very much for being here. I am going to ask whoever is controlling the clock—whoever's presence is back there someplace that controls these things—so if you can just take 10 minutes, I am going to ask each witness, give them up to 10 minutes to state their testimony.

All of your written testimonies will be made a part of the record in their entirety. I just ask you to sum it up.

Dr. Wright, thank you for being here.

STATEMENT OF DONALD WRIGHT, M.D., M.P.H., PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. WRIGHT. Thank you. Good morning, Mr. Chairman and other distinguished members of the committee.

I am Dr. Don Wright, and it is a pleasure to appear before you as the principal Deputy Assistant Secretary for Health at the U.S. Department of Health and Human Services. I speak for the department from my position in the Office of Public Health and Science, also known as OPHS.

Today, I would like to focus on the essential contribution of prevention to our Nation's health and the Administration's leadership since the launch of the President's Healthier U.S. Initiative in 2002.

Clearly, we need more than improved access to care and enhanced performance in our healthcare system. We need to develop a comprehensive system that not only delivers disease care and services to those who are ill, but also promotes and protects the health of those who are well. This is prevention at its best.

Before we move forward, let me tell you a little bit about my division. Led by the assistant secretary for health, OPHS is housed within the Office of the Secretary. We are charged with leadership and development of policy recommendations on population-based public health and science and, at the discretion of the secretary, with coordination of initiatives that cut across agencies and operating divisions within HHS.

We believe a focus on prevention will bring our vision—a nation in which healthy people live in healthy communities, sustained by effective, efficient, and coordinated health systems—significantly closer to reality. The purpose of prevention is to protect and promote good health when possible through healthy lifestyles and environments, avoiding risky behaviors, and participating in preventive screenings and vaccines through all stages of life.

Unfortunately, time does not permit me to discuss the multiple prevention and wellness activities that HHS and its agencies support in collaboration with partners at the State, regional, and community level. I can say that our activities are embodied by the HHS prevention priority, which builds on existing and emerging prevention policy and programs, based on the best available evidence on how to prevent or limit the effects of chronic disease through promotion of healthy diet, physical activity, medical screenings, and avoidance of tobacco use and other unhealthy behaviors.

The principal public health planning guide, upon which the department and literally tens of thousands of our partners and stake-

holders have relied over a period of three decades to make progress toward that vision, is Healthy People. Healthy People's current overarching goals are to increase the quality and years of healthy life and to eliminate health disparities.

Healthy People is broadly premised on our understanding that the risk of many diseases and health conditions are reduced through preventive actions and that a culture of wellness deters and diminishes debilitating and costly health events.

Healthy People's underpinning is the recognition that disease prevention is not only desirable, it is doable, and it is achievable. Indeed, disease prevention and health promotion choices are useful wherever people may be as they go about their daily lives.

The vision of Healthy People and healthy communities involves broad-based prevention efforts, which are integrated into neighborhoods, schools, workplaces, clinics, families, and community health promotion programs. HHS is joined in the development of Healthy People by many nontraditional partners in the Federal Government, such as the U.S. Department of Agriculture, Education, Housing and Urban Development, Justice, Interior, Veterans Affairs, and the Environmental Protection Agency.

The Government Accountability Office has held Healthy People up as an example of a way to help enhance and sustain collaboration among Federal agencies that have significant differences in agency missions and organizational cultures.

There are two cross-departmental activities that are part of our prevention priority that I would like to mention. Through the coordinated and collaborative effort of the Office of Disease Prevention and Health Promotion, the NIH, the President's Council on Physical Fitness and Sports, and the Centers for Disease Control and Prevention, HHS recently released the first-ever Federal Physical Activity Guidelines for Americans.

Becoming and remaining physically active is one of the most important steps that Americans of all ages can take to improve their health. The guidelines provide science-based information to help Americans, aged 6 years and older, improve their health through appropriate physical activity.

In addition, there is also the Healthy Youth for a Healthy Future campaign, led by the Office of the Surgeon General with input from across the department to help prevent overweight and obesity in children. This initiative seeks to increase public awareness of the child overweight and obesity epidemic and to share information about effective community efforts to reduce this problem and its consequences.

To date, the acting surgeon general has visited more than 30 cities to promote awareness of successful community interventions that encourage healthy living. He has also participated in community roundtable discussions with public health stakeholders and local leaders to discuss prevention and physical activity and nutrition problems.

In closing, the department's investment in a comprehensive prevention infrastructure with the support of a growing prevention and communication science base, sets the stage for healthcare reform in which the public should be able to expect seamless coordi-

nated care and the best support for making healthy decisions that science has to offer.

I am confident that broad consensus has emerged across health professions and among stakeholders who care about improving public health. Prevention has added value, and ultimately, increased focus on prevention will save untold numbers of lives and dollars.

Thank you very much.

[The prepared statement of Dr. Wright follows:]

PREPARED STATEMENT OF DONALD WRIGHT, M.D., M.P.H.

Good afternoon, Mr. Chairman, and other distinguished members of the committee. I am Dr. Don Wright and it is a pleasure to appear before you as the Principal Deputy Assistant Secretary for Health of the U.S. Department of Health and Human Services (HHS). I speak for the Department from my position in the Office of Public Health and Science, OPHS.

Today, I would like to share with you how we have invested the tax payers' dollars in building the prevention evidence base and the infrastructure that will help launch a reformed health care system: one that is person-centered, provides seamless care in the clinic and in the community, delivers disease care and services to those who are ill, and also puts prevention first by promoting and protecting the health of those who are well.

The Department's commitment to prevention is strong and as you will see is reflected in the broad and diverse activities across the Department.

I am proud to provide testimony about our Department's comprehensive approach to prevention, coordinated by OPHS which is led by the Assistant Secretary for Health. We are working every day to realize our vision of a Nation in which healthy people live in healthy communities, sustained by effective, efficient and coordinated health systems.

THE CASE FOR PREVENTION

Largely preventable, chronic diseases have replaced infectious diseases as major killers in the United States. Chronic diseases cause 7 out of every 10 deaths each year. We know that 40 percent of deaths are caused by modifiable behaviors, such as poor nutrition, physical inactivity, and tobacco. Smoking, which causes heart disease, chronic bronchitis, emphysema and contributes to a host of other chronic diseases, costs our citizens' untold suffering and loss of years of potential life every year and our economy billions of dollars in direct and indirect costs.

Expenditures for health care in the United States continue to rise. The vast majority of health care dollars are spent on direct medical care, despite the fact that clinical care is credited with only 5 of the 30 years that were added to life expectancy during the last century. Chronic disease consumes more than a trillion dollars every year. That's $3 out of every $4 we spend on health care compared to approximately 5 percent of total U.S. health care dollars spent on public health and preventive measures.

There is broad agreement among experts that prevention reduces health care costs. Precisely how much money preventive medicine saves is not clear, but certainly a stronger commitment of resources to prevention could significantly reduce rates of chronic illness and dramatically relieve the suffering of millions of Americans. Through successful prevention efforts we could reduce or even eliminate health care spending on preventable diseases and conditions. By making prevention the cornerstone of our health system and policies, we could realize one of our overarching goals—to increase the quality and years of healthy life. We could improve productivity and move toward eliminating illness, injury, suffering, pain and deaths that ought not to occur.

According to the Trust for America's Health, with an investment of $10 per person per year in proven community-based disease prevention programs, the Nation could yield a net savings of more than $2.8 billion in 1 to 2 years; more than $16 billion within 5 years, and Return on Investment (ROI) of $5.60 for every $1; and more than $18 billion within 10–20 years, and ROI of $6.20. The Congressional Budget Office notes that ". . . Proposals that encourage more prevention and healthy living can help promote better health outcomes, although their net effects on Federal and total health spending are uncertain."

HHS FOCUS ON PREVENTION

In 2006, Secretary Mike Leavitt named prevention one of his top priorities to improve the Nation's health and to help prevent debilitating and costly health problems. Good individual health is built on a foundation of personal responsibility for wellness, which includes participating in regular physical activity, eating a healthful diet, taking advantage of medical screenings, and making healthy choices to avoid risky behaviors. To foster this preventive culture of wellness, the Department is investing in strengthening the prevention infrastructure and science base that offer the public the support they need to make informed healthy decisions whether at the individual, community, or State level.

THE NATIONAL PREVENTION INFRASTRUCTURE: THE HEALTHY PEOPLE INITIATIVE

For three decades the Department has built a national prevention infrastructure, focused upon establishing national health goals and measurable benchmarks tracking our success. This infrastructure of government and private sector stakeholders in health, the *Healthy People* Initiative, provides a comprehensive set of national 10-year health promotion and disease prevention objectives aimed at improving the health of all Americans. Since its inception, *Healthy People* grass roots input has helped identify the most significant preventable threats to health and establish national goals to reduce these threats.

Healthy People is founded upon the notion that establishing objectives and providing benchmarks to track and monitor progress over time can motivate, guide, and focus action. Each iteration of *Healthy People* has been the product of a multi-year, comprehensive collaborative process that reflects the ideas and expertise of a diverse range of individuals and organizations, both Federal and non-Federal, concerned about the Nation's health.

Currently, the Department is leading the development of *Healthy People 2020*. The initiative, in the tradition of its predecessors, will provide the definitive vision and strategy for building a healthier Nation. *Healthy People* is used by virtually all of our States and numerous foreign governments to develop their health plans.

We have gathered testimony from around the country that has shaped the framework for *Healthy People 2020*. The stakeholders believe that now is the time for our Nation to join together to address determinants of health—factors that directly influence health—such as physical environment, social environment, individual behavior, genetics and health care delivery systems. It is an exciting time at HHS as we begin to consider the objectives for the next decade that could have the greatest impact on these determinants of health.

PREVENTION SCIENCE

Thanks to the Department's investment in prevention science, there is a growing evidence base confirming the benefits of multiple prevention practices. Today, I will highlight the solid science of physical activity, nutrition, clinical preventive services, community preventive services and communication.

This year, the Department, through a collaborative effort developed and released the first-ever Federal ***Physical Activity Guidelines for Americans***. **Additionally**, OPHS, in collaboration with CDC and other agencies, developed easy to understand, actionable guidance to help Americans fit a healthy level of physical activity into their lives.

Becoming and remaining physically active is one of the most important steps that Americans of all ages can take to improve their health. The Guidelines provide science-based information to help all Americans aged 6 years and older improve their health through appropriate physical activity. A communications toolkit for supporting organizations was developed to provide resources to encourage people to get the amount of physical activity they need.

Another important influence on health, nutrition, also has an impressive emerging science base which illustrates how to stay healthy by making healthy food choices. HHS works with the Department of Agriculture to develop the ***Dietary Guidelines for Americans***. Issued every 5 years, the Dietary Guidelines reflect the most accurate science, serve as the cornerstone for Federal nutrition policy, and are one of our most important tools for empowering Americans to enhance their health and help prevent lifestyle-related chronic disease. This year, HHS published the first-ever bilingual "**Road to a Healthy Life, Based on the Dietary Guidelines for Americans**" for Hispanic and Latino families nationwide. Obesity rates have increased in this population, and research shows that this audience needs better understanding of how to apply our national nutrition guidelines.

This publication is just one example of HHS's focus on **Eliminating Health Disparities** and work toward achieving a nation where children, families, and communities have equitable opportunities for attaining optimal health, regardless of race/ethnicity, geography or any other demographic characteristic.

Two additional factors that impact health are taking advantage of proven clinical preventive services and community-based prevention support services.

The **Agency for Healthcare Research and Quality** (AHRQ) supports the U.S. Preventive Services Task Force—an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services [*http://www.preventiveservices.ahrq.gov*]. The task force rigorously evaluates clinical research to assess the merits of preventive services, including screenings, counseling services and preventive medications, for people without signs or symptoms of disease. The USPSTF library of recommendations currently includes over 125 evidence-based recommendations. In 2008, the USPSTF released 12 recommendations: 3 preventive services for pregnant women; 3 services for children; and 6 services for adults. These included new recommendations on screening for diabetes; prostate and colorectal cancer; and, counseling to promote breastfeeding.

AHRQ ensures that Americans receive these proven clinical preventive services by developing tools and products to facilitate the dissemination and use of the evidence-based USPSTF recommendations. Each year, AHRQ publishes ***The Guide to Clinical Preventive Services***, a pocket-sized book formatted for clinicians to consult for prevention guidance in their daily practice. AHRQ also has created the ***electronic Preventive Services Selector***, a Web site that allows clinicians to search USPSTF recommendations during an office visit based on a patient's age, sex and risk factors. The Selector can also be downloaded to a clinician's PDA or Blackberry. AHRQ is currently working to embed the Selector into electronic health records.

To accomplish this work, AHRQ also builds and leverages public-private partnerships. Partnering with the National Business Group on Health and CDC, AHRQ supported the publication, ***A Purchaser's Guide to Clinical Preventive Services***, to move the science of clinical prevention into benefit coverage decisions. Over 250,000 copies have been distributed. In its ***Hispanic Elders Learning Network***, AHRQ, working with Federal and local partners, mobilized, organized, and coordinated local DHHS and community resources to reduce disparities in health outcomes among Hispanic elders in eight communities.

In addition, AHRQ is moving the field of prevention science by investing in research to improve our understanding of the preventive health care needs of patients with multiple chronic conditions. The ultimate goal of this work is to develop personalized, patient-centered decision aids for patients and their providers. In collaboration with the Office of Disease Prevention and Health Promotion, the Web site, My healthfinder (*www.healthfinder.gov*) provides personalized prevention recommendations specific to the user's age, gender and pregnancy status. It was designed to be understandable and actionable for everyone, including people with limited health literacy.

The *Guide to Community Preventive Services* summarizes what is known about the effectiveness, economic efficiency, and feasibility of interventions to promote community health and prevent disease. The Task Force on Community Preventive Services, an independent decisionmaking body convened by CDC for HHS, makes recommendations for the use of various interventions based on the evidence gathered in rigorous and systematic scientific reviews of published studies conducted by review teams for the guide. The findings from the reviews are published in peer-reviewed journals and also are made available online. The task force has published over 100 findings across 16 topic areas, including tobacco use, physical activity, cancer, oral health, diabetes, motor vehicle occupant injury, vaccine-preventable diseases, prevention of injuries due to violence, and social environment.

ADDITIONAL HHS PREVENTION ACTIVITIES

As I mentioned earlier, there is tremendous work going on within HHS in the area of prevention which supports and expands upon the framework established by the *Healthy People* initiative. I'd like to share some other examples which represent the diversity of the contributions that HHS makes.

The **HealthierUS initiative** is a national effort to improve people's lives, prevent and reduce the costs of disease, and promote community health and wellness. It focuses the Nation's attention on high impact prevention practices: getting and staying physically active, eating a nutritious diet, avoiding risky behaviors and getting preventive screenings.

Among its many educational and scientific efforts, the Office of the Surgeon General heads a prevention initiative, **Healthy Youth for a Healthy Future** to help prevent overweight and obesity in children. This initiative seeks to increase public awareness of the child obesity epidemic and to share information about effective community efforts to reduce child overweight and its consequences. To date, the Acting U.S. Surgeon General visited more than 30 cities to learn about local programs and meet with public health stakeholders and community leaders to discuss local prevention, physical activity and nutrition programs.

The **Office of HIV and AIDS Policy** (OHAP) is using the power of new media to reach untapped audiences who are at risk for HIV/AIDS—giving people the information they need on HIV at the time and in the format they want. New media is a highly effective, low-cost way of reaching at-risk individuals with HIV prevention, testing, and treatment messages—and AIDS.gov is spearheading HHS' use of new media to prevent the spread of HIV/AIDS.

The **Office of Population Affairs** (OPA) manages the title X program, the only Federal program solely dedicated to family planning services with a mandate to provide "a broad range of acceptable and effective family planning methods and services," and related preventive health services such as information and education, routine gynecological care, clinical breast examinations, Pap tests, and sexually transmitted diseases (STDs) and HIV/AIDS prevention education, testing and referral services. In addition, the Adolescent and Family Life (AFL) program provides discretionary demonstration grants to develop, to implement and to test innovative approaches through two initiatives: (1) prevention programs promoting abstinence among adolescents; and (2) care programs providing health, education and social services to pregnant and parenting adolescents, their infants, teen fathers, male partners and their families.

The **Office on Women's Health** (OWH) educates and advocates for healthy behavior and choices among women and girls to prevent illness and improve health outcomes. To address this priority, the OWH conducts media campaigns such as the National Lupus Awareness Campaign to increase awareness of the disease and to promote early detection of it; supports programs to end violence against women on college and university campuses; funds programs to encourage the use of a public health systems approach with an evidence-based strategy and a gender focus to improve service delivery and to increase access to care; and, implements programs that address cardiovascular diseases, obesity prevention, and other diseases that affect the health and well-being of women and girls. These efforts and others, address another OWH priority area—reduction of the leading causes of death for women and girls.

The **President's Council on Physical Fitness and Sports** is an advisory committee of volunteer citizens who advise the President through the Secretary of Health and Human Services about physical activity, fitness, and sports in America. Among other activities, it leads and oversees the President's Challenge—a program that encourages all Americans to make being active part of their everyday lives.

The **Office of the Assistant Secretary for Planning and Evaluation** (ASPE) is the principal advisor to the Secretary on policy development in health, disability, aging, human services, and science, as well as economic policy. ASPE conducts research and evaluation studies, develops policy analyses, and estimates the cost and benefits of policies and programs including the Department's prevention activities.

The **Office on Disability** (OD) works collaboratively with Federal agencies and non-Federal partners to develop and coordinate policies aimed at improving the health and lives of persons with disabilities, for example, promoting the *Surgeon General's Call to Action (CTA) to Improve the Health and Wellness of Persons with Disabilities* through the national action plan, and physical activity for youth with disabilities in conjunction with the President's Healthier U.S. Initiative through the OD's "I Can Do It, You Can Do It!." During emergency or catastrophic events, OD helps to ensure that medical and general shelters are accessible for persons with disabilities.

The **Administration on Aging** (AOA) has been a principal partner with the Centers for Medicare and Medicaid Services (CMS) in providing outreach, education and personalized counseling, through the Aging Services Network, to inform and encourage beneficiaries to take advantage of Medicare's Part D and preventive benefits including: flu and pneumonia shots; screenings for cardiovascular disease, colorectal cancer and diabetes, the "Welcome to Medicare" physical exam, and diabetes self-managing training. AOA is partnering with CDC, AHRQ, CMS and HRSA and private philanthropy to help community-based aging services provider organizations, such as senior centers, to implement science-based prevention-focused models that have proven effective at helping seniors to better manage their chronic conditions, reduce their risk of falling, and improve their nutrition and physical activity. AOA

and its HHS partners are working with eight metropolitan communities to address the serious health disparities affecting Hispanic seniors, the fastest growing minority group within the older population.

The **Centers for Disease Control and Prevention's** (CDC's) primary focus is on protecting health, rather than treating illness, and carries out that mission through health promotion, prevention and preparedness, rather than disease care; and on creating holistic approaches for improving the population's health across all stages of life, not narrowly defined activities. CDC efforts on a set of fundamental Health Protection Goals are designed to accelerate health improvement, reduce health disparities, and protect people at home and abroad from current and new health threats. These goals drive research priorities, policy development, and programs and interventions.

The **National Institutes of Health** (NIH) supports a broad spectrum of research on prevention, including efforts to improve nutrition, increase physical activity, and reduce sedentary behaviors. In the area of obesity prevention, for example, NIH-funded scientists are investigating a variety of behavioral and environmental interventions in children and adults; in diverse populations, with an emphasis on those disproportionately affected by obesity; and in a variety of sites, including schools, the home, worksites, primary care practices, and other community settings. Preventing the serious diseases associated with obesity is also a research focus. For example, the multi-center HEALTHY study is testing a middle school-based intervention to reduce risk factors for type 2 diabetes, including overweight and obesity. Components of the HEALTHY study include changes in school food services and physical education classes, along with activities to promote healthy behavior and family outreach. Through its translational research efforts, the NIH supports studies to explore potentially cost-effective ways to bring the results of intervention studies to broader community settings and medical practice.

At the same time, the NIH is pursuing research that may inform the development of new strategies to prevent (as well as treat) obesity. These include basic research avenues as well as epidemiologic and other studies to provide insights into potential contributors to obesity, such as economic factors and aspects of neighborhoods that may influence eating patterns and activity. Finally, through its information, education, and outreach activities, the NIH is disseminating research results to patients, healthcare providers, and the public. For example, the NIH is currently updating its Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. In a major national public education and outreach effort for children, the NIH's We Can! (Ways to Enhance Children's Activity and Nutrition) program is designed to help children 8–13 years old stay at a healthy weight. We Can! is based on evidence from research findings. The program focuses on parents and families in the home and community settings, and many national partners and supporting organizations are promoting We Can! messages and materials.

The **Substance Abuse and Mental Health Services Administration (SAMHSA)** has made progress in reducing drug and alcohol misuse and abuse.

SAMHSA reports that illicit drug use has dropped more than 20 percent among teens. To continue to drive these numbers down, SAMHSA supports community-driven substance abuse prevention and mental health promotion programs through Strategic Prevention Framework State Incentive Grants and Drug-Free Community grants.

SAMHSA is concurrently emphasizing mental health prevention activities. It is important to note that half of all lifetime cases of diagnosable mental illnesses begin by age 14 and three-fourths by age 24. Furthermore, 1 in 12 adolescents experience a significant depressive episode each year, underscoring the need for an upstream approach. This past year SAMHSA expanded its efforts in prevention beyond Suicide Prevention to include a new imitative called Project LAUNCH.

Project LAUNCH promotes the wellness of young children 0 to 8 years of age. It is grounded in the public health approach by promoting coordinated programs that take a comprehensive view of health, addressing the physical, emotional, social and behavioral aspects of wellness. The first six grants under this program were awarded this past September.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Promoting preventive health is an underlying component of all **Centers for Medicare & Medicaid Services** (CMS) programs, initiatives, and outreach efforts to Medicare beneficiaries, providers, partners and caregivers. Preventative health efforts are thoroughly entrenched in the CMS' outreach and education activities.

Medicare: Medicare covers many important screenings and other prevention benefits to help people with Medicare live healthier and more active lives. When beneficiaries become eligible for Medicare, they are offered a "Welcome to Medicare" physical to assess their overall health condition. Medicare also covers cardiovascular disease and diabetes screenings, glaucoma tests, osteoporosis screenings, mammography, cervical cancer screenings, prostate cancer screenings, colorectal cancer screenings, influenza and pneumococcal vaccinations, and smoking cessation counseling.

Most recently, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized the HHS Secretary to add coverage (beginning in 2009) of additional preventive services recommended by the U.S. Preventive Services Task Force and determined through the Medicare National Coverage Determination process to be reasonable and necessary for Medicare beneficiaries. In making such determinations, the Secretary may consider the relation between predicted outcomes and the cost of such services.

CMS is currently conducting or developing several prevention demonstration projects, for example, the Cancer Prevention and Treatment Demonstration for Racial and Ethnic Minorities and a Senior Risk Reduction Demonstration.

Medicaid: While States are the primary administrators of Medicaid and State Child Health Insurance Program (SCHIP), CMS is responsible for supporting States in their efforts to achieve safe, effective, efficient, patient-centered, timely and equitable care.

CMS works with States to implement several quality/prevention efforts including smoking cessation counseling, prenatal care, neonatal improvement outcomes, asthma management, immunizations for children and adults, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, lead screening, cancer screenings, and obesity prevention initiatives.

The mission of **Food and Drug Administration** (FDA) is to prevent illness and injury through the regulation of foods and medical products. FDA continues to implement recommendations contained in the FDA Obesity Working Group Report of 2004.

In an Advance Notice of Proposed Rulemaking (ANPRM) on the Revision of Reference Values and Mandatory Nutrients, November 2007, FDA addressed comments on two prior food labeling ANPRMs (serving size & prominence of calories).

FDA is increasing awareness/use of nutrition facts on labels in making individual choices regarding food through the following activities:

- Promoting "Spot the Block—Get Your Food Facts First" launched with the Cartoon Network, March 2007.
- Expanding "Make Your Calories Count," an interactive learning tool.
- Developing curriculum with National Science Teachers Association.

The **Health Resources and Services Administration** (HRSA) is the primary Federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable including people living with HIV/AIDS, pregnant women, mothers and children. For example, community-based and patient-directed Community Health Centers serve populations with limited access to health care, low income, no insurance, limited English proficiency, as well as migrant and seasonal farm workers, individuals and families experiencing homelessness, and those living in public housing.

Health centers provide comprehensive, primary health care and preventive care services. In 2007 health centers served over 16 million patients. Many programs within HRSA contain prevention as a key component such as The Maternal and Child Health Services Block Grant Program providing grants to States to reduce infant mortality, to provide access to comprehensive prenatal and postnatal care for women, and to increase the number of children receiving health assessments and follow-up diagnosis and treatment. In addition, the Healthy Start program provides intensive services tailored to the needs of high risk pregnant women, infants and mothers in communities with exceptionally high rates of infant mortality. To increase the healthcare workforce who can provide preventive services to vulnerable populations, HRSA funds programs to recruit and retain physicians in rural hospitals and clinics. HRSA's telehealth program uses information technology to link isolated rural practitioners to medical institutions over great distances.

The **Indian Health Service** (IHS) has a Prevention Initiative to bring more focus on preventive health care within IHS and among Tribally operated programs. The IHS Prevention Task Force (PTF), with broad representation from IHS and Tribal programs, is responsible for identifying the key components for a coordinated and systematic approach to preventive health activities at all levels of health care for American Indians/Alaskan Natives. The work of the IHS Prevention Task Force is

fully integrated with past and on-going health initiatives within HHS, such as *Healthy People* 2010 and more recently the Secretary's Steps to a Healthier U.S.

The focus areas of the Prevention Initiative are also entirely consistent with the priorities of the IHS Strategic Plan and performance measures identified in the congressionally directed Government Performance and Results Act (GPRA) reporting system. Additionally, the PTF receives guidance from the Policy Advisory Committee which consists of Tribal leaders, at the national and local levels, and representation from other Federal agencies (e.g., CDC, NIH) that focus on health promotion and disease prevention.

HHS PREVENTION BUDGET

I am profoundly honored to be a part of this robust Prevention Infrastructure and Science Base that holds great promise for helping us realize our vision, which is worth repeating here—A Nation in which healthy people live in healthy communities, sustained by effective, efficient and coordinated health systems.

The FY 2009 President's Budget includes discretionary funds to support prevention activities across the Department and to sustain this Prevention Infrastructure and Science base. Additionally, the FY 2009 Budget includes mandatory funds for prevention efforts in Medicaid and Medicare.

SUMMARY

As my description of HHS activities illustrates, our disease prevention efforts cut across agencies and missions. Encouraging Americans to make healthy choices, contributes to the creation of a culture of wellness, which is, after all, everybody's business.

The Department's investment in a comprehensive prevention infrastructure and growing prevention and communication science base sets the stage for health care reform in which the public should be able to expect seamless, coordinated care and the best support for making healthy decisions that science has to offer.

It is accurate to say that whatever the specifics of future efforts to reform American health care, a consensus exists that the system of the future will be founded upon prevention and recognition of its value. Put another way, if prevention is the future—and it is—then the future is now.

Senator HARKIN. Thank you very much, Dr. Wright. Thank you for your service.

You know, I want to start off by just saying, I asked my staff for the organizational chart for HHS. I can't find you. It is not there. Where are you?

Dr. WRIGHT. I am in the Office of Public Health and Science, report to the assistant secretary for health.

Senator HARKIN. Public Health and Science? Well, there is an assistant secretary for health, and I guess if I looked further, I would find some different things that that person is in charge of, right, in different boxes and things like that?

Dr. WRIGHT. Yes, sir. Sir, the Office of Public Health and Science is within the Office of the Secretary, and it is our responsibility to try to coordinate activities across the various operating divisions. So many of the issues of HHS have contributions made by the various operating divisions and staff.

Senator HARKIN. My point is that your office ought to be right up there. I mean it ought to be one of the first things that people see when they go to HHS, and they see an—quite frankly, there ought to be an assistant secretary. Is that the next in line, or is that the deputy secretary? The assistant secretary for prevention, wellness, public health.

They ought to be able to look and say that is where you are, right there. Can't find you. You are buried someplace down there. My point being is that, again, we have not elevated this to the position it ought to be.

As we move ahead in our health reform debate, I think one of the things we ought to look at is your office and where it is and why it isn't in a more strategic position in the secretary's office, with a higher level of public knowledge of you and where you are in there and what you do. Because there are things that you are doing that the public ought to know about.

That is my first point. I am not denigrating you. I am just saying that that office ought to be boosted up and made into a very key position in HHS.

The second thing is, and I think it is very clear—Senator Coburn alluded to that—and we all know that when we are talking about prevention and wellness, a lot of it occurs not just under the health umbrella, as we think about it. It occurs outside someplace—transportation, schools, exercise in our schools, nutrition, what our kids are eating.

I wear another hat. I had an earlier hearing this week on the reauthorization of the child nutrition bill—the school lunch, school breakfast, WIC programs. That is a big part of it also in terms of prevention.

It reaches into all kinds of areas, and then you get down to the States and what are States doing. Some States are doing some really interesting things. Some local jurisdictions are doing very good things on wellness, but it is all disconnected.

We don't have, as Senator Coburn said, we don't have the metrics to measure what is really good, what really works and what is not working. We need to know that also.

So, I guess my second question has to do with whether there is any structure or office, where your office would be working with Agriculture, with Transportation, with Education, on and on and on, on prevention and wellness? Is there such a structure?

Dr. WRIGHT. Thank you, Senator.

I think that is a very good question. And clearly, for us to impact the healthcare system in a positive manner, we do have to reach out further than the healthcare system—schools, community centers, communities—and look at how we can have a positive impact in health from a variety of standpoints.

The answer to your question, Is there an office within OPHS or within the HHS that reaches out and across departments to seek their help with these issues?, and the answer to that is yes. It really is the overarching Healthy People program that provides the organizational framework.

We have realized that we clearly need to help with the other departments as we try to advance health issues in this country. The Department of Education has been so important with the issue that Senator Coburn mentioned about physical education and the part that plays in childhood obesity. Clearly, the Department of Interior has been involved, the Department of Housing and Urban Development, the Veterans Administration, and others.

These are part of the Federal interagency working group that creates the Healthy People 2010 goals that we are working on now. But we have also started looking into the next decade, and the Federal interagency working group for Healthy People 2020 is now meeting, and we have representation across the Federal family to seek their input. Clearly, the more support we have from the var-

ious departments, the greater success we will enjoy on down the road.

Senator HARKIN. Thank you very much, Dr. Wright. Thank you. Senator Coburn.

Senator COBURN. Dr. Wright, a couple of questions. You have released the guidelines on physical fitness. How were they promoted?

Dr. WRIGHT. That is a great question, and clearly, it is one thing to have guidelines and then see that that is actually carried at the community level. I think one of the areas that we have learned in public health is clearly there has to be grassroots campaigns to ensure that what we know are quality guidelines are translated into actions at the local level.

We are trying to get the message out. This is a new guideline that was actually only released in October of this year. So we are very much in the rollout.

Senator COBURN. So what is the plan to get the message out?

Dr. WRIGHT. We are using the President's Council on Physical Fitness, the members of that group, to speak on behalf of the physical activity guidelines.

Senator COBURN. Is there an advertisement that runs next to a McDonald's advertisement?

[Laughter.]

No, I am serious. The fact is, we spend $834 million a year at CDC for chronic disease prevention, alright? NIH spends $6.74 billion a year on chronic disease research. SAMHSA spends $1.8 billion on prevention and treatment. The Administration for Aging and Nutrition spends $779 million.

Where are the ads to teach American people what they need to know? The question I have is—you can have all of the guidelines in the world. You can rearrange the deck chairs all you want, but there are no metrics to say that we have accomplished anything—and it doesn't matter what the guidelines are if they are not communicated.

So, my question is, where is the package that says here is what we want the American people to know, and here is how we are going to make sure they know it? And it doesn't sound to me like you all have a package to communicate it.

Now you may have a plan, but the fact is, is if you have a plan and you haven't communicated it, you haven't had any impact on health. That is my big problem with most of what we are doing on prevention. We have great people working on prevention. They are right on.

But when we are not teaching people that their body mass index has a direct correlation with their long-term health, and there is nothing on the airwaves and there is nothing on the Internet that pops up that says, "What is your BMI? Your future risk for cancer, diabetes, or hypertension is related to it," we have not begun getting in the game of teaching prevention.

That is why I said we need to change the paradigm, and we need a plan that says we are going to go out and compete with the private sector that are destroying the health of the American people by giving them the message on the things they can do, whether they do it or not. The vast majority are going to make good decisions, but we are not even out there with the message.

What is the plan, what is the exact plan to get the guidelines for physical fitness out to the American people so they know what it is?

Dr. WRIGHT. Right. Senator Coburn, your point is well taken. The guidelines are only as good as they are implemented at the person level. And clearly, we will move forward in this area.

The statistics are not promising. There are 40 percent of Americans that have no physical activity whatsoever, and so there is a great opportunity for improvement in that area. We really have reached out to many of the external stakeholders, and we have over 1,000 that have agreed to help us on the outside actually get the message of the physical activity guidelines out.

We will make increased efforts to reach the people. The community health centers will be one area that we get our message out. And we are also putting together a community tool kit that will allow communities to try to make individuals within that community aware of the value of physical activity and what needs to occur at the local level to encourage that.

Senator COBURN. You don't have a promotional kit to go with Ad Council ads that says here is what you need to know about your physical activity? If you are a parent, if your child isn't getting this much exercise, your child is going to be at risk for this, this, and this?

I understand that your examples are the way we have done it. That is my whole point in saying we have to have a paradigm change. If we are going to go after prevention, we have to educate the American people on prevention.

We can have the best guidelines in the world, if they don't know what they are and the physicians in this country don't know what they are, and they are not part of the graduate medical education recertification test of knowing what they are, so that it is an important part of their getting recertified, if we don't have a master plan that says we are going to put this information out, and then we are going to make sure it gets communicated.

We see the Ad Council ads all of the time, but we hardly ever see one related to prevention. And that is, most of the people that are out there are doing that as a public service. A great public service would make sure parents knew what their kids need to do in terms of exercise or addressing the school board. Why don't we have physical fitness anymore in our schools?

I will guarantee you I behaved a lot better in school as a youngster because I was more tired after physical exercise than when I wasn't doing physical exercise.

Thank you, Mr. Chairman.

Senator HARKIN. Thank you, Senator Coburn.

Senator Reed.

Senator REED. Well, thank you very much, Mr. Chairman.

Mr. Secretary, welcome.

One aspect of prevention is an old, reliable one. That is immunization. The CDC estimates that full immunization would cost about $1.1 billion a year, and the 317 program, which is the major program assisting State and local governments, the request this year is $465 million.

I understand these are difficult budget times, but could you give me a sense of how the figure was arrived at, given the need and given the fact that immunization is something that obviously seems to be central to every discussion of preventive healthcare, of health quality throughout the Nation?

Dr. WRIGHT. Senator, first of all, let me say I agree with you that immunization programs are one of the most effective public health strategies and one of the most effective preventive measures that we can invest in.

You know, as a member of OPHS, my role is one of coordination across the various operating divisions within HHS, and I am really not familiar with the details of the immunization budget and the shortfalls that occur. I do know over my lifetime as a physician, the number of recommended childhood immunizations has markedly increased, and we have seen decreased childhood morbidity as a result of that.

That comes with a price, and the cost of immunizing the child is much higher now than when I was in my training. We do have a National Vaccine Program Office in OPHS that looks at these issues as well. I am happy to get back with you as it relates to the immunization budget, but I don't have those numbers at my fingertips.

Senator REED. Part of this touches, I think, on the theme that Senator Coburn was addressing, which is that a strategy prioritizes the most important initiative and then the next most important, etc. In your deliberations with your colleagues, it would seem to me that immunization sort of has to be at the top of any of these lists, and sometimes it is overlooked or underfunded.

Not only do I think it is appropriate to look at immunization, but also it would help us, I think, if you could clearly articulate sort of what are—the first issue is immunization. The second would be addressing obesity. The third would be whatever. If you have that strategy, we would appreciate it.

Dr. WRIGHT. Sure. Well, certainly, we want to invest prevention dollars where we will have the greatest impact, and immunizations would fit into that category. But the areas that I think are really the pillars of prevention are healthy diet and encouraging Americans to eat nutritious meals every time they sit down and make the appropriate dietary choices each time they pull up to the dinner table.

The issue that I just brought up is physical activity. We have 40 percent of Americans who are not receiving any physical activity, and yet the science is replete in examples and in evidence of the value of physical activity. So that is another cornerstone that we really need to move forward with.

Medical screenings, making sure that individuals receive the appropriate medical screenings at the appropriate time as recommended by the U.S. Preventive Services Task Force.

And then, avoiding risky behaviors. Clearly, at the top of the list of risky behaviors would be tobacco use, and we need to continue to invest our energies, first of all, in preventing the initiation of the tobacco habit among America's youth and among American adults. But we also need to invest our energies in helping those that are already addicted to tobacco to stop that health behavior.

Senator REED. Final question, Doctor. Many of the benefits that accrue from these strategies will be seen 10 years, 20 years ahead, but the cost is immediate. Is there any thought being given to a longer-term budget authority, or more in general terms, how do you consciously take into consideration the gap between the cost and the benefit?

Dr. WRIGHT. Thank you, Senator.

That is a very insightful question. In reality, some of the dollars we invest in prevention will result in reduced healthcare costs, but it may be years down the road before we realize those costs.

I look at the dollars we spend on prevention of initiation of tobacco smoking. Clearly, the individual that we prevent from starting that habit has reduction in healthcare costs down the road. But quite frankly, those may not be realized for decades. So it is an important issue.

When we look at the cost of healthcare and the value that prevention plays in that, I want to strike a cautionary note. Clearly, subject matter experts in this area differ as to the savings that can come out of a comprehensive prevention program.

There is no question that some of our interventions can prevent diabetes and other chronic illnesses. Will there be a net savings? I think that is debatable. There are subject matter experts that think the savings will be significant and others that think that they will be somewhat negligible.

But from my vantage point, the justification for prevention programs are ample. Clearly, if we can prevent chronic diseases—and over 40 percent of chronic diseases are preventable—we can alleviate human suffering, we can improve the quality of life for Americans, and we can increase the productivity, a point that Senator Harkin made in his opening statements. Those facts alone provide the justification to move forward with a prevention agenda.

Senator REED. Thank you, Mr. Secretary.

Senator COBURN. Mr. Chairman, I just wanted to add for the record the CDC's numbers on the vaccine for children was $2.7 billion. It will be 2.766 this next year. Immunizations for respiratory disease, pandemic influenza is $157 million, and discretionary non add-ons is $466 million. So, in total, they are spending about $4.6 billion through CDC on programs for immunization and the like.

Senator HARKIN. Dr. Wright, I see you have Dr. Royal behind you, who is with the uniformed services. In the next panel, Dr. Levi points out the commissioned services and how we are not—there is a congressionally mandated cap right now, which I was really, quite frankly, unaware of. And that cap is about 2,800 right now.

At some point, but not today, I intend to delve into this in a future hearing about the role of the uniformed services in public health. It seems like we haven't utilized them enough, and we haven't gone out to recruit young people to be in the Public Health Service and the benefits that accrue and how they can take this as a career path.

Hopefully, at one of my next hearings, we are going to have the uniformed services up here to talk about their role and what they could do. And I just wonder if you have any thoughts on that?

Dr. WRIGHT. Senator, I agree with the value you place on the Commissioned Corps. They are invaluable to what we do at HHS,

and the Admiral is just one example of numerous Commissioned Corps officers that we have carrying out the very important business of HHS.

I will make you aware of the fact that we are in the process of transforming the corps, and there has been an effort to increase the enrollment in the corps. There is a transformation office that is increasing their efforts to reach out and recruit potential corps members.

I am pleased to say that over this past year, the year that I have been at HHS, the number of corps members has increased by approximately 200. So we are moving in the right direction.

Senator HARKIN. Well, that is good to know. It needs to be a little bit more accelerated than that, I think. And I think there are some things we can do in terms of scholarships, loan repayments, all kinds of things that we could focus on to build up this public health corps sector in the United States with public health workers through the commissioned services.

Dr. WRIGHT. All the things you have mentioned would be valuable strategies to help us achieve that goal.

Senator HARKIN. Do you have anything else?

Dr. Wright, anything else you would like to say?

Dr. WRIGHT. No, thank you very much.

Senator HARKIN. Well, thanks for being here, Dr. Wright. Thank you.

Now we will move on to the second panel.

Again, I would like to welcome our second panel. Thank all of you for being here.

Thanks for submitting your testimony earlier so I could read it all yesterday. And again, all of your written testimonies will be made a part of the record in their entirety. I will ask each of you if you could just take 10 minutes or less to summarize so we can get into a discussion.

I will introduce each of you. We will just go from left to right. Our first witness will be Dr. Jeff Levi. "Lee-vee" or "Lee-vi?"

Mr. LEVI. Lee-vee.

Senator HARKIN. Dr. Levi, the executive director of the Trust for America's for Health. He is also an associate professor at the George Washington University's Department of Public Health and previously served as deputy director at the White House Office of National AIDS Policy.

Dr. Levi has a Master's from Cornell University, a Ph.D. from George Washington University.

Trust for America's Health advocates for a modernized public health system and addresses many of the critical problems threatening the health of our Nation. They have released several reports this year that are of great interest.

I think the chart that I was referring to was from you, Dr. Levi, and all these other ones that came out. I was privileged to be at your rollout this summer with former Senator Lowell Weicker. I have read a good bit of this and walked through it, and there are some great things in these documents.

I thank you, and I thank Trust for America's Health for all that they are doing, and please proceed. And if you will set that clock

at 10 minutes so Dr. Levi knows—whoever is setting these clocks. More time than I expected.

Senator HARKIN. Thank you very much, Dr. Levi. Please proceed.

STATEMENT OF JEFFREY LEVI, PH.D., EXECUTIVE DIRECTOR, TRUST FOR AMERICA'S HEALTH, WASHINGTON, DC

Mr. LEVI. Good morning, and thank you for this opportunity to testify.

Senator Harkin, your leadership and that of Chairman Kennedy give us great hope in the public health community that this round of health reform discussions will really be about the health of Americans, not just about healthcare.

Trust for America's Health believes that a strong public health system and public policies focused on disease prevention should be a cornerstone of the health reform plan. My written testimony develops seven points related to prevention and health reform.

First, universal quality coverage and access to healthcare is critical to protecting and promoting the health of Americans.

Second, investment in both community-based and clinical prevention is critical to ensuring that universal coverage is as cost-effective as possible.

Third, stable and reliable funding for core public health functions and community-based prevention is essential.

Fourth, a national prevention plan that harnesses the potential of existing Federal programs across the Government is long overdue.

Fifth, the public health workforce must be strengthened to maximize the potential of public health to contribute to better health and lower healthcare costs.

Sixth, the concept of quality assurance and evidence-based interventions should be extended to all public health programs, including community-based prevention.

And seventh, a reformed healthcare system must be prepared to react and mitigate the consequences of a public health emergency.

In the brief time I have, I want to focus on three elements—the importance of community prevention, assuring a reliable funding stream, and development of a national prevention strategy.

Mr. Chairman, as you mentioned, last July we issued a report based on an economic model developed by the Urban Institute that found that an investment of $10 per person per year in effective community-level prevention programs to improve physical activity and good nutrition and prevent smoking could result in more than $16 billion in savings and healthcare costs annually within 5 years. This is a return of $5.60 for every $1 spent.

As a part of health reform, we need to jump start broad-scale community prevention in this country. Our written testimony has a detailed proposal for creation of a targeted community makeover grant program to provide funding for a comprehensive, coordinated approach to community-based prevention activities, with a particular focus on reducing chronic disease rates and addressing health disparities.

I would argue that the community makeover grant program is that paradigm shift that Senator Coburn was talking about. In our prevention report, we describe some of those kinds of programs,

many of which involve social marketing campaigns to target changes in certain types of behavior.

We have done a significant amount of research that actually does polling and focus groups to see what the American people want from the Government in terms of public health. And I think Senator Coburn is correct. They don't want to be lectured at, and they don't want to be mandated to do things.

They want to know what is the best guidance. I think it is actually true that the new physical activity guidelines that HHS has issued are phenomenal guidelines. They are clear. They are evidence-based. But what we don't have is a plan to then get the American people to adopt them.

Our mantra is that we need to help people make healthy choices. Some of that is about giving them the right information. But sometimes when we look at communities, we also have to address what is happening in their communities that is making it hard for them to actually implement those guidelines.

If we are telling people to walk more and there aren't sidewalks in their community, then we have to address that. If we are telling people to eat healthier and there aren't supermarkets in their neighborhoods, then we have to address that.

Senator Harkin's proposal about changing how the food stamp program works, the demonstration program he is hoping to see implemented soon, would actually give people higher reimbursement if they buy healthier foods. It is those kinds of things that the evidence shows actually results in behavior change and can dramatically reduce the chronic diseases that we are concerned about.

But community prevention will only be fully effective if there is a reliable funding stream and well-trained workforce to implement these programs and the core public health system that supports prevention. Therefore, we recommend the creation of a trust fund mechanism to support clinical and community-based prevention along with related public health functions and infrastructure.

I would note, parenthetically, that a critical component of the public health infrastructure is the workforce. And as Senator Harkin mentioned earlier, that is a real issue that we need to address, both in the context of the Commissioned Corps and its status, but also in terms of having more community health workers.

They don't necessarily have to be master's trained public health folks, even though I teach in a school of public health. We need more people out in the community educating folks, helping people make those healthy choices.

It is my hope that you will be able to work with the folks developing the economic stimulus package to give more attention to training and workforce development in public health. There is an opportunity to train people and to rapidly increase the community health workforce that is out there.

Finally, Trust for America's Health (TFAH) recommends that public health and prevention be elevated throughout the Federal Government by creating a national prevention strategy. The strategy needs to direct all Federal agencies and departments to consider how their budgets, policies, and programs influence health.

The Healthy People 2010 document is a very useful document in terms of setting goals for the Nation, but it is not a strategy. It

does not crosswalk the goals that are set in Healthy People 2010 to specific programs and specific investments that the Government is making to help Americans reach those goals.

It is our hope that in a new administration, that this direction will actually come from the White House so that all agencies recognize that it is important to have a defined strategy with clear milestones to achieve a healthier population. And I think, Senator Harkin, you were absolutely right in terms of the diversity of the Federal agencies that need to be part of that process.

This Administration did a phenomenal job in developing a national strategy for pandemic influenza that recognized that it is not just the Department of Health and Human Services that has a role, but every agency across the Federal Government. And we need to think about that in the same way when we are thinking about prevention, particularly as we focus on chronic diseases.

Thank you again, Mr. Chairman, for your tremendous leadership in focusing our Nation's health efforts on prevention, and we look forward to working with you to assure that prevention remains a central element of health reform.

Thank you.

[The prepared statement of Mr. Levi follows:]

PREPARED STATEMENT OF JEFFREY LEVI, PH.D.

Good morning. My name is Jeffrey Levi, and I am the Executive Director of Trust for America's Health (TFAH), a nonpartisan, nonprofit organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a National priority. I would like to thank the members of the committee for the opportunity to testify on this very important issue—the role of prevention and public health as a component of the health reform debate. Senator Harkin, your leadership and that of Chairman Kennedy, give great hope to those of us in the public health community that this round of health reform discussions will really be about the health of Americans, not just about health care.

TFAH believes that America must provide quality, affordable health care to all. A strong public health system and public policies focused on disease and injury prevention should be a cornerstone of a health reform plan. I want to focus on seven critical points related to prevention and health reform in my testimony today:

1. Universal, quality coverage and access to health care is critical to protecting and promoting the health of Americans.
2. Investment in *both* community-based and clinical prevention is critical to ensuring that universal coverage is as cost-effective as possible.
3. Stable and reliable funding for core public health functions and community-based prevention is essential.
4. A national prevention plan that harnesses the potential of existing Federal programs across the government is long overdue.
5. The public health workforce must be strengthened to maximize the potential of public health to contribute to better health and lower health care costs.
6. The concept of quality assurance and evidence-based interventions should be extended to all public health programs, including community-based prevention.
7. A reformed health care system must be prepared to react to and mitigate the consequences of a public health emergency.

UNIVERSAL COVERAGE

Any health reform plan must assure universal, quality coverage and access to health care to give all Americans the opportunity to be as healthy as they can be. All individuals and families should have a high level of services that protect, promote, and preserve their health, regardless of who they are or where they live. Full coverage of preventive services, without copayments or deductibles will maximize the potential of evidence-based prevention. But coverage alone is insufficient. A reformed system must also assure access to care. State and local health departments often provide direct primary care and/or clinical preventive services to significant

portions of the population, and therefore, need to be assured adequate funding streams if that role continues in a reformed system.

CLINICAL AND COMMUNITY-LEVEL PREVENTION

As we chart a new course for our Nation's health care system, it is important that we look for ways to achieve greater cost efficiency. America spends $2.2 trillion on health care each year, far more than any other nation, while spending a few cents on every dollar on public health. Clearly, we must begin to control these skyrocketing health care costs, but achieving better health outcomes must be the driving force behind our investments and choices. With that in mind, disease prevention must be at the center of our efforts. Two important components that Congress should consider in a prevention-centered health reform initiative are clinical and community-level prevention programs.

Expanding clinical preventive services, including immunizations, screenings and counseling, could save many lives. A report by the Partnership for Prevention found that increasing the use of just five preventive services would save more than 100,000 lives each year in the United States.[1] To maximize our investment in prevention, it is essential that we support both clinical and community-level prevention programs, as the two work hand-in-hand. Many clinical preventive interventions require a strong community-level base to be effective. For example, a doctor can encourage a person to be more physically active, including writing a prescription for a person to get more exercise. However, unless a person has access to a safe, accessible place to engage in activity, he or she will not be able to "fill" this prescription.

Community prevention can also be very cost effective. Earlier this year, TFAH released a report, *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*, which examines how much the country could save by strategically investing in community-based disease prevention programs. The report concludes that an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save the country more than $16 billion annually within 5 years. This is a return of $5.60 for every $1.00 spent. The economic findings are based on a model developed by researchers at the Urban Institute and a review of evidence-based studies conducted by the New York Academy of Medicine. The researchers found that many effective prevention programs cost less than $10 per person, and that these programs have delivered results in lowering rates of diseases that are related to physical activity, nutrition, and smoking cessation. The evidence shows that implementing these programs in communities reduces rates of type 2 diabetes and high blood pressure by 5 percent within 2 years; reduces heart disease, kidney disease, and stroke by 5 percent within 5 years; and reduces some forms of cancer, arthritis, and chronic obstructive pulmonary disease by 2.5 percent within 10 to 20 years, which, in turn, can save money through reduced health care costs to Medicare, Medicaid and private payers.[2]

To take advantage of this potential return on investment, TFAH recommends the creation of **community makeover grants**, an infusion of funding to be used to support rapid implementation of the policy, programmatic and infrastructure improvements needed to address the social determinants of health and reduce chronic disease rates. These grants would build upon existing programs with a more significant investment in a coordinated set of population-wide interventions aimed at helping to keep people healthier for a longer time and ensuring that universal coverage is as cost-effective as possible. These grants would have a strong evaluation component, and their ultimate success would be measured by the change in prevalence of chronic disease risk factors among members of the community. (See Appendix A for a full description of this grant proposal.)

We strongly recommend that these community makeover grants be initiated as soon as possible—*prior to* implementation of the reformed health system to assure that as many Americans as possible are as healthy as they can be as they enter the reformed health care system. An initial investment of $500 million, especially if targeted at underserved communities with high rates of uninsurance, could reach tens of millions of Americans and dramatically improve their health status.

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[1] Partnership for Prevention. *Preventive Care: A National Profile on Use, Disparities, and Health Benefits*. August 2007. *http://www.prevent.org/content/view/129/72/*.

[2] Trust for America's Health. *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*. July 2008. *http://healthyamericans.org/reports/prevention08/*.

STABLE AND RELIABLE FUNDING FOR PREVENTION

We strongly urge Congress to ensure that any health care financing system that is developed as part of health reform will include stable and reliable funding for core public health functions and clinical and preventive services. A strong public health system is necessary to help promote better health, monitor the health of the country, and protect people from health threats that are beyond individual control, including bioterrorism, foodborne disease outbreaks, and natural disasters. The Nation must adequately fund Federal, State, and local public health departments and programs so that they can fulfill their responsibility for protecting the health of the public. Public health needs a predictable, sustainable funding stream. Effective implementation of community-level prevention programs requires providing support to community organizations and coalitions that directly carry out this life-saving work.

To that end, TFAH recommends the creation of a trust fund mechanism to support clinical and community-based prevention, along with related public health functions. There are various approaches that could be taken to assure this reliable funding stream for prevention. One example would be the creation of a Wellness Trust, an independent entity that would become the primary payer for preventive services and would recommend priority prevention activities. A Wellness Trust would put prevention and wellness at the center of our healthcare system. S. 3674, introduced by Senator Clinton, and H.R. 7287, introduced by Congresswoman Matsui, are variations of this concept and would vastly improve access to clinical and community preventive services, information and resources.

A NATIONAL PREVENTION PLAN

We can also promote prevention through leadership, planning and modest structural changes at little to no cost—by focusing existing Federal programs on health promotion. **TFAH recommends that public health and prevention be elevated throughout the Federal Government by creating a national prevention strategy.** The strategy will outline a few priority national prevention goals and direct all Federal agencies and departments to consider how their budgets, policies and programs influence health. The National Strategy to Combat Pandemic Influenza serves as a good example of the way in which Federal agencies, under White House leadership, can coordinate their efforts to deal with a public health threat. A national prevention strategy would serve a similar coordinating role. It could be overseen and evaluated by a newly created public health board, which could serve as an independent voice on science and public health. Such a board would ensure that the strategy is properly coordinated and that progress toward achieving interim chronic disease reduction goals is being made. Since a broad range of policies, ranging from transportation to agriculture to education, all influence the public's health, it is important that we develop a strategy to organize and coordinate government-wide prevention efforts involving an array of departments and agencies not all traditionally involved in public health.

Better coordination of health programs and policies is also necessary within the Department of Health and Human Services (HHS). There is currently no senior official with medical, scientific, and public health expertise with the authority to assure consistency in policy and coordination among the various agencies addressing health and public health issues, and to champion the allocation of necessary resources and require accountability for such investments. To address this problem, Congress should consider creating the position of Undersecretary for Health (USH) in the Department of Health and Human Services to whom all the Public Health Service (PHS) agencies, the Office of the Assistant Secretary for Preparedness and Response (ASPR), and the Centers for Medicare and Medicaid Services (CMS) would report. This would ensure better coordination within HHS, which will be essential as the new administration implements policy and programmatic changes. (See Appendix B for a full description of this proposal.)

THE PUBLIC HEALTH WORKFORCE

In order to assist in the implementation of the structural and funding recommendations addressed above, we need a well-trained workforce. There is a well-documented shortage of healthcare workers, and it is very important that we continue to provide financial incentives to encourage individuals to enter the healthcare workforce. At the same time, we are also facing shortages in the public health workforce.

A 2007 survey by the Association of State and Territorial Health Officials (ASTHO) found that the State public health agency workforce is graying at a higher rate than the rest of the American workforce, and workforce shortages continue to

persist in State health agencies. This workforce shortage could be exacerbated through retirements: 20 percent of the average State health agency's workforce will be eligible to retire within 3 years, and by 2012, over 50 percent of some State health agency workforces will be eligible to retire.[3] Further, according to a 2005 Profile of Local Health Departments conducted by the National Association of County and City Health Officials (NACCHO), approximately 20 percent of local health department employees will be eligible for retirement by 2010.[4]

Public health departments serve an important function by helping to promote health and prevent disease, prepare for and respond to emergencies and potential acts of bioterrorism, investigate and stop disease outbreaks, and provide other services such as immunizations and testing. Yet, the average age of new hires in State health agencies is 40, according to the 2007 ASTHO survey. Public health needs a pipeline of young workers.

Thus, TFAH recommends that as Congress addresses the overall workforce shortage in the health sector, the public health workforce must be included in such efforts. Specifically, we recommend that Congress provide financial incentives such as loan repayment, scholarship assistance, or retraining opportunities to encourage individuals to work in governmental public health. Congress should also provide funding for a regular enumeration of the public health workforce, as well as a dissemination of public health workforce training, recruitment, and retention tools. This will enable us to have the necessary data available to establish a baseline that we can use to measure the impact of workforce initiatives. Congress should also continue its revitalization of the Commissioned Corps to ensure that our Nation's premier public health professionals have the resources they need to serve our Nation most effectively.

It is important to note that the workforce problem is being exacerbated dramatically by the current economic downturn. Even prior to consideration of health reform, TFAH urges that steps be taken to address the workforce crisis as part of the economic stimulus package for two reasons. First, many States and localities have been forced to cut back on their staffing because of budget shortfalls. One survey by the National Association of County and City Health Officials, showed that more than half of local health departments have lost positions either due to layoffs or attrition. Second, as we develop workforce retraining programs as part of the stimulus package, there is an opportunity to train workers for community-level prevention work that would dramatically improve our ability to implement prevention programs. (See Appendix C for a full description of TFAH's workforce recommendations.)

QUALITY ASSURANCE FOR EVIDENCE-BASED PREVENTION

TFAH believes that our investment in prevention should be based on evidence-based interventions with a strong level of accountability for outcomes. Every effort should be made to ensure the country and communities are investing in the most effective programs possible. To that end, we recommend creating, within the Centers for Disease Control and Prevention, a ***Public Health Research Institute***, that would build the evidence base for prevention and help develop the new field of public health systems and services research, which is committed to providing a strong evidence base for all public health activities.

In order to control costs and use Federal funding most efficiently, it is essential that we promote accountability and measure progress toward improving health outcomes. All Federal programs should set aside sufficient funding to evaluate their effectiveness so that we can target our resources and maximize our investments in public health.

PREPAREDNESS

A final area to be addressed is emergency preparedness. Funding for State and local preparedness and hospital preparedness has decreased year after year. Especially at a time when States are cash-strapped, Federal funding for preparedness is necessary to protect our safety. **TFAH urges Congress to ensure that a reformed health care system will be prepared to react to and mitigate the consequences of a public health emergency.** The health system must contribute to critical public health functions such as surveillance, surge capacity, reimbursement for preparedness and response, and community resilience. Congress should

[3] ASTHO. 2007 State Public Health Workforce Survey Results. *http://www.astho.org/pubs/WorkforceReport.pdf.*

[4] NACCHO. Profile of Local Health Departments. *http://www.naccho.org/topics/infrastructure/profile/resources/2005reports/index.cfm.*

provide ongoing financial support for health facilities to build the capacity to manage a sudden increase in demand. Toward that end, Congress should consider linking hospital reimbursement to emergency preparedness by offering bonus payments or other financial incentives to hospitals that meet a certain baseline of preparedness. A consistent level of funding for preparedness must be achieved, and as we consider health reform, we must remember the essential link between our preparedness and our health.

CONCLUSION

In conclusion, TFAH believes that these seven elements are critical to assure that a reformed health system is truly about the health and wellness of the American people—assuring that they are as healthy and as productive as they can be. Focusing on prevention will not only reduce the burden on the reformed health care system, but it will assure that we have a healthier, more economically competitive workforce. In this time of economic crisis, a focus on prevention and wellness is that much more important.

Thank you again for the opportunity to testify—and thank you again for your continued leadership in assuring that prevention is central to this health reform effort.

APPENDIX A.—COMMUNITY MAKEOVER GRANTS OUTLINE

Goal: Provide funding for a comprehensive, coordinated approach to community-based population-level prevention activities in order to reduce chronic disease rates, address health disparities, and develop a stronger evidence base demonstrating the effectiveness of wide-scale, rapid implementation of community-based prevention activities.

Rationale: Communities across the Nation are eager to combat the epidemics of obesity and chronic disease. Research has shown that effective community level prevention activities focusing on nutrition, physical activity and smoking cessation can reduce chronic disease rates and have a significant return on investment. A report from Trust for America's Health entitled *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities* concluded that an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save the country more than $16 billion annually within 5 years. This is a return of $5.60 for every $1.00 spent. The Centers for Disease Control and Prevention funds a number of programs that focus on chronic disease prevention; yet currently, there is no one program that funds the planning, wide-scale implementation and evaluation of a holistic, coordinated approach to prevention that engages key stakeholders from all sectors of a community.

The Community Makeover Program would build on the strategies and approaches of a number of CDC's programs (REACH, Steps to a Healthier U.S., Pioneering Healthier Communities, the School Health Program) to provide and fully fund a unified, comprehensive prevention strategy for a community or State. Demand for this program is expected to be high, and the program will likely encourage State and local investment, as well. When CDC puts out a solicitation for community funding, for every community the agency funds, at least 10 communities cannot be funded. Furthermore, when States and communities receive funding from CDC, they are able to leverage additional local funds. For example, in Minnesota a $5 million investment by CDC has led to a $47 million investment by the State.

Timeline: 5 years.

Funding: CDC would provide grants for the planning, implementation, evaluation, and dissemination of best practices for community makeover grants. CDC would also provide training for key policymakers at the State and local level regarding effective strategies for the prevention and control of chronic diseases. Grantees would receive an infusion of funding for rapid implementation of a variety of programs, policies and infrastructure improvements that would enhance access to nutrition and activity and promote healthy lifestyles. To the extent permissible by law, grantees would be expected to leverage funding from other Federal, State, local governmental or private funding. Grantees would be encouraged to provide in-kind resources such as staff, equipment or office space. When awarding grants, CDC would be permitted to consider an applicant's ability to leverage support from other sources. CDC would also be required to consider the extent to which a grantee's application addresses social determinants of health. CDC would be permitted to provide preference to low-income communities addressing disparities when awarding funds.

Funding would be based on the population of the community, up to $10 per person per year.

Sites: Competitive grants would be awarded to governors, mayors, and/or a national network of a community-based organization. The number of grants should be limited, based on funding available, so that meaningful change can be supported.

Activities: (A) Planning.—Grantees would be required to develop a detailed community makeover plan, including all of the policy, environmental, programmatic and infrastructure changes needed to promote healthy living and reduce disparities. Communities or States previously funded through the Pioneering Healthier Communities, REACH, Steps to a Healthier U.S., Achieve Program, the Division of Adult and Community Health, the Division of Nutrition, Physical Activity and Obesity, or an equivalent privately funded program would be given preference for funding. To formulate the community makeover plan, they would convene key constituencies in a community or State, such as elected officials, urban planners, public health representatives, businesses, media, educators, parents, religious leaders, city/State transportation planners, local park and recreation directors, public safety/law enforcement, food companies, insurance carriers, community organizations, community or other foundations, and other stakeholders.

Grantees would be required to coordinate their planning and programming with other programs in their community or State that focus on chronic disease prevention, including those listed above, in addition to Safe Routes to Schools, farm to cafeteria programs, and other nutrition and physical activity programming. Grantees would also be expected to work with other programs funded by CDC, and to detail their evaluation methodology. The community makeover plan would be submitted to CDC for approval, and CDC would provide ongoing technical assistance.

Key areas of focus for the plans would include all of the following:

- creating healthier school environments, including increasing healthy food options and physical activity opportunities;
- creating the infrastructure to support active living and access to nutritious foods in a safe environment (examples include: green space, such as parks, walking and biking paths, farmers' markets, street lights, sidewalks, and increased public safety);
- developing and promoting programs targeted to a variety of age levels to increase access to nutrition, physical activity and smoking cessation, enhance safety in a community, or address any other chronic disease priority area identified by the grantee;
- reducing barriers to accessing nutritious foods and physical activity;
- assessing and implementing worksite wellness programming and incentives;
- working to highlight healthy options at restaurants and other food venues; and
- prioritizing strategies to reduce racial and ethnic disparities, including social determinants of health.

(B) Implementation.—Grantees would be fully funded to implement community makeover plans. CDC would convene grantees at least annually in regional and/or national meetings to discuss challenges, best practices and lessons learned. Using the Healthy Communities model and processes developed at CDC as a guide, grantees would be required to develop models for replication. Pending successful evaluation, they would be required to serve as mentors for other States and communities.

(C) Evaluation.—The effectiveness of the program would be measured by the change in prevalence of chronic disease risk factors among members of the community. Decreases in weight and fat consumption and increases in minutes of physical activity and fruit and vegetable consumption could be used as measures for children whose schools participate in the community makeover plan, as well as for adults who participate in physical activity and nutrition programs. Other process measures, such as the number of restaurants that highlight healthier options on menus or the number of participants who self-report that they have increased their physical activity levels, could also be used. CDC would provide a literature review and framework for the evaluation, and grantees would work with an academic institution or other entity with expertise in outcome evaluation and be required to report to CDC on the evaluation of their programming and to share best practices with other grantees. Community specific data from the BRFSS would be used to assess changes in risk factors and health behaviors across communities.

APPENDIX B.—UNDERSECRETARY FOR HEALTH

Proposal: Create the position of Undersecretary for Health (USH) in the Department of Health and Human Services to whom all the Public Health Service (PHS)

agencies,[5] the Office of the Assistant Secretary for Preparedness and Response (ASPR), and the Centers for Medicare and Medicaid Services (CMS) would report. The USH position would assume the elevation of the current position of Assistant Secretary for Health (ASH), which currently is a scientific advisory position, but until 1996 had line authority over the PHS agencies.

Rationale: There is currently no senior official with medical, scientific, and public health expertise with the authority to assure consistency in policy and coordination among the various agencies addressing health and public health issues, and to champion the allocation of necessary resources and require accountability for such investments. At a minimum, the USH should oversee the PHS agencies and ASPR; ideally CMS would also report to the USH. While the Deputy Secretary provides some level of administrative coordination, one of the biggest challenges facing HHS is to restore the scientific integrity of policymaking and assure that there is coordination among the various public health and safety net programs.

Process: Creating the USH, with authority over PHS, CMS and ASPR, would require new legislative authority. In the meantime, the Secretary has the authority to restore the line authority of the ASH over the PHS agencies. This would send a strong signal about the need for scientific leadership and coordination and would make the position of ASH more attractive to potential nominees. The Secretary should take this action immediately as a precursor to legislative action creating the USH.

Examples of Lack of Coordination: There has been no health/scientific official to resolve or address:

- Ongoing difficulties in assuring coordination of preparedness activities between ASPR and CDC;
- Poor coordination between CDC and CMS with regard to best approaches for addressing hospital-acquired infections;
- Coordination of Medicaid and HRSA safety-net programs (community health centers, the Ryan White program) to assure seamless provision of care and maximize access to services;
- Consistency and appropriate divisions of labor between NIH and CDC with regard to prevention research;
- Coordination of mental health and health care services provided by HRSA and SAMHSA;
- Challenges to the scientific judgment of agency officials on questions such as the efficacy of condoms; and
- Coordination and consistency of programs, grants, and policies affecting State and local governments as developed across the health agencies.

APPENDIX C.—PUBLIC HEALTH WORKFORCE

U.S. PUBLIC HEALTH SERVICE COMMISSIONED CORPS

- Establish a dedicated funding stream for the Commissioned Corps under the management and fiscal control of the Surgeon General. Currently, the Commissioned Corps does not receive an annual appropriation. The salaries of the physicians, pharmacists, environmental health experts, nurses, and other Corps officers are paid by the Federal agency in which they serve. Without an established funding stream, recruitment for the Corps is difficult. Members of the Corps must volunteer their time and often pay out-of-pocket for recruitment materials or trips, and new recruits must find their own commission. A dedicated funding stream for the Corps would centralize payment for salaries and recruitment.
- Lift the cap on the number of active duty, Regular Corps members. The Commissioned Corps consists of approximately 6,000 officers who serve in the Regular Corps and the Reserve Corps. At present, the Regular Corps has a congressionally mandated cap of 2,800, which has almost been reached. There are nearly 3,200 Reserve Corps members, also on active duty, who work in similar jobs and receive the same pay and benefits as Regular Corps members. Many new enrollees enter the Reserve Corps with hopes of securing a slot in the Regular Corps since only these Corps members are eligible for promotion to the highest ranks. They are less likely to lose their jobs in a force reduction. Additionally, an estimated 25 percent of those entering the Corps in previous years came from the armed services, as all of the

[5] The Public Health Service agencies are: Agency for Healthcare Research and Quality, Agency for Toxic Substances and Disease Registry, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, and the Substance Abuse and Mental Health Services Administration.

federally commissioned uniformed services have equal pay, rank, and retirement benefits. As the cap is approached, there is a disincentive for new recruits and members of the Armed Forces to join the Corps and for Reserve Corps members to remain in the Corps.

• Establish a new "ready reserve" component within the Corps. The Commissioned Corps needs a highly skilled and well-trained reserve in place that is able to respond to emergencies and urgent public health threats, along similar lines as the uniformed services' reserve. The ready reserve would be comprised of retired Corps members who would keep their day jobs, submit to an appropriate number of drills and training throughout the year, and would be available and ready to be deployed on short notice. Additionally, ready reserve members would backfill routine positions at Federal agencies when active Corps members are deployed. Current Corps structure does not provide for someone to fill in and resume the responsibilities of an active member's day job when he or she is deployed. Ready reserve members could also be used in underserved communities to assure access to care, particularly for vulnerable populations.

• Create health and medical response (HAMR) teams to be Federal first responders deployed in the event of a terrorist attack, natural disaster, or other public health crisis. HAMR teams would consist of full-time Corps members who would organize, train, and be equipped to provide public health preparedness and response throughout the year. When not responding to a crisis, members could also be sent to State and local public health departments with severe workforce shortages. They would still be paid by the Federal Government so as not to further burden State public health budgets.

• Incentivize retired Corps members to move into faculty positions in public health-related disciplines. Many academic institutions across the country are experiencing faculty shortages in the public health field. Retired Corps members could alleviate this shortage and also inform students about the Corps. An existing program, "Troops to Teachers," could be modified to include teaching in the public health field, thus addressing the faculty shortage and encouraging students to pursue a career in governmental public health.

PUBLIC HEALTH RESEARCH INSTITUTE

A new Public Health Research Institute should be established to conduct and coordinate the following services:

• Identify and disseminate public health best practices and provide information about career categories, skill sets, and workforce gaps. With this information, States and localities will be better informed to make decisions about policies and program implementation. The institute would also help ensure greater accountability for the use of tax dollars.

• Conduct a public health workforce enumeration survey to determine current distribution of jobs including trend lines, wages, benefits, training, and pathways to enter public health. The institute would be responsible for conducting an enumeration survey every 2 years and publicizing information about career categories, skill sets, and workforce gaps.

• Address complex issues such as social determinants of health and generate data on health outcomes.

• Build on existing partnerships within the Federal Government while also considering initiatives at the State and local levels and in the private sector. Accountability measures will be established. The institute will evaluate and report on Federal, State, and local public health workforce initiatives, as well as those in the private sector.

INTERAGENCY ADVISORY PANEL

• Various Federal Government agencies play a role in workforce policy. For example, most Federal dollars expended on job training and workforce development are overseen by the Department of Labor. The Department of Education also coordinates with the Department of Labor on workforce efforts through various loan and grant programs. The Department of Health and Human Services, the Department of Defense, the Veterans Administration, the Environmental Protection Agency, and the Department of Transportation are all involved in the public health workforce area.

• To ensure that there is a comprehensive public health workforce strategy, an interagency advisory panel to coordinate workforce development at all levels of government should be created. The purpose of the panel would be to:

- Help link Federal, State, and local public health workforce development;
- Coordinate recruiting and training efforts; and

• Coordinate technical assistance to expand the public health workforce.

• The interagency advisory panel should also be replicated at the State level.

AREA HEALTH EDUCATION CENTERS

• The public health workforce needs an influx of better trained and younger workers. State public health departments have an 11 percent vacancy rate and face looming mass retirements.

• Area Health Education Centers (AHEC's) are federally funded programs that link university health science centers with community health delivery systems to provide training sites for students, faculty, and practitioners.

• A few States, such as Connecticut, have used some of their AHEC funds to establish Youth Health Service Corps initiatives which train and then place high school students as volunteers in community health agencies. The students, who may include those enrolled in vocational and technical education, not only provide some relief to the workforce shortage problem, but may also help develop a pipeline for future public health workers. Under the Youth Health Service Corps model, an AHEC may partner with not only health entities, but also programs such as Learn and Serve America, a part of the Corporation for National and Community Service.

• All AHECs should be required to establish Youth Health Service Corps initiatives to assist in the recruitment of young people into health fields.

COMMUNITY COLLEGES AND VOCATIONAL SCHOOLS

• State and local public health departments should partner with community colleges and vocational and technical education and job corps centers to identify candidates for the field. Since nearly 40 percent of community college attendees are first generation college students, and many are nontraditional students, they are an ideal group to target for recruitment. Course offerings at community colleges are very flexible, making it easier to partner with State or local public health departments to address needed training.

• Health-focused career academies and health apprenticeship programs should be established at vocational and technical education centers. Health departments should partner with Tech-Prep programs and Job Corps centers where they exist, to help diversify the public health workforce.

STATE AND LOCAL WORKFORCE BOARDS

The Federal W*orkforce Investment Act* of 1998 established State and local workforce boards to oversee, coordinate, and improve State and local employment and training programs. Currently, the composition of these boards warrants reform. The following are recommendations:

• All boards should include members representing the public health field in order for public health to be part of overall workforce development in all States and local communities.

• State and local workforce boards should establish initiatives that encourage the development, implementation, and expansion of health sector programs.

NOVEMBER 18, 2008.

Hon. HARRY REID,
Senate Majority Leader,
S-221,
Washington, DC 20510.

Hon. MITCH MCCONNELL,
Senate Minority Leader,
S-230,
Washington, DC 20510.

Hon. NANCY PELOSI,
Speaker of the House,
H-232,
Washington, DC 20515.

Hon. JOHN BOEHNER,
House Minority Leader,
H-204,
Washington, DC 20515.

DEAR MAJORITY LEADER REID, SPEAKER PELOSI, AND MINORITY LEADERS MCCONNELL & BOEHNER: From first responders to scientists searching for ways to prevent disease, our public health workforce is vital to protecting our Nation's health and economy. But our public health workforce is in crisis. There is a serious shortage of public health workers with the expertise needed to meet the depth and breadth of the responsibilities they are expected to carry out.

We are writing to express our support for inclusion of funding for job creation, recruitment and training in a potential stimulus package. In particular, we request that support for the State and local public health workforce be a specifically permissible use of any funding that may be allocated for infrastructure and job training priorities. We believe that in addition to providing funds for infrastructure projects that can immediately create jobs, the stimulus can serve as a vehicle to promote long-term growth and economic development by helping to build a pipeline of well-trained workers, including those entering the public health workforce.

A 2007 survey by the Association of State and Territorial Health Officials (ASTHO) found that the State public health agency workforce is graying at a higher rate than the rest of the American workforce, and workforce shortages continue to persist in State health agencies. This workforce shortage could be exacerbated through retirements: 20 percent of the average State health agency's workforce will be eligible to retire within 3 years, and by 2012, over 50 percent of some State health agency workforces will be eligible to retire. Further, according to a 2005 Profile of Local Health Departments conducted by the National Association of County and City Health Officials (NACCHO), approximately 20 percent of local health department employees will be eligible for retirement by 2010.

Public health departments serve an important function by helping to promote health and prevent disease, prepare for and respond to emergencies and potential acts of bioterrorism, investigate and stop disease outbreaks, and provide other services such as immunizations and testing. Yet, the average age of new hires in State health agencies is 40, according to the 2007 ASTHO survey. Public health needs a pipeline of young workers, and the stimulus offers an important opportunity to begin to cultivate interest in public health among the Nation's youth.

Governmental public health can be an important career pathway for displaced workers whose jobs have been eliminated. Public health offers a wide array of possibilities, from epidemiology to information technology (IT) to environmental engineering. Re-training workers to tailor their skills to public health careers would help stimulate job growth and improve the quality of life in communities that are currently underserved due to habitual vacancies in State and local health departments.

As you develop a stimulus package and consider broad infrastructure projects, we ask that you consider the public health workforce to be an important dimension of State and local infrastructure. A sustainable public health workforce is crucial to

our economic development and quality of life. Thank you for your attention to this request.

Sincerely,

American Public Health Association; Association of State & Territorial Dental Directors; Association of State and Territorial Directors of Nursing; Association of State & Territorial Health Officials; Association of State & Territorial Public Health Social Workers; Commissioned Officers Association of the U.S. Public Health Service; Council of State and Territorial Epidemiologists; National Alliance of State and Territorial AIDS Directors; National Association for Public Health Statistics and Information Systems; National Association of Chronic Disease Directors; National Association of County and City Health Officials; State and Territorial Injury Prevention Directors Association; Trust for America's Health.

December 2008

Preliminary Findings:
NACCHO Survey of Local Health Departments' Budget Cuts and Workforce Reductions

Background

The National Association of County and City Health Officials (NACCHO) surveyed 2,422 local health departments nationally in November–December 2008 to assess the impact of current economic conditions on local health departments' budgets and workforce. The survey, to which 1,079 local health departments distributed across 46 states responded, found that a majority of respondents are experiencing adverse impacts and expect those to continue next year.

Jobs Provided By Local Health Departments are Dwindling

In 2008, more than half of local health departments have either laid off employees or lost them through attrition and have been unable to replace them due to budget limitations. About one-third predict layoffs in 2009. Among the largest health departments, 84 percent reduced their staff in 2008, and 45 percent expect to lay off staff in 2009. Extrapolating the survey results to all local health departments, there has already been an estimated total loss of between 3,000–6,000 local public health workers nationally, and those numbers will increase in 2009.

Local Health Departments' Budgets are Eroding

Nationally, 27 percent of local health departments are working under a current budget that is less than the previous year, and 44 percent expect to do so next year. The impact falls disproportionately on health departments serving large jurisdictions, of which two-thirds expect next year's budget to be lower than this year's. For local health departments in large jurisdictions that experienced budget declines this year, the median budget reduction was $1.5 million.

The burden of declining budgets also is falling disproportionately on health departments in certain states. More than 50 percent of the local health departments in nine states (Arizona, California, Florida, Georgia, Oklahoma, Pennsylvania, South Carolina, Virginia, and Vermont) have already experienced cuts. More than 80 percent in 10 states anticipate cuts next year (Arizona, California, Florida, Georgia, Idaho, Pennsylvania, South Carolina, Virginia, Vermont and Washington).

TABLE 1: PERCENTAGE OF LOCAL HEALTH DEPARTMENTS REPORTING STAFF REDUCTIONS (BY JURISDICTION POPULATION)

	Percentage of Local Health Departments that:			
Jurisdiction Population	Laid Off or Lost through Attrition in 2008	Laid Off Staff in 2008	Lost Positions through Attrition in 2008	Expect to Lay Off in 2009
All LHDs	53%	21%	46%	32%
<25,000	31%	15%	21%	21%
25,000–49,999	46%	15%	41%	25%
50,000–99,999	62%	19%	56%	40%
100,000–499,999	77%	34%	70%	51%
500,000+	84%	40%	83%	45%

TABLE 2: PERCENTAGE OF LOCAL HEALTH DEPARTMENTS REPORTING DECLINING BUDGETS (BY JURISDICTION POPULATION)

	Percentage of Local Health Departments Reporting Declining Budgets	
Jurisdiction Population	Current budget compared to prior year	Next year's budget compared to current year
All LHDs	27%	44%
<25,000	22%	38%
25,000–49,999	19%	38%
50,000–99,999	25%	45%
100,000–499,999	37%	55%
500,000+	44%	67%

FOR MORE INFORMATION, CONTACT
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NACCHO
The National Connection for Local Public Health
www.naccho.org

Public Health

NACCHO is the national organization representing local health departments. NACCHO supports efforts that protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, seeking health equity, and supporting effective local public health practice and systems.

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

Now we move to Dr. Ken Thorpe, Robert W. Woodruff professor and chair of the Department of Health Policy and Management at the Rollins School of Public Health at Emory University in Atlanta, GA. He is the executive director of the Institute for Advanced Policy Solutions, co-directs the Emory Center on Health Outcomes and Quality.

Dr. Thorpe is also the executive director of the Partnership to Fight Chronic Disease, a national coalition of patients, providers, community organizations, business and labor groups, and health policy experts committed to raising awareness of policies and prac-

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tices that save lives and reduce healthcare costs through more effective prevention and management of chronic disease.

Thank you very much for being here, Dr. Thorpe. Please proceed.

STATEMENT OF KENNETH E. THORPE, PH.D., ROBERT W. WOODRUFF PROFESSOR AND CHAIR OF THE DEPARTMENT OF HEALTH POLICY & MANAGEMENT, ROLLINS SCHOOL OF PUBLIC HEALTH OF EMORY UNIVERSITY, ATLANTA, GA

Mr. THORPE. Thank you, Senator Harkin, Senator Coburn, Senator Reed. I look forward to working with you in this next session of Congress on these issues.

I am going to make four very brief points, starting with some of the statistics we know, but I think it is important to frame the discussion to talk about how critical prevention can be in solving some of our Nation's healthcare ills.

Second is to focus on the issue that seemingly and sort of inexplicably to me is still under debate—does prevention work?

Third, to talk about some of the lessons we have learned about successful programs.

And finally, to start to lay out what can we do right now, as part of the healthcare reform debate, to take some of those best practice lessons and implement them?

Let me start with the first set of points on the data. You heard Senator Coburn already mention the fact that three quarters of what we spend nationally is linked to chronically ill patients. In the public programs, it is even worse. Ninety-five percent of what is spent in Medicare is linked to chronically ill patients. Eighty-three percent of what we spend in Medicaid is linked to chronically ill patients.

Obviously, unless we deal with the issue of chronic disease and prevention, we are never going to deal with long-term entitlement to spending reform and get entitlement spending under control, let alone reduce the cost of private health insurance.

The second fact is that we know obesity in this country has doubled since the mid-1980s. That doubling of obesity, by itself, accounts for 15 to 25 percent of the growth in spending. Put another way, if we could have magically found a way to have frozen the obesity levels in this country at 1987 levels, we would have spent about $220 billion less today on healthcare.

Third fact, Medicare. Three conditions, largely preventable—diabetes; hypertension; hyperlipidemia, bad cholesterol—by itself over the last decade accounts for 15 to 20 percent of the growth in Medicare spending.

And the final fact is that if you look at lifetime spending for people entering the Medicare program who are obese versus Medicare beneficiaries who are normal weight, a normal weight adult spends 15 to 35 percent less over the course of their lifetime in the Medicare program than an obese adult does with one or more chronic healthcare conditions.

Those are the facts. And I think Senator Harkin's point, unless we make this a centerpiece of healthcare reform, we are never going to deal with the issues around cost and affordability and quality. So we really need to take it, I think, more seriously as a centerpiece of what we do on reforming our healthcare system.

Second set of issues. Does prevention work? I think, unfortunately, my colleagues in the academic field have confused the issues quite substantially because most of the studies out there looking at prevention are focusing on secondary prevention, which is disease detection. And they are looking at does disease detection work?

Well, the fact is some can save money, colorectal screening and immunizations. But the fact is we do disease detections to get people into the system quicker to improve their healthcare outcomes.

What is missing from the debate is does primary prevention work? Primary prevention is the ability to try to prevent disease in the first place, and I think the answer to that question is really twofold. One, yes. Two, design matters a lot. That is, there are programs that are poorly designed that don't work, but there are very effective programs in the schools, in the community, and in the workplace that, if put together in a coherent way, can save money and can improve health outcomes.

There are at least 13 published studies out there that have shown that well-designed workplace studies—and you are going to hear an example of one from Pitney Bowes—can be effective in saving money. On balance, those studies show that the well-designed programs save $3.50 for every $1 invested, and that is just looking at the medical care costs. Because one thing we do know is that for every $1 that we lose to chronic disease on medical care costs, we lose $4 on productivity.

The productivity component of this is even bigger than the medical care cost piece of this. There are several examples of the successful firms that have done this—Johnson & Johnson, Citibank, Hannaford Brothers grocery chain, Caterpillar, Safeway. You are going to hear from Pitney Bowes.

There are a lot of good examples out there of successful programs that have saved money. There are community-based programs that have saved money. You have heard from Jeff, and you are going to hear from the YMCA about some of their experience.

And there are school-based interventions to Senator Coburn's point that we need to look at and understand what is it that they are doing in the schools in terms of getting more physical activity of those kids that is actually reducing childhood obesity? If you look at what Governor Huckabee did in the State of Arkansas to reduce those obesity rates among kids, I think that is a program and a set of initiatives that deserve a second look.

Third issue, it seems to me that what we need to do is, rather than ask the question does the average program work, let us look at the good ones. Let us look at the effective programs that have been shown to and demonstrated to save money and improve health outcomes and identify the key design features of those programs about why they are effective.

For example, we know in workplace programs that several design aspects of those programs are effective and need to be more widely used in American business. Giving people financial incentives to participate in health risk appraisals. Reducing or eliminating cost sharing for things that we want to deliver to chronically ill patients like annual eye exams and extremity exams and so on.

Carefully crafted individual care plans to do both population health for people that are healthy, but also for people with diagnosed chronic disease to work with them to meet key objectives. By making even healthcare services available at the workplace, to have nurse practitioners and others coming in and working with patients to achieve some of those care guidelines is very effective.

And leadership from the top. This has to be something that the corporate CEO level shows that this is a priority, that there is buy-in from the very top, and that it shows that the company is serious about working with its workers to improve productivity and reduce costs.

Those are just some things that have shown to be effective in designing this.

So getting to the last point, what can we do right now that I think are just common sense initiatives? And in the testimony, I laid them out. They are in more detail, but I am just going to mention three of them very quickly.

No. 1, it seems to me that we are going to have a long debate about health insurance and healthcare reform. But what we can do right now to get patients into the system is provide a universal wellness benefit to all uninsured individuals in this country that focuses on prevention—health risk appraisals, a physical exam, screening.

And most importantly, for each of the patients coming in, you put together a care plan for people who are healthy, people who are asymptomatic—that is, they are pre-diabetic. We put together a care plan for them. And for people who are diagnosed with disease, we get them care right now because, let us face it, we are spending money on this population anyway.

We are spending $50 billion a year on the uninsured in one form or another. We do it in a very reckless, I think, and thoughtless way. Too late, they show up in the emergency rooms. Why not get people into the system early, right off the bat?

I think one thing that we can do is take some of these key design features we have learned about how to change behavior and make them available to people who don't have health insurance right now.

Second, I think the big challenge we face in Medicare is what are we going to do to coordinate care in the traditional Medicare program? So if all of the money is in chronically ill patients and most of the beneficiaries are in traditional Medicare, we know that that program is not set up to do a very good job to prevent and provide healthcare services to chronically ill patients.

I think you heard Senator Sanders talk a lot about community health centers. I think if we expanded that concept at the State level to build community health teams of nurse practitioners and others that would work with small physician practices, to manage Medicare for beneficiaries who have chronic disease, would be a step in the right direction.

If you think about it, 83 percent of physician practices in this country are in groups of one or two. So there is a lot of talk about medical home and building that kind of capacity, most of American medicine, unfortunately, does not flow through the Mayo Clinic. It flows through small physician practices.

And the final point that I would make is we need to take some of the lessons from Jeff's work and from the YMCA and identify what is it about those interventions that generates those savings in the design of them and challenge the States and communities to put those types of programs in place. Let them innovate in the design.

We don't want to mandate and tie their hands on this, but I think we want to provide the information and provide some financial incentives to communities that get those programs out into the schools and into the communities as soon as possible.

Those are things that I think are common sense initiatives that we could do right off the bat. We could do it as part of the overall healthcare reform debate. I think that they would have, I would hope, bipartisan support because they are not particularly the usual ideological flashpoints that we get into the debate on healthcare reform, and I would like to see, hopefully, in the upcoming Congress some discussion and attention to some of these prevention issues as part of the overall debate.

Senator Harkin, Coburn, Senator Dodd and Reed, I look forward to working with you on these issues. Thanks for inviting me.

[The prepared statement of Mr. Thorpe follows:]

PREPARED STATEMENT OF KENNETH E. THORPE, PH.D.

Good morning, Senators, and thank you for the opportunity to speak today about the importance of science-based prevention in assuring health security for all Americans, reducing the burden of ill health, and stemming rising health spending. I would like to thank Senator Kennedy, Senator Enzi, and Senator Harkin for your leadership in this area. Thanks also to the members of the committee for holding this important hearing today. My name is Ken Thorpe; I am a professor of health policy and chair of the department of health policy and management at Emory University in Atlanta, GA. I am also executive director of the Partnership to Fight Chronic Disease, a nonpartisan, nationwide group focused on reducing health care costs through disease prevention and more effective care.

My testimony today will focus on three issues fundamental to health reform:

1. What are the key drivers of rising health care spending overall and in the Medicare program?
2. What role can primary prevention and more effective care management assume in slowing the rise in spending? Specifically, is there evidence we could build on from successful programs?
3. How could we adopt these lessons into a broad health reform initiative, as well as reforms in Medicare and Medicaid?

KEY DRIVERS OF INCREASED HEALTH SPENDING

Increases in health expenditures, and how to rein them in, are among the critical policy challenges the United States faces. National health spending is estimated to have grown almost 7 percent in 2007, reaching over $2 trillion, or roughly $7,800 per person. Medicare and Medicaid together now account for 23 percent of Federal spending and nearly 6 percent of gross domestic product (GDP), including the States' share of Medicaid.[1] Absent policy re-direction, the growth rate is expected to hold steady at nearly 7 percent through 2017, reaching more than $4 trillion. Health spending is expected to be in excess of 16 percent of gross domestic product (GDP) in 2007 and nearly 20 percent in 2017.[2]

Crafting effective solutions to the high and rising costs of health care requires a clear understanding of where we spend our health care dollar and the factors accounting for rising spending. First, patients with chronic diseases such as diabetes, hypertension, and pulmonary disease account for 75 percent of national health spending, and an even higher proportion in public programs: 96 cents of every dollar in Medicare is spent on patients with chronic disease and 83 cents of every dollar in Medicaid.[3]

Chronic diseases have played a major role in the rise in health care spending:

• The increase in treated disease prevalence accounts for about two-thirds of the rise in spending over the last 20 years.[4 5]

• The rising rate of obesity—which has doubled for adults and tripled for children since 1980—accounts for about 20–25 percent of the overall rise in spending.

• Within the Medicare program, just three obesity-associated chronic conditions—diabetes, hypertension, and high cholesterol—accounted for more than 16 percent of the rise in spending between 1987 and 2002.[6]

• The residual is due to improved technology, enhanced disease screening and detection, and changed clinical guidelines.[7] It is not clear what percentage of the rise is traced to innovations per se. The unexplained component of rising health care costs—ascribed by some observers to technology—includes a broad range of effects, encompassing, for example, more intensive treatment of asymptomatic patients with one or more cardiovascular risk factors (increased treatment intensity of adults with metabolic syndrome is a case in point),[8] as well as changes in the definition of treatable disease and targeted patient populations for medication therapy for asthma, diabetes, hypertension, and abnormal cholesterol.[9]

Until very recently, most proposals for reducing Federal health care spending have focused on re-directing national government spending onto other payors. These proposals include reducing provider reimbursement, increasing beneficiary cost sharing, increasing the age of Medicare eligibility, tightening eligibility or means testing, and reducing optional services in Medicaid, among others. But none of these proposals addresses the underlying factors driving the rise in health spending. Their adoption would merely shift Federal spending to others, and likely would result in higher costs in the long run, as chronically ill beneficiaries with limited financial resources forgo needed preventive and restorative care.[10] The following sections present strategies to address key health spending drivers and effectively reduce expenditure growth.

ROLE OF OBESITY AND SMOKING

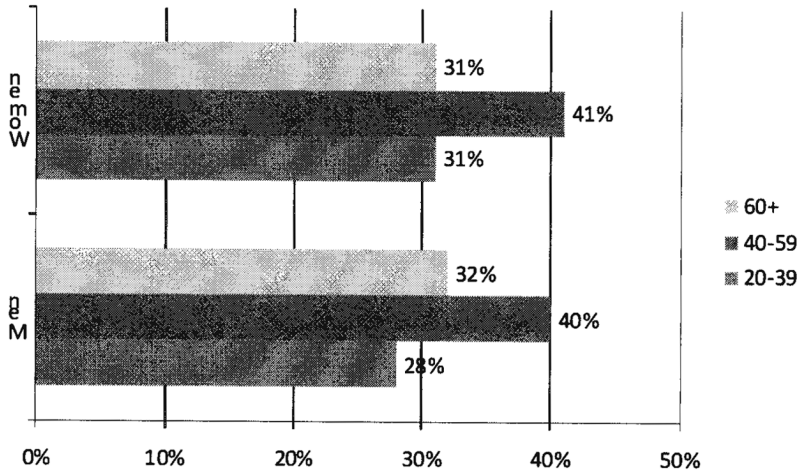
Over the past quarter century, obesity has increased dramatically in the United States. The most recent data from the Centers for Disease Control and Prevention (CDC) report that 32 percent of adults aged 20 and older are overweight and 34 percent are obese.[11 12] In 2007 more than a third of U.S. adults—*over 72 million people*—were obese. Obesity rates differ only slightly by gender but vary significantly by both age and race/ethnicity, resulting in significant health disparities. See Figures 1 and 2. Forty percent of adults ages 40–59 are obese, compared with about 30 percent of both older and younger adults. African-American women are more likely than other adults to be obese.

As obesity prevalence has increased among Americans, so have rates of associated chronic conditions. In 1958, 1.6 million Americans were living with diagnosed diabetes.[13] By 2008, that had increased to 17.9 million—a rise in diagnosed prevalence of more than 1,000 percent. Another 5.7 million people are undiagnosed, bringing the total diabetes burden to nearly 24 million people—almost 8 percent of the entire American population.[14] Virtually all the increase in diabetes prevalence during this period is associated with rising rates of overweight and obesity. Overall, more than a quarter of the increase in U.S. health spending is attributable to the rise in obesity over the past two decades. If the prevalence of obesity were the same today as in 1987, health care spending in the United States would be 10 percent lower per person, or about $200 billion less each and every year. Health care costs would have risen 0.7 percentage points less per year, every year—a hefty amount over time.[15]

Although tobacco use has sharply declined over the last 40-plus years, more than one in five U.S. adults still smoke, about 46 million people. The majority—70 percent—say they would like to quit. Smoking-related chronic diseases include cancers, cardiovascular disease, and respiratory diseases.[16] Prenatal exposure to tobacco smoke is a major risk factor associated with Sudden Infant Death Syndrome (SIDS),[17] infant prematurity and low birthweight.[18] Parental smoking is associated with higher rates of childhood asthma, an increased likelihood of using asthma medications, and an earlier onset of the disease.[19] Tobacco use causes 440,000 deaths in the United States every year. Deaths associated with smoking account for more deaths than AIDS, alcohol use, cocaine use, heroin use, homicides, suicides, motor vehicle crashes, and fires combined.[20] Additionally, about 8.6 million people are disabled by a disease caused by smoking, such as lung cancer or chronic obstructive pulmonary disease.[21 22] For every person who dies of a smoking-related disease, 20 more are living with at least one serious illness. Smoking cost the United States over $193 billion in 2004, including $97 billion in lost productivity and $96 billion in direct health care expenditures, or an average of $4,260 per adult smoker.[23]

Figure 1

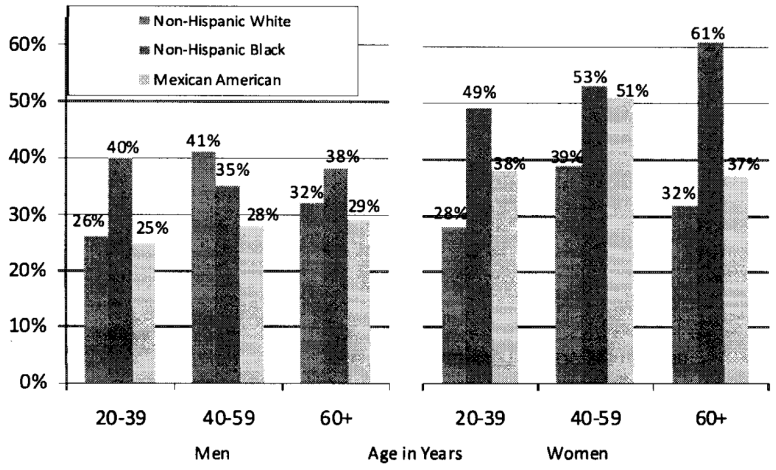
Adult Obesity Differs Across Age Groups



Source: CDC/NCHS. 2007.

Figure 2

Adult Obesity Differs By Race/Ethnicity



Source: CDC/NCHS. 2007.

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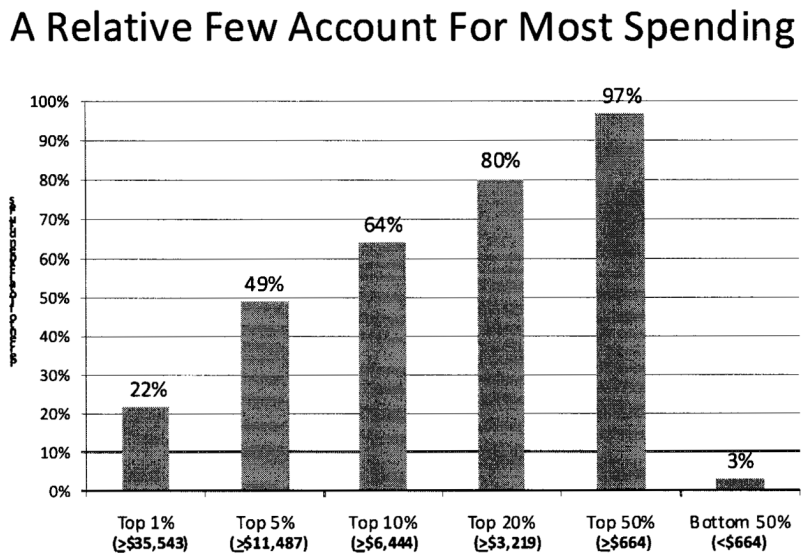
To slow the rise in health spending, our Nation must significantly reduce obesity and smoking in order to reduce the incidence and prevalence of chronic diseases. Figures 3 and 4 show how spending is concentrated among patients and conditions, respectively.

Investing in effective primary prevention is essential. The long-term financial incentives are substantial, particularly for Medicare to fight obesity and improve the health status of both newly enrolled and current beneficiaries. At least 80 percent of older Americans are living with at least one chronic condition, and 50 percent have at least two. More than half of Medicare beneficiaries are currently treated for five or more medical conditions annually, accounting for over three-quarters of total program spending.[24] More than a third report having a disabling condition that limits their daily activities; these adults are less likely to be physically active and more likely to be obese.[25]

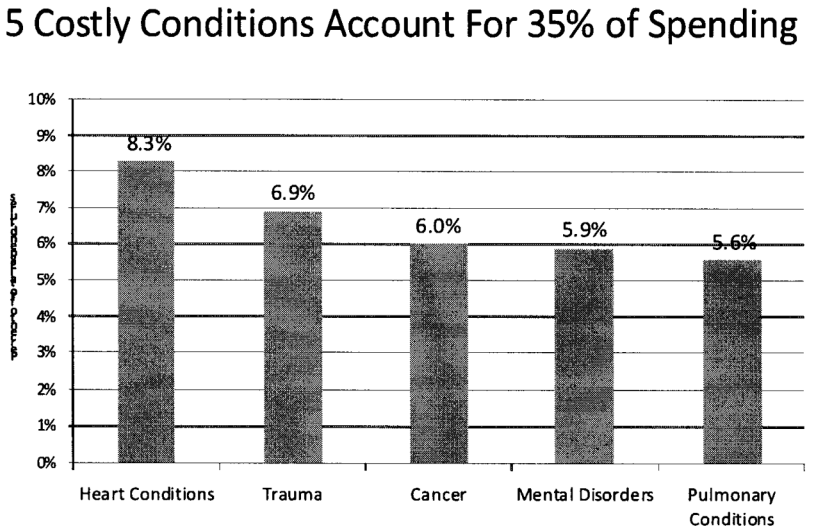
Two recent studies have demonstrated that seniors aged 65–70 who are normal weight, with no chronic diseases, spend 15–35 percent less over their lifetime than do obese adults with chronic diseases.[26] The cost of providing health care for a patient aged 65 or older is three to five times greater than the cost for someone younger than 65,[27] and thus sizeable potential downstream savings accrue to Medicare if beneficiaries are in better health prior to enrolling in the program. A large study of both men and women found that those with favorable cardiovascular risk profiles before age 65 had substantially lower average Medicare charges: overall, two thirds lower for men and half as low for women. Charges related to both cardiovascular disease and cancer, specifically, were less for those who entered Medicare heart-healthy.[28] Another large study found that spending even in the last year of life, when charges are generally highest, was lower for those who entered Medicare at low risk for heart disease.[29] Unfortunately, that is not true for many soon-to-be-eligible beneficiaries: In 2005, CDC documented that half of Americans aged 55–64-years-old had high blood pressure and 40 percent were obese.[30] Reducing the number of Americans who enter Medicare chronically unhealthy is a cornerstone to reducing costs over the long term, and so is keeping them as healthy as possible once they are enrolled. Effective lifestyle interventions that reduce the share of adults 65 and older who are obese and overweight by 10 percentage points could lower the average growth in Medicare spending over the next decade or two by approximately 0.3 percentage points annually.[31]

Figure 3



Source: Conwell LJ, Cohen JW. Characteristics of people with high medical expenses in the U.S. civilian noninstitutionalized population, 2002. *Statistical Brief* #73. March 2005. Agency for Healthcare Research and Quality, Rockville, MD.
Note: Figures in parentheses are expenses per person.

Figure 4



Source: Olin GL, Rhoades JA. The five most costly medical conditions, 1997 and 2002: estimates for the U.S. civilian noninstitutionalized population. *Statistical Brief* #80. Agency for Healthcare Research and Quality, Rockville, MD.

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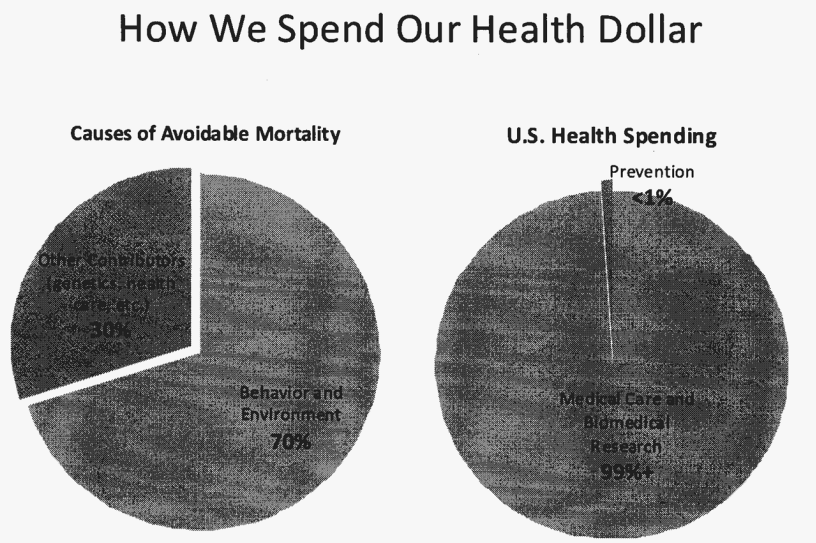
EFFECTIVE PRIMARY PREVENTION

Addressing the high and rising rates of chronic disease will require effective disease prevention programs (primary prevention), disease detection (secondary prevention), and disease treatment (tertiary prevention). Most of the academic literature has historically focused on the role that secondary prevention—disease detection—has assumed in reducing health care spending. Most clinical preventive services—by design—add modestly to overall health costs. However, several clinical screens, such as diabetes screening targeted to patients with hypertension, especially those 55 to 75;[32] one-time colonoscopy screening for colorectal cancer among men ages 60 to 64[33]; and influenza vaccination appear to reduce total health care spending. Determining the most cost-effective applications for clinical preventive services requires answering the basic questions of who, what, when, where, and how. A leading source of information and data is the U.S. Preventive Services Task Force, an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. The task force is an important, though perhaps underappreciated, national resource.

Far less attention has been paid to the role that *primary* prevention—a key policy tool highlighted in both Senator Obama's and McCain's health care proposals—could assume in reducing health care spending and improving overall health outcomes. Figure 5 shows our Nation's relative investment in prevention.

Figure 5



Source: Institute of Medicine. 2003. *The Future of the Public's Health in the 21st Century*. Washington, D.C.: The National Academies Press. Citing: McGinnis JM, Williams-Russo P, Knickman JR. 2002. "The Case for More Active Policy Attention to Health Promotion." *Health Affairs* 21:78-93 and McGinnis GM, Foege WH. 1993. "Actual Causes of Death in the United States." *JAMA* 270(18): 2207-2212.

The Preventive Services Task Force has a public health analog, the Task Force on Community Preventive Services, which examines the evidence for population-based prevention services. A growing body of research supports the effectiveness of individual and population-based primary prevention for obesity and smoking, as well as other needed interventions. Considerable and growing evidence shows that well-designed, targeted interventions designed to prevent disease (primary prevention) save money. Relatively little attention has been given to identifying the key design features of these effective interventions and to making them more widely used and available.

Research points to multiple examples of effective primary prevention interventions that, if more widely adopted, could reduce health care spending and improve patient outcomes. These include school-based programs, community-based interven-

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tions, and worksite health promotion (WHP) combining primary prevention to forestall disease as well as secondary prevention to improve health.

Several scientific reviews report that WHP programs reduce medical costs and absenteeism and produce a positive return on investment. For example: At Citibank, a comprehensive health management program showed an ROI of $4.70 for every $1 in cost. A similar comprehensive program at Johnson & Johnson reduced health risks including high cholesterol levels, cigarette smoking, and high blood pressure, and saved the company up to $8.8 million annually.[34] Other companies such as Hannaford Brothers ($6 million in savings) and Safeway grocers have reported similarly positive results. These empirical studies have demonstrated two significant results: First, lifestyle interventions can be effective in reducing the prevalence of chronic disease and overall health care spending, and, second, program design is critically important to program success. The key to successful programs is evidence-based design and delivery. Based on these rigorous assessments of best practices, key design features of successful programs include:

- financial incentives to participate in health risk appraisals,
- reducing or eliminating cost sharing for preventive services,
- carefully crafted individualized care plans with incentives to meet key objectives,
- the availability of health care personnel at the workplace, and
- leadership from the top.

There is also substantial evidence of the cost reductions that accrue from well-designed smoking cessation programs. One recent study examining Florida results found that each $1 spent on a cessation program produced savings of $1.90 to $5.75.[35] Identifying these key design features of these programs and providing both information and financial incentives to smaller firms to adopt them would be a wise investment.

Evidence-based community and school-based programs show similar returns on investment. A recent analysis from the Trust for America's Health and others found significant reductions in total health care spending linked to well-designed and implemented community-based lifestyle interventions. Savings ranged from a short-term return on investment of $1 for every dollar invested, rising to more than $6 over the longer term.[36]

Our Web site, *www.fightchronicdisease.org*, contains a comprehensive catalog of school, community, and workplace-based programs that have been effective in reducing disease prevalence and or costs. A multifaceted approach—reaching people where they live, play, work and go to school—will be critical.[37] In addition, health coverage policy tools are available, including a universal wellness benefit for adults and eliminating (or sharply reducing) co-pays on prevention services. The benefits of these policy strategies are proven, and they should be widely implemented.

FOUR POLICY OPTIONS FOR INTEGRATING BEST PRACTICE APPROACHES TO PREVENTION AND CARE MANAGEMENT INTO HEALTH CARE REFORM

The key spending facts presented above provide a clear framework for interventions that reduce disease prevalence through reductions in obesity and smoking and more effective management of chronically ill patients. These initiatives are important for Medicare and Medicaid as well as for private health plans and employers, employees, and retirees. I will very briefly outline four policies that could improve health and reduce health spending:

1. Implementing a **universal wellness, prevention, and treatment benefit** encompassing chronic disease risk reduction, screening, and treatment for uninsured adults modeled on existing CDC programs for low-income, uninsured adults. This benefit would not substitute for universal coverage, but would provide immediate population health and treatment options for the uninsured. This benefit could incorporate some of the key design elements of successful workplace health promotion programs outlined above. As a result, the benefit could significantly improve the health of working age adults as well as their health profile as they enter Medicare, offering significant long-term cost savings. The comprehensive program should include population health management, disease screening, and treatment designed to prevent disease, detect and diagnose early and, where appropriate, provide care in the most appropriate health care settings.

Over time, this wellness benefit could be extended via Federal grants to States and to small employers, allowing them to offer similar benefits to younger uninsured adults (and children) in community settings, schools, and small businesses. Within 2 years, the wellness benefit should be available to all uninsured adults and children on a temporary basis as the discussion over expanded insurance unfolds.

The new wellness benefit should adopt the key design features of workplace and community-based primary prevention interventions demonstrated in the research literature to improve health outcomes and reduce costs. To fully realize the benefit's gains, those without insurance who are diagnosed with any of the most common serious chronic medical conditions (cancers, diabetes, heart disease, hypertension, stroke, and pulmonary conditions and co-morbid depression and mental disorders) should receive clinically appropriate medical treatment. An existing model for this approach is CDC's Breast and Cervical Cancer Treatment Program.[38] Uninsured and underinsured women at or below 250 percent of Federal poverty level are eligible for cervical screening (ages 18 to 64) and breast screening (ages 40 to 64). Services include clinical breast examinations, mammograms, Pap tests, diagnostic testing for women whose screening outcome is abnormal, surgical consultation, and referrals to treatment. Another CDC program, WISEWOMAN, provides screening and lifestyle interventions for many low-income, uninsured, or under-insured women aged 40–64 (also women eligible for Medicare, but unable to pay the Part B premium), including blood pressure, cholesterol, and diabetes screening/testing; dietary, physical activity, and smoking cessation interventions/classes; and medical referral and follow-up as appropriate.[39] Using these successful programs as a model, though applied to a broader range of conditions, the wellness benefit should cover all clinically indicated preventive maintenance care (e.g., annual eye and foot exams, hypertension screening and treatment, HgA1c testing, nutritional counseling), all with no cost sharing.

Prevention services such as physical exams in Medicare should also be at no cost to beneficiaries. Although Medicare has several preventive benefits, they chiefly cover screenings, not lifestyle modification, and are designed to detect disease earlier—but, with few exceptions, detection may not reduce spending and likely actually increases it, as more people are diagnosed and treated. Deductibles and cost sharing that apply to these benefits discourage their use and limit potential effectiveness. For example, new beneficiaries bear the full cost of the "Welcome to Medicare" physical exam if they have not yet met their annual deductible; if they have, they have a 20 percent co-pay. This is penny wise and pound foolish—Medicare has a substantial incentive to make sure beneficiaries entering the program are healthy, normal weight, non-disabled, and without chronic illness.

2. Sustaining science-based community-level interventions with **community challenge grants**. The Steps to a Healthier U.S. Cooperative Agreement Program is a national, multi-level program that funds communities to implement chronic disease prevention and health promotion programs that target three major chronic diseases—diabetes, obesity, and asthma and their underlying risk factors of physical inactivity, poor nutrition, and tobacco use. This program should be expanded with the stipulation that grantees must use evidence-based approaches from data collected by the CDC and others.

3. Supporting evidence-based **worksite health promotion**. As Senator Harkin noted in submitting Senate Resolution 673—which was agreed to by unanimous consent—the *Healthy People 2010* national objectives for the United States include the workplace health-related goal that at least 75 percent of employers, regardless of size, will voluntarily offer a comprehensive employee health promotion program. Workplace health interventions have a proven track record, and should be incentivized.

4. Finally, creating **more effective care management** in the traditional Medicare program is a key priority. Today's chronically ill patients receive just 56 percent of the clinically recommended preventive and maintenance care they need.[40] Changing this will require creating more integrated health care delivery models, bundling payments to health care providers, and accelerating the diffusion of health information technology. Moving in this direction is particularly challenging given fragmentation of benefit design (Parts A, B, D), and of clinical information, and thus, of treatment. Most physician practices (83 percent) consist of just one or two doctors[41]—they account for nearly 45 percent of all physicians nationally. While larger groups may move toward a medical home concept, an alternative approach will be required for most smaller-group practices. This could occur by strengthening primary care by linking smaller physician practices with community health teams (CHT) comprising care coordinators, nurse practitioners, social and mental health workers, community health and outreach workers. This model can help ensure that evidence-based clinical preventive services reach those who need them. In combination, CHT and physician practices would meet the criteria for a medical home. Recent evaluations of care management interventions have found the potential for substantial savings in high per capita cost Medicare areas, including one in Florida that resulted in a 9.6 percent reduction in spending for congestive heart failure patients in high cost areas near Miami.[42]

In addition to Medicare, other payors, such as Medicaid, private health plans, and self-insured firms could voluntarily contract with the CHTs to provide prevention and care management, particularly in areas with underdeveloped care management capacity. These teams have proven effective in North Carolina, demonstrating cost savings, improved health outcomes, and increased access to needed services.[43] Another is under development for patients in Vermont, following State legislation passed in 2007.[44] Pennsylvania has established a similar initiative.[45] The CHT model capitalizes on missed opportunities for prevention and better case management that can trim overall health costs, particularly by reducing poor medical management outside physicians' offices, thereby reducing preventable hospital admissions.

Incentives for improving health outcomes and reducing unnecessary care are an essential element of integrated care. Integrated care teams, both the primary care practices and the CHT staff, should be eligible for additional payments if key performance measures are met. The National Quality Forum is working to develop consensus measures focused on preventable hospital readmissions.[46] Lower re-admissions for key chronic conditions should be a major focus of these new and expanded primary care practices. MedPAC has estimated that 18 percent of all hospital stays resulted in a readmission within 30 days.[47] Medicare paid $15 billion for those readmissions, of which approximately $12 billion were potentially avoidable. Other measures could include improvement in clinically recommended services, such as blood sugar and blood pressure exams, which are often not provided, resulting in unnecessary hospital, clinic, and emergency room visits when more acute stages of chronic illnesses occur. Improvements in other measures with clinical consensus in the management of diabetes, hypertension, and pulmonary disease, among others, could also be used to incent better care quality and health outcomes.

CONCLUSIONS

Reforming the way in which the U.S. health system provides care to chronically ill patients is an essential first step in rationalizing our Nation's health investment. Reforming the traditional FFS Medicare program would go a long way in spurring this transformation. The United States leads industrialized nations in per capita and total health spending.[48] But we are last in preventable mortality.[49] Good preventive benefits alone are not sufficient to achieve high rates of preventive care. The major reasons for low uptake are beneficiary cost-sharing, lack of comprehensive coverage for all recommended services, patients' health literacy and knowledge of preventive services, language barriers, physicians' time/payment for preventive services, and the lack of a regular source of care or provider.[50] Care itself—along with how we finance and pay for that care—must change.

The broader use of primary prevention efforts in schools, workplaces, and communities can reduce the growth in chronic disease and with it health care spending. Coupled with enhanced primary, secondary, and tertiary prevention in clinical settings, the opportunities for cost savings are substantial. These elements should be carefully coordinated in the design of health insurance benefits (e.g., no cost sharing for services clearly needed to manage and treat chronic disease) and in the re-design of our health care delivery system. Placing more emphasis on prevention and redesigning the care management process in the traditional Medicare program presents a clear and immediate opportunity and challenge. I look forward to working with all of you on this issue.

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Senator HARKIN. We are graced with the presence of Senator Dodd, and I will yield to him for any statements he wants to make, obviously, and for the purpose of introducing our next witness.

STATEMENT OF SENATOR DODD

Senator DODD. Well, thank you very much, Senator Harkin. Let me thank our witnesses and thank you, Senator Harkin, for the hearing this morning on prevention.

This is going to be a major part of the debate, and just listening to you, Dr. Thorpe, and knowing of the work at Pitney Bowes, I am pleased to introduce Dr. Mahoney to this audience. You have made reference already to some of the very creative things that are occurring already. We don't have to invent ideas. There are a lot of them being executed as we gather here this morning.

This will be a major part of this debate and discussion in the coming weeks. So I would ask consent, Mr. Chairman, to have an opening statement included in the record regarding the issues here.

I would just point out we had hearings in July, two of them, on obesity. In fact, Senator Harkin has been a leader on this issue and Senator Bingaman, and others over the years that have really worked on the issue of obesity and related issues of prevention.

There are so many things we can do to make such a difference on these issues. As we said, $2 trillion is spent each year on diseases that are preventable.

[The prepared statement of Senator Dodd follows:]

PREPARED STATEMENT OF SENATOR DODD

Mr. Chairman, I want to thank you for holding this important hearing, hopefully the first of several on comprehensive health care reform. And I want to thank our distinguished witnesses for being here today and providing us with their expertise.

As this committee begins examining the health care system it is fitting that we begin with prevention. As our Nation spends more than $2 trillion on health care, it is disturbing that we have not made better progress on preventing disease and promoting health. When the Senate convenes next year we must make promoting prevention and strengthening our public health system high priorities within health care reform.

As the title of this hearing suggests, and many health policy analysts have commented, our health care system is really a sick care system—a system that is far more likely to provide for treatments that are costlier and less likely to be successful than if the system prevented the disease or condition in the first place. This is a reality of our system that we cannot afford to permit. Our health care system should be designed to prevent diseases and conditions before they occur or before the worst and most expensive outcomes take hold.

In July, I held two hearings on childhood obesity. These hearings focused on the shocking truth that our children may be the first generation of Americans who will live shorter, less healthy lives than their parents.

Nearly 1 out of every 3 of America's children are obese or are at risk of becoming obese—25 million children in all, Already the health consequences of this preventable condition are crystal clear. Right now, children are increasingly being diagnosed with type 2, "adult-onset" diabetes, high blood pressure and high cholesterol. The list goes on—stroke, certain types of cancers, osteoarthritis, certain liver diseases. And obesity, in children or adults, is incredibly costly for our health care system. The obese spend 36 percent more on health care—they spend 77 percent more on medications. As health care spending has exploded in the last 20 years, 1 out of every 4 of the added dollars has gone to treat obesity-related problems. If we can make preventing obesity in children and adults a priority we can help people be healthier and reduce the costs of health care. This is just one example of how prevention can benefit us as we reform health care.

Take for example the costs incurred by the system for babies born prematurely. As highlighted by a 2006 report by the Institute of Medicine, preterm births cost the United States more than $26 billion (or $51,600 per premature infant) in medical care, treatment costs, and lost household and labor market productivity. Of course, that number cannot capture the emotional toll a premature baby takes on the family.

Although in about half of all premature births, we don't know the exact cause, we do know that the weight of the mother and use of

tobacco products during pregnancy are leading factors for low-birth weight and premature babies. If we could address these risk factors early and consistently, we could make tremendous strides toward preventing preemies and promoting healthier babies.

Newborn screening, tobacco cessation, and early intervention with mental and behavioral health are some other obvious examples. And there are many more.

We must take this opportunity to make prevention a part of a true health care system. This means that we have to support both clinical preventive health services such as newborn screening and immunizations and community public health efforts.

Many States and communities across the country are eager to promote healthier living for their citizens but lack either the resources to act or clarity about where to begin. There needs to be strong national priority setting and leadership along with increased Federal funding tied to accountability. Health care providers from big insurers to small health clinics agree that patients should get needed preventive clinical services. The U.S. Preventive Services Task Force shows which clinical services are both beneficial for health and are cost-effective for adults. But the incentives in the current health care system are tilted away from such preventive services and there is far less information about clinical services for children. We can and should take on these tasks as part of our efforts to reform health care.

I am proud to be working with Senator Kennedy and Senator Harkin on this issue. Senator Kennedy is the strongest champion of health reform in the Senate and I feel confident he can help carry this over the finish line next year. And Senator Harkin has been a long time leader in making prevention a priority. As we go forward, I know we'll be joined by Senators on both sides of the aisle. And I look forward to hearing from our witnesses about how we can accomplish these goals.

Thank you Mr. Chairman.

Senator DODD. I am pleased to introduce Dr. Jack Mahoney, who is here with us this morning. He was strategic healthcare initiatives director at Pitney Bowes. He was a key team player in the company's innovative healthcare programs, and we admire you for that work.

His responsibilities included advanced healthcare planning for employees, integrating disease management and wellness initiatives, and benefits planning for employees and retirees. Since retiring, Dr. Mahoney has assumed the role of chief consultant for strategic health initiatives at Pitney Bowes and continues to play a very active role in that area.

He was responsible for designing health benefits for employees, integrating disability and disease management and wellness initiatives, and has written several books that analyze value-based insurance and challenge traditional benefit design programs.

Doctor, we thank you for coming today and being a part of this, and I am honored to be your Senator and to represent you. Pitney Bowes is a great company and a great corporation, and they make great products, obviously. But in addition to that, have demonstrated real leadership when it comes to their employees and retirees as well.

So we thank you for being present here this morning.

Dr. MAHONEY. Thank you, Senator Dodd.

Senator HARKIN. Thank you very much.

Senator Coburn.

Senator COBURN. I will just ask a unanimous request to submit questions in writing to our panelists.

I have to leave for another hearing, but I want to express my appreciation for them being here and their testimony. I think it is valuable, and my hope is that we can do something on a bipartisan basis on prevention.

Senator HARKIN. Absolutely. Thank you very much.

Dr. Mahoney, please proceed.

STATEMENT OF JOHN J. (JACK) MAHONEY, M.D., CHIEF CONSULTANT FOR STRATEGIC HEALTH INITIATIVES, PITNEY BOWES, STAMFORD, CT

Dr. MAHONEY. OK. Thank you, Senator Harkin, Senator Dodd, Senator Reed. It is my pleasure to be here, and I thank you for the invitation to be able to talk about some of the things that we have done at Pitney Bowes over the past 17 years.

Just by way of quick background, Pitney Bowes has 27,000 employees in the United States who are involved in all aspects of integrated mail and document management services. We have a very diverse workforce. It is geographically spread. So we have work groups that are as small as 2 people and as large as 2,500 employees at a single site. So we have quite a variety of challenges, if you will, in trying to implement programs.

I first started working with Pitney Bowes back in the early 1990s. In those days, Pitney was, as all companies, looking at their healthcare costs and healthcare cost increases. So under the leadership of Mike Critelli, who was then head of human resources, who subsequently became our CEO, we began to look at, first, the health plans. So we did what most companies would do in terms of introducing managed care, looked at plan design and cost sharing.

But the significant difference, I think—and again, this was under Mike's leadership—is he said,

> "If we can afford to invest in computers and other equipment to increase the well-being and productivity of our employees, we can certainly invest in healthcare."

What happened was, we were able to achieve some savings in our health plans. We reinvested the money. And some examples of that, we instituted a comprehensive wellness program. It was called Healthcare University, and the program was aimed at helping employees either maintain or adopt healthy habits.

It was an incentive-based program. It still is an incentive-based program that basically allowed the employee to accrue credits that translated into dollars with which they could buy their healthcare for subsequent years. So, in effect, it was a premium reduction plan.

Simultaneously, we put in onsite medical clinics, and these were low-level primary care clinics. But the most important thing is we were able to use those clinics as outreach for our wellness pro-

grams. So we had nurse practitioners and nurses who were actually working with the employees to improve health.

Another significant investment then was our employee assistance program. It is one thing to look at physical health. We thought it was important to look at mental health also. So we put in a comprehensive employee assistance program, which basically was free to employees.

I would add that this went in concurrent with a benefit design, which was full parity in coverage for mental health and substance abuse. So we were one of the first companies to get to parity well before we were required to.

The last part of this was the investment in a data warehouse. It is one thing to look at what you would like to do. It is another to begin to accumulate the data so that, again, you have a roadmap of where you have been and where you are going to.

Well, our progress through the 1990s was acceptable. We were able to manage costs. We were comfortable with the wellness program rolling out there. But in the year 2000, we looked at it and said, "There is something lacking here." You know, we are just sort of putting out fires, if you will, on the health plan.

With the wellness program, we were doing what everybody seemed to think was the right thing to do, but in reality, we thought we could really do more. So we went into this in a couple of different veins.

The first, in wellness, we ramped up the program. But it is one thing to say that you espouse wellness, it is another to set up the environment for individuals so that they can be healthy. So it was simple steps, but significant ones.

Changing the food in the cafeteria, and that meant not only making healthy food available, but making sure that it was priced affordably. So, quick example—it costs more for a bag of potato chips in our cafeteria than it does for a fresh piece of fruit.

Very simple things. Changing the configuration of the office building so that stairway—in our corporate headquarters, the stairways were hidden in the corners. We put in a big central stairway. The idea was to get people to get out, walk around, socialize, and by that way, they get exercise.

We were big advocates of public transportation. No. 1, obviously, it is good for the environment. But No. 2, if you take public transportation, you probably walk more. You are walking back and forth to the train station or to the van stop and back into the building.

Any and every subtle clue that we could possibly do to enhance the environment. If you will, some people have called it a culture of health, but it really is the environment.

The other part of that is, OK, so you can do those things, but then you have to look hard at your benefit plan designs. Sadly, many benefit plans either inadequately cover preventive services or put a deductible in front of them. So we said we can't have that.

We re-designed so that all of our employees, beginning then and through now, have access—the only plans that are offered to them are ones that have comprehensive preventive services with preventive care being offered at either a minimal co-pay or no co-pay, especially for immunizations, and there is no front-end deductible. So we wanted to eliminate the access barrier there.

By the way, that is something, along with the behavioral health piece, that we could not have done without the ERISA pre-emption giving us the latitude to do those innovations.

Well, the other area, we have talked a lot about chronic disease, and we would concur with all of the comments on chronic disease, but there is a big caveat here. And that is that, indeed, people with chronic disease are more costly, but if you dig into it a little bit more deeply, the cost is direct cost plus disability—is not so much the presence of the diagnosis, it is the person with the condition who is inadequately or inappropriately treated, and especially somebody who is not compliant with their medication therapy.

We took, at that time, a radical step, back in 2001, of saying we would reduce co-pays for chronic disease medications, and our targets were asthma, diabetes, and hypertension. We have been very pleased with the results, and we have expanded the program now so that it covers osteoporosis and cardiovascular disease in general, and at this point, it also covers smoking cessation programs—like the medications for helping people to quit smoking.

We put that into place, and then, concurrent with that—we are a manufacturing company, to some extent, although services are involved there. And supply chain side is something very valuable, and that is you have to improve your supply chain.

We went out and basically made our health plans accountable to us for quality and efficiency, not cost. We thought that if we got to quality and efficiency, then we could manage the cost.

It was a strenuous exercise. It is an annual exercise. It is resource-intensive. We have changed health plans many times. But we are on notice that unless a health plan can deliver all of those services—preventive services, disease management services, quality, and efficiency—we will not do business with them.

So, to wrap up, what have we gained out of all of this? Well, I can't give you really tight ROIs, but what I can tell you is that at this point, our costs per employee are 18 percent below what we would expect to see with other comparable companies. We know that about a third of that is due to our efficiency in the health plans and quality, but the remainder is due to the efforts in primary and secondary prevention, our initial wellness program and the chronic disease management programs.

We have a benefit that is affordable for the employees. That is one of our hallmarks. And it is highly regarded by the employees. It is amazing to see how they will write in positive comments about it in the annual engagement survey.

What have we learned out of all of this? Well, a few basic steps. There is value in investing in health. The value is not only in managing costs, but it is competitive advantage.

One of the offshoots of our programs is that we have seen our disability rates go down. Translated, that means we have more effective workers who are able to deliver the services which are valuable to our customers. So it has delivered cost savings, competitive advantage.

You can't do this without data. A data warehouse has been incredibly valuable to us all through the process. We clearly recognize that the least expensive product is not the best. Buy quality.

Be able to measure quality. Hold people accountable for the quality.

Clearly, the answer to all of this is not shifting cost to people. It is really about how do we improve the infrastructure?

And last, but not least, I would echo what Ken said. It doesn't happen without effective executive leadership. And we have been blessed with a CEO who really believed in that, sponsored it, and has been, if you will—I hate to use the word, but—cheerleader through the whole process, an instigator.

Thank you, Senators, for the opportunity, and I am happy to answer questions later.

[The prepared statement of Dr. Mahoney follows:]

PREPARED STATEMENT OF JOHN J. (JACK) MAHONEY, M.D.

Good morning, Mr. Chairman, Senator Enzi, and distinguished committee members, I am Dr. John J. (Jack) Mahoney. Recently, I officially retired from Pitney Bowes. Prior to my retirement, I was the company's Director of Strategic Healthcare Initiatives. Today, I continue to work with Pitney Bowes on a consulting basis to assist the company in its advanced health care planning and wellness initiatives.

Pitney Bowes is the world's leading provider of integrated mail and document management systems, services and solutions. Pitney Bowes invented the postage meter in 1920, which enabled the post office to offer more convenient and secure postage payment at lower cost for business mailers. Today, Pitney Bowes helps organizations of all sizes engineer the flow of communication to reduce costs, increase impact, and enhance customer relationships. Starting in the mail and print stream, and expanding into digital documents, Pitney Bowes has developed unique capabilities for improving the efficiency and effectiveness of the communication flow critical to business.

I joined Pitney Bowes in 1997, as the Corporate Medical Director and the head of Global Health Care Management. Soon after I joined the company, our new Chairman, Mike Critelli, asked us to help him "rethink" our health benefits programs. Pitney Bowes has a tradition of offering its employees comprehensive health benefits. However, like many other companies, health benefit costs at our company were growing much faster than other costs. Similar to many other companies, we began to look for ways to control costs while maintaining employee satisfaction with our benefit offerings.

Like most businesses, we initially considered traditional cost-cutting techniques, such as cutting benefits or shifting more of the cost to the employee as a way to contain year-to-year increases in health care benefit costs. However, as we looked at the experiences of other companies, we quickly realized that their cost-cutting approaches did indeed generate savings for a year or two but, by year three, most of these businesses saw large increases in the cost of employee health benefits. By the end of the third year, all of the savings of the first 2 years had disappeared.

At Pitney Bowes, we wanted to design a program that would work over the long term—not just for a year or two. We started with the premise that health care benefits should be about health, not just about treating illness. We asked ourselves, "If we are willing to invest in new computers and other new equipment to make our employees more productive, then why shouldn't we as a company be willing to invest in the health of our employees to make them more productive?" It is true that this approach did not offer savings in the first year, or even the second year but, by year three, Pitney Bowes was able to achieve real reductions in the cost of employee health benefits.

Pitney Bowes has created health care programs that promote healthy behaviors. Our benefit programs are predicated on the belief that it is more effective to maintain health than to attempt to restore it. We believe that proper nutrition, appropriate levels of exercise, healthy lifestyles, and early detection, intervention and treatment provide opportunities for our employees to effectively manage their health. After much research, we implemented a strategy of linking voluntary, healthy behavior adoption to financial incentives. We built a platform called "Health Care University," which enables participants to gain benefit credits for completing a health risk assessment or for participating in various kinds of wellness programs. This initiative exceeded our expectations in terms of employee satisfaction and improved the overall health of our employee base.

Like many other businesses, we also found that the cost of providing care to a small number of employees with chronic health problems accounted for a disproportionate share of our health benefit expenditures and a decline in productivity. We quickly learned that we could predict future costs by looking at population-level data from prior years. For example, we discovered that we were likely to spend over $10,000 for hospitalization and emergency care of employees with diabetes who either did not use, or did not have, economical access to maintenance drugs. The solution was clear. We knew that we needed to modify our plans to reduce the likelihood that debilitating and costly health emergencies would happen in the future. In short, we needed to remove as many impediments to disease management as possible. Consequently, our company re-designed our benefit plans to reduce employee co-pays for brand-name chronic disease medications by between 50 percent and 85 percent.

As a result of these measures, we were able to reduce treatment costs for diabetic employees by 17 percent and treatment for asthma by 18 percent. Similarly, our focus on adherence to treatment plans reduced emergency department use by asthma patients by 30 percent, hospitalizations by 38 percent and disability costs by 50 percent.

More recently, we became aware of the many benefits associated with creating a positive work environment for our employees. As we renovated our World Headquarters, we reduced the number of walled offices and shrunk average offices sizes. We also largely eliminated desktop printers, copiers and fax machines, and replaced them with core area multi-functional devices. Taking these steps has created more exposure to natural sunlight for our employees and encouraged them to walk around more during the day, which we believe produces positive health benefits.

In addition to these changes to our employees' physical space, we also altered meal options in our cafeterias to ensure that healthier food was more plentiful, lower cost, and more easily accessible than less-healthy options. We also gradually reduced portion sizes for all meals to reflect the recommended healthy intake. For employees who have chosen to participate fully in our benefit offerings, the impact of these initiatives on wellness results has been tremendous.

I recognize that some may question company programs designed to promote healthy lifestyles, exercise programs, good nutrition and incentives to treat chronic disease—believing they are only words crafted by public relations departments. However, Pitney Bowes believes that a healthy workforce makes us more productive and better able to compete in the global marketplace. In fact, our health care costs per employee are 18 percent below that of our benchmark companies. One-third of our cost savings can be attributed to efforts to improve the quality and efficiency of care delivery, while two-thirds can be attributed to improving the overall management of chronic conditions.

We also believe our employees have a responsibility to "self-manage" their own health. However, employers have a responsibility to provide employees with the necessary tools. Pitney Bowes is one of the founders of an initiative called Dossia, a non-profit, third-party organization with members such as Intel, BP, AT&T and Walmart. Dossia's goal is to fund the development of a Web-based framework through which U.S. employees, dependents, retirees, and eventually others, can maintain private, personal and portable health records, as a way of empowering individuals to pursue health and to reduce provider medical costs. Dossia's premise is that we cannot overcome the health crisis in this country until Americans manage their health care.

Pitney Bowes has benefited from the *Employee Retirement Income Security Act* (ERISA), which grants self-insured companies like Pitney Bowes considerable latitude in developing new and innovative approaches to employee benefits and healthcare. Congress recognized that self-insured plans assume the risk of employee benefits and therefore have the greatest incentive to operate efficiently and economically. Eliminating this incentive by eroding the ERISA pre-emption could stifle innovation and creative problem-solving.

While government can, and should, play a role in helping those unable to afford or access health care benefits, employers have the most direct financial interest in creating and maintaining meaningful benefit programs. I am particularly concerned about congressional proposals that purport to retain the employer-based health care system, but would, in fact, result in what insurers call terminal "adverse selection" for employer-based plans. These types of proposals could cause employment-based plans to disappear.

In summary, the key to Pitney Bowes' success has been:

- viewing health care as an investment, not just another cost;
- developing good data;

• promoting and encouraging employees to adopt behaviors that maximize good health;
• recognizing that the least expensive product is not always the most cost-effective; and
• recognizing that shifting more of the cost of some health care benefits on to the employee does not always save money in the long run.

Thank you again, Mr. Chairman, for your consideration of these comments. I would be happy to answer any questions that you or your colleagues may have.

Senator HARKIN. Very good. Dr. Mahoney, that was great. A great tour de force of what can happen in the private sector, and we will have more interaction when we are through our last witness. But thank you very, very much.

Finally, from Iowa, we welcome Ms. Carol Hibbs, the executive director of the Community YMCA of Marshalltown, IA. Ms. Hibbs has served as co-coach of the Marshalltown Pioneering Healthier Communities initiative since September of 2005. She is a graduate of Iowa State University with a degree in journalism and mass communications, and we look forward to hearing about the success of a prevention program at the community level.

Ms. Hibbs, welcome to the committee.

STATEMENT OF CAROL HIBBS, EXECUTIVE DIRECTOR, COMMUNITY Y OF MARSHALLTOWN, IA

Ms. HIBBS. Thank you. Thank you for the introduction.

And Senator, I want to thank you for your support and being a leading role and prioritizing prevention and healthcare and also for being the honorary chair of the Pioneering Healthier Communities initiative. Thank you very much for that.

Marshalltown is a rural community. We have about 27,000 people. Over the last two decades, we have rapidly transformed into a much more diverse community, both culturally and economically. We estimate that our Hispanic population has more than doubled since the 1990 census, and in our school district now, more than 40 percent of the students are Hispanic.

We also have a school district that has more than 50 percent of the students on free and reduced lunch. So we face some economic challenges. Our Y is very proud of the fact that we are open to everyone in our community and that we currently provide financial assistance to about 20 percent of our 6,800 members.

In 2005, we participated in the Pioneering Healthier Community initiative of the YMCA of the USA. This initiative focuses on collaborative engagement with community leaders to influence policies and environments for improved health and well-being.

Locally, we recruited a high-level team of community leaders from all sectors to come to Washington to learn about proven policy and environmental change strategies. Our team left excited, and we were convinced that we could collectively influence opportunities for our residents to be healthier through the planning and implementation of programs and policies.

Our engagement of the community has brought about healthy changes, some of which included that we conducted a walkability assessment of our downtown to achieve our goal of Marshalltown becoming a bike and pedestrian friendly community. As a result, a sidewalk task force was created, mapping sidewalks, assessing

needs, and creating a plan for the city with a priority on sidewalks near schools.

A commitment was made to create a Safe Routes to School program for the entire community and to secure the necessary resources for it. Plans were developed for a pedestrian river walk along Linn Creek, which flows through the heart of our community.

We have worked with local community college students to plant more trees along the biking path to increase usage there. We helped school districts develop wellness policies, and two of our local schools that focused on physical activity throughout the day, revising the PE curriculum, establishing nutrition information for families on school lunches and healthy vending options.

We have implemented a program called "Fit Kids," an after school living healthy program that targets low-income children. Then we also have a program entitled "Healthy You" that serves ages 17 to 78 to offer comprehensive behavior change strategies. It gives them the environmental and emotional support that they need to make these important changes.

Now to make this process work, decisionmakers all must be onboard because many of the decisions they make can influence the environments in support of healthy behavior. Now I think you will agree that your Federal investment into our team of $50,000 is a small change that needs to occur in every city, town, and neighborhood in America, especially since our team has been able to leverage those dollars more than six times over with contributions and grants.

Now today, the YMCA movement has 91 communities engaged in the Pioneering Healthier Communities model. And for Iowa, we have Des Moines and the Quad Cities, in addition to Marshalltown. In Connecticut, there is New Haven. And Senator Reed's State of Rhode Island, there is Providence, and Senator Coburn's State, in Oklahoma, there is Tulsa.

And the 2,686 YMCAs across the country stand ready to work with our communities on this proven change model.

Thank you.

[The prepared statement of Ms. Hibbs follows:]

PREPARED STATEMENT OF CAROL HIBBS

Good morning, I'm Carol Hibbs, Executive Director of the Marshalltown, IA Community Y. I'm honored to be here to say a few words about the success of our community change model, focused on chronic disease prevention. This project has been convened by the YMCA, but is indeed a *community* success story.

Before I begin I want to thank my Senator, Senator Harkin for his leading role in prioritizing prevention in health care and for serving as the Honorary Chair of the YMCA's Pioneering Healthier Communities initiative. Without you, Senator, this program would not be what it has become today—a movement toward the social and cultural change we need to make the healthy choice the easy choice in our communities.

Marshalltown is a rural community of about 27,000. Over the last two decades, we have rapidly transformed into a much more diverse community—both culturally and economically. Experts estimate that our Hispanic population has more than doubled since 1990. In the school district, more than 40 percent of the students are Hispanic. Also, more than 50 percent of Marshalltown students qualify for free or reduced priced lunch. Our YMCA is proud to be open to everyone in our community and we currently provide financial assistance to about 20 percent of our 6,800 members.

In the summer of 2005, our community applied to participate in the YMCA of the USA's Activate America: Pioneering Healthier Communities initiative. Pioneering

Healthier Communities focuses on collaborative engagement with community leaders, how environments influence health and well-being, and the role policy plays in sustaining change. We believe no one organization can effectively solve the Nation's chronic disease crisis; therefore YMCAs joined with others to increase opportunities that ultimately impact healthier lifestyles.

In Marshalltown we recruited a high-level team of community leaders from all sectors—including the hospital, local business, the school district, economic development and our Mayor—to come to Washington for 3 days of information and education. We heard from national experts about evidence-based strategies that build sustainable healthy communities through changes in policy and the built environment. Our team left Washington excited and convinced we could collectively help Marshalltown residents become healthier.

The Pioneering Healthier Communities Model takes the macro approach to change. Again, combining programs and projects for implementation in all sectors of our community; and promoting policy changes—all of this with a constant, healthy dose of information and education in community-wide forums that explain why we are trying to make a particular policy change. Our engagement of the community has brought about healthy changes, including:

• Developing a community walking guide distributed through numerous community sites and events.

• Developing wellness policies in two of our local schools that focused on incorporating physical activity throughout the school day, revising the PE curriculum, establishing guidelines and nutrition information for families around school lunches, and providing healthier options in the vending machines.

• Creating a "Gym in a Box" with a large local hospital to promote healthy eating and active living among their employees.

• Working with the local community college students to plant more trees along biking paths in the city to increase usage.

• Implementing Fit Kids, an afterschool program targeting low-income kids to incorporate healthy activity and healthy snacks into their lives along with the President's Council physical fitness test every 12 weeks.

• Introducing Healthy University for 17–78-year-olds allowing hundreds of individuals to receive assistance with comprehensive behavior change strategies to reduce obesity—including the necessary environmental and emotional support to help individuals be successful.

• Conducted a walkability assessment in our downtown to achieve our goal of *Marshalltown becoming a pedestrian/bike friendly community*. The first meeting was attended by 40 interested community leaders and was followed by another meeting of 60 leaders. We now have city government, community walking & biking advocates, Iowa Department of Transportation officials and the local planning commission working together toward common goals. As a result:

1. A *sidewalk task force* was created that mapped sidewalks in the city to assess needs and prioritized a plan for the city with the highest priority being around schools.

2. A commitment was made to creating a Safe Routes to Schools program for the entire community.

3. Plans are underway for the development of a pedestrian river walk along Linn Creek which flows through the center of the community.

This work is not easy. Silos must come down in communities and money from local, State and Federal Governments along with that from the private sector must be leveraged. Community leaders who influence the environments of where we live, work, and play must all be on board to create healthy ones. Community leaders in Marshalltown have been surprised to learn just how many decisions they make weekly or monthly that influence healthier choices.

We believe keys to our success include:

• Recruiting community leaders and key influencers as part of the team to come to Washington to participate in the initial conference—we must reach beyond the public health community to influence public health outcomes.

• Creating a healthy community plan that asks all sectors of our community to make a contribution.

• Reaching into so many parts of the community and encouraging participation along with constant information and education—several segments of the community are now energized and unified around this healthy community effort.

• Challenging the team to not only implement new programs and special projects—but to constantly look at policy changes that can be made in our schools, worksites and neighborhoods so healthy eating and active living is an easier choice.

• Acting as a central coordinating organization, the Marshalltown Community Y convenes the group and coordinates the work—but engages everyone. This has worked well in Marshalltown because the politics of this work with public officials and the private sector is managed and not a barrier so the community can make these important changes.

This effort involves more than just telling people to eat less and exercise more. The YMCA has learned that the majority of kids and families need support in achieving their health and well-being goals. We call these individuals "health seekers"—they want to improve, but making everyday healthy choices is frequently a struggle, even when it has obvious advantages. Yes, people are responsible for their own behavior but too often society creates barriers, or at the least does not provide enough support, to help kids and families realize their health goals.

Today, the YMCA movement has 91 communities engaged in the Pioneering Healthier Communities model (see attached map/list). There have been significant policy changes, new programs implemented and a great deal of awareness created around evidence-based models that result in 91 healthier communities. We are anxious to share our model with others and there are hundreds of communities interested and ready to do this work.

I want to emphasis however that there are no shortcuts. We have faced challenges. I believe everyone on our team would say the learning process has had a direct correlation on the outcomes and bringing the community together toward common goals for a healthier Marshalltown. I'm certain that each of you on this committee would agree that your Federal investment into this team of about $50,000 since 2005, is a small investment compared to the change that needs to occur in every city, town and neighborhood in America. In addition, we have been able to leverage those dollars more than six times over with contributions and grants with local funders, hospitals, Safe-Routes-to-School funding and a Carol White PEP Grant.

America's 2,686 YMCAs, at more than 10,000 sites serving more than 21 million people each year—half of which are children and youth stand ready to enthusiastically support chronic disease prevention policies for the individual, the family and our communities. Thank you for allowing me to share what I believe is one of the best models of community-based prevention programming.

HEALTHY COMMUNITY INITIATIVES: PHC & ACHIEVE

YMCA | ACTIVATE AMERICA

1 2004	Santa Clara & South San Mateo Counties, CA • Boulder, CO • State of Delaware • Des Moines, IA Boise, ID • Tampa, FL • St. Louis, MO • Rochester, NY • Pittsburgh, PA • Dallas, TX • Seattle, WA State of West Virginia • Milwaukee, WI
2 2005	State of Arkansas • Tucson, AZ • Orange County, CA • Clearwater, FL • Marshalltown, IA Lexington, KY • Shreveport, LA • Attleboro, MA • West Michigan (Grand Rapids) Marshall, MN • Springfield/Greene County, MO • Charlotte, NC • Lincoln, NE • Rye, NY Tulsa, OK • Chester County (Brandywine Valley), PA • Greater Greenville, SC • Rapid City, SD Tarrant County (Fort Worth), TX • Dane County (Madison), WI
3 2006	Shasta County, CA • Central Connecticut Coast • Elgin, IL • Quad Cities, IL and IA • Fort Wayne, IN Greater Louisville, KY • Mid Coast Maine • Mid-Delmarva, MD • Rahway, NJ • Champaign County, OH Cleveland, OH • Memphis, TN • Fox Cities, WI
4 2007	San Francisco, CA • Colorado Springs, CO • Longmont, CO • Rockford, IL • Hockomock Region, MA Ann Arbor, MI • Battle Creek, MI • Itasca County, MN • Asheville Area, NC • Fargo, ND and Moorhead, MN Omaha, NE • Woodbridge, NJ • New York, NY • Providence, RI • Chesterfield/Darlington/Hartsville, SC La Crosse, WI • Marysville, WA • Spokane, WA
5 2008	Birmingham, AL • Hot Springs, AR • Hayward, CA • Savannah, GA • St. Clair County, IL • Lawrence (Indianapolis), IN Topeka, KS • Worcester, MA • Red Wing, MN • Neosho, MO • Winston-Salem, NC • Sussex County, NJ • Cincinnati, OH Marietta, OH • Nashville, TN • Burlington, VT • West Bend, WI
A ACHIEVE	Black Hawk County, IA • Wichita, KS • Greater Mount Desert Island, ME • Cleveland County, NC Albuquerque, NM • Salamanca, NY • Stark, OH • Allentown, PA • Houston, TX • Tacoma-Pierce County, WA

Senator HARKIN. Thank you very much, Ms. Hibbs, and thank you for your leadership in Marshalltown.

Of course, I am very much aware of what you have been doing out there. I have visited out there more than once, and the changes that have been brought about are incredible.

I think our panel here shows, we have the community involvement. We have the private sector. We have academia and, in the first panel, the Federal Government. The one thing that perhaps is missing—but we will get to that at some point down the line—and that is the States and what can State governments do and how they would be involved.

But there are so many things that communities can do, and some of them are doing ingenious things. And as someone said, we have to find these sort of best practices somehow and get those out and somehow incentivize those best practices that work.

I know of another community where they received a grant for a community wellness program, and one of the things they did, which I thought at the outset was not—I didn't think it was going to work that well. I was proven wrong. They convinced the local grocery store—in this case, it was Hy-Vee, which is a big chain in Iowa. And this local store, working with dieticians, nutritionists, they put little arrows along the aisles of the grocery store with an arrow and a heart on it. And these were the heart healthy things that you could buy.

I went to the store and looked. Of course, in the candy section and stuff, you don't see any of those. And in the cereal sections, where they have the sweetened cereals, you don't see any. But in the other cereals, you do, and in the vegetables and fruits, all those

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arrows are all over. It was just a visual representation to the average shopper of this is a good thing to buy.

It had a tremendous effect. You would be amazed at how the difference in purchasing went up just in that one grocery store. So just little things like that.

I remember when Tommy Thompson was Secretary of Health. I went down to visit him once, and I saw a sign by the elevator at the Department of Health and Human Services. It said, "The stairs are this way, and if you climb stairs, you will burn so many calories," that type of thing.

As you pointed out, I think it was, Dr. Mahoney, you changed so that people would start taking stairs more and using stairs more. Simple things like that, that can change the environment. I can't recall exactly who it was, but someone said you have to build the environment so that people could be healthy.

While I agree with Senator Coburn that people will make these choices if they are given the information, but if you can't find the stairs to climb or they are dark and forbidding, you don't want to do that. If you want your kids to walk to school, but there is no sidewalk, well, you might want to make that choice, but they can't walk along the busy street if there is no sidewalk.

There are a lot of these things that we have to think about in terms of if we give this information to people—I think it was you, Dr. Mahoney, who said you have to build this environment.

Dr. MAHONEY. Right.

Senator HARKIN. You have to build the environment so people will find that these things are sort of easy to do, accessible to do.

Well, anyway, that is just my editorial comments on this. I have a series of questions, and I will just start with a couple, and then I will yield to Senator Dodd.

But Dr. Levi, you have talked about this national prevention strategy. Again, I would be looking for who would establish it? How would you implement it? How would it differ from ongoing Healthy People process?

Can you flesh that out just a little bit more for me on this national prevention strategy? How do we establish it? How is it run? How do we get going on it?

Mr. LEVI. Sure. I mean, I think our immediate vision would be for either Congress to mandate the creation of this or for, one would hope, the President to ask his domestic policy council staff to convene a working group within the Federal Government that would bring all of the relevant agencies together.

They would be tasked for identifying not just what they are currently doing, but what existing programs could do to promote health and to really begin to change the—this is a cultural shift within Government. It is not just about convincing the American people to think healthier and be more active and think about health in their own lives, but I think we need a culture shift in the Government to recognize just how dramatically almost every agency of the Federal Government can affect health.

By bringing all of those agencies together, setting some clear goals, we may want to start with one issue, obesity, because of its dramatic impact on—obesity and physical activity and its impact on so many chronic diseases, as Dr. Thorpe indicated. I think that

would give us an opportunity then to see the range of programs and the range of effects.

Then identify what additional money, what additional resources, what additional staffing will be needed to really make those programs health focused. And so, it means certainly we would argue, within HHS, looking at some of the CDC programs and saying how much of this money is really getting out into the community? How can we put Pioneering Healthier Communities on steroids? I probably shouldn't say that.

[Laughter.]

Some equivalent of that to—that is a different oversight hearing.

[Laughter.]

But how do we make sure that every community can be not just doing the coalition building that Pioneering Healthier Communities does and not require the Pioneering Healthier Communities to depend on leveraging other resources, but actually give them the resources to make those changes.

When they think they need more sidewalks, let us help them provide the resources to build those sidewalks. When they need to build a supermarket in a neighborhood, if that is something that is deficit, let us provide the loan payments and the support. And frankly, that could all be part of an economic stimulus package or developing the infrastructure.

So it is thinking within HHS along those lines, but then making sure that the Department of Transportation, when it is giving grants around transportation, around highways, to make sure that there are bike paths, to make sure that there are sidewalks, all those things. And if you think about it over time, almost every agency of the Federal Government has a role to play in this, and that is what needs to be brought together.

Once we have identified what those things are, then there need to be goals set for each of those agencies with milestones along the way. And again, I referenced earlier the pandemic flu plan. There are annual 6-month, 12-month, 18-month, 24-month milestones that agencies have to meet, and they are reported on publicly. That would be one element of, I think, what we need.

The second element I think is critical within HHS. The difficulty in finding the Office of Science and Public Health was not accidental. It is hidden. I think we need to make sure that public health really is a tremendous focus of everything that happens within HHS, and it is not just the programs in the Public Health Service and in CDC, NIH, and so on.

It is also CMS. It is Medicare and Medicaid and their ability to affect that. Right now, no one below the secretary has line authority over those agencies. And so, part of what we mentioned in our written testimony is that the Assistant Secretary for Health should once again have line authority over the Public Health Service agencies so that they can be implementing that national plan and can be all working in the same direction.

We would also like to see Congress elevate that assistant secretary position to an under secretary position so that we could also incorporate the preparedness and response programs and, particularly relevant to this discussion, the CMS programs. So that CMS

is not just reimbursing for care, but also thinking about its public health and prevention role.

Senator HARKIN. Well, hopefully, these are things that we can start working on and incorporating. With the new administration coming in, it is probably an appropriate time to start looking at how we can restructure HHS to accomplish that.

To all of you who are here, I invite any of your input on what should be in this stimulus bill that we will probably be passing, probably in January sometime. But I think one of the things that we are not looking at is this area of what we ought to be doing in the stimulus package. Public health workers, things like that.

Any other thoughts that any of you have on stimulus package stuff, even Healthier Communities things. A lot of these are construction-type projects. One community I am aware of built a walking path around the whole town, but they connected it to the retirement center and the nursing home and things like that so that they could get out easy, get right out on it, even in wheelchairs, and use wheelchairs to move around on the path and everything.

Just things like that that we ought to be thinking about as part of the stimulus package also. With that, I would turn to my colleague, Senator Dodd.

Senator DODD. Well, thanks, Senator, very, very much.

Let me also commend all of you. In fact, I should have mentioned earlier Dr. Levi was a very good witness for us back in July, when we had our hearings on obesity, and I should have made reference to that when I opened my remarks. Senator Harkin has raised a good series of questions here about that.

Let me just say, I underscore the point of the under secretary position. I think you have to create a structure, an architecture that allows you to get there. And while we get a lot of these ideas, if you don't have the architecture in place to do what is being suggested across the board in this area, then I think you are sort of lurching.

I always find—and Senator Harkin, I know, has probably encountered this, too—as we go to our colleagues and others to make an appeal at the various times on various funding schemes in this area, it is not uncommon to have someone say, "I will tell you what. I will help you with the first request and the second, but not the third and the fourth. I just can't do it." Not understanding that if you don't do three and four, one and two don't work.

You really do have to have a comprehensive, a holistic approach to this if, in fact, that $10 investment you are suggesting it would cost would save us some $16 billion. I think that is a graphic way of describing the kind of investments that could be made.

Or as Pitney Bowes showed, I think the case that we need to make strongly is that not only is this smart from a health standpoint and a moral and ethical standpoint, this is very good business. Pitney Bowes saved 18 percent, I think is the number. You correct me if I am wrong.

Dr. MAHONEY. On chronic diseases.

Senator DODD. I am sorry? On chronic diseases?

Dr. MAHONEY. I am sorry. We are 18 percent below benchmark companies.

Senator DODD. Benchmark companies, which was a very important point to make to an audience out there that says this is all well and good. Pitney Bowes is a big corporation. You can afford to do it. You are healthy and wealthy. We are struggling. How can we do this?

This is a money saver. If you are only impressed by economics, that is all you care about, this is the best idea you are going to have. In a difficult time financially, this is smart economics, in addition to being right public policy.

I appreciate these ideas. And Senator Harkin is correct, we ought to be raising ideas as quickly as we can here, with an administration coming in that is committed to change, these are some fundamental ideas that we ought to incorporate early on if we are going to be successful in developing, I think, the kind of comprehensive plans that we are talking about.

I will leave those questions. I want to get to two quick questions, if I can, because one of the problems that we have—and again, it is a practical issue—and that is a public health workforce. And again, we talk about expanding the needs for this. We celebrate tremendously the success, but we have a real shortage in this area.

I think both Senator Harkin and others on the committee would like to know how we could help in that regard. So let me ask you to focus on that a bit, what Congress can do. I realize the quick answer is money, but that is it seems to me there needs to be more thoughtful strategy about this than just that answer.

I would like you to comment on that, if you could. The recruitment, retention, how we do that, if you would? And let me—I have a couple of other quick questions for our other panelists. But if you would respond to that, Dr. Levi?

Mr. LEVI. Yes. We can submit a longer litany of things for the record. But I think it falls in several categories. First, we have delayed in reauthorizing Title VII and VIII of the Public Health Service Act, and I think those are the core of making sure that the Federal programs are in place.

But we also need to make sure that we have a pipeline of new workers. Twenty percent of the average State health agency's workforce is going to be eligible to retire within 3 years, and that is just keeping things going as it is now, as opposed to the additional responsibilities and needs we will have if we really engage in the kind of community prevention work that we have all been talking about.

There are all sorts of things I think Congress could do that would not necessarily be highly costly. Some of it could be scholarships or loan repayment programs. We need to be thinking not just about master's level trained folks, but people in community colleges who can receive specific training to do community health work and work in public health departments.

Perhaps provide some incentives for juniors and seniors in colleges to become public health majors. More and more undergraduate institutions are offering public health programs as majors.

We also need to be thinking about the ongoing workforce programs that are out there. The State workforce boards do not have a requirement that there be someone who can think about and

know about public health jobs that could be created and have public health expertise. So we could leverage some existing programs that are already out there for workforce development that could help us expand the workforce.

There are a number of other things that we have in our testimony, and we can provide additional detail. But I think you are absolutely right that we can reform the system all we want, but if we don't have the workforce in place to actually carry the message of prevention and implement these programs and support the public health infrastructure that is so critical to surround the healthcare system, we are not going to succeed.

Senator DODD. Let me jump to two other issues, and I apologize for kind of jumping around here, but sensitive to time. And Tom is a tremendous help in this, as he has been on so many issues, and wrote back—it finally got adopted in 1993, the Family and Medical Leave Act.

It was a highly controversial effort, surprisingly so. We were the last country in the world, I think, to provide a leave program. I remember South Africa, even under days of apartheid, adopted a family and medical leave policy, and proud of the fact that something like 75 million Americans have been able to take advantage of the program over these many years.

Dr. Mahoney, I think Pitney Bowes has a paid family and medical leave program. At least I have been told that. Is that the case?

Dr. MAHONEY. No, sir. We have a family and medical leave program, and we also have a disability program. But there is not a——

Senator DODD. Not a separate program? Well, what I want to get at is because we are talking about a paid leave program, and I won't take the time to go through how it works, but it is not as just a simple paid leave program. It is scaled and so forth to understand the obvious concerns of some businesses about this additional cost.

But I wondered if you might comment, the panel here that has some knowledge of this, about the benefit of this. Eighty percent of the people who don't take leave don't do so because they just can't afford to, which is not a surprise to people, I suppose, when you are out there struggling at this juncture.

The idea that you could take 12 weeks off to be with a family member recovering from an illness, I want to talk about this in the context of prevention. Because it has been more than mountains of data that will tell you that a person recovering, in a sense, does so much more quickly when they have ability to be with loved ones.

I remember Dr. Koop testifying before us as a pediatric surgeon, just the recovery rates of a child where a parent could be present. The McDonald houses, just the evidence is overwhelming. But I wonder if I could get a quick comment on what your assessment would be of a paid family and medical leave proposal?

Dr. MAHONEY. I would feel ill-equipped to begin to comment on it. I don't have any experience with that.

I would agree with your comment, though, very much so that people do heal better and have a quicker recovery if there is a social environment around them. But I would also add that part of the issue that we see with medical leave is people having to care

for loved ones who really have a condition that could have been prevented.

So I think it just re-emphasizes the whole process. If we focus on the prevention, we are going to see a ripple effect through many of our programs, whether it is FMLA or disability or even workers compensation.

Senator DODD. Any other comments on this, you and Dr. Thorpe?

Mr. THORPE. I would just say it is part of a broader workforce strategy that we need to look at. Most care that is delivered to people at home or in the community are provided by informal caregivers. They are under recognized and under appreciated.

And particularly if you look at the demographics that are likely to happen over the next 10, 15, 20 years, the demand for that type of in-home service is going to do nothing but escalate. So I guess the concern would be do we have the capacity in the formal care giving setting right now to actually deal with what is going to happen over the next 15 or 20 years with respect to shifts in the age distribution of the population?

So it would seem to be a flexible strategy. I think if you think of it as part of an overall workforce strategy, it makes some sense.

Senator DODD. Good.

Dr. Levi.

Mr. LEVI. The only other thing that I would add briefly is certainly if you think about infectious diseases and the lack of adequate paid sick leave, that can be a real deterrent for people to stay home, and that can have a dramatic impact on the workforce. People come to work ill, and they spread infectious disease. That is a problem with an ordinary flu season, for example.

But it is a much bigger problem if we face something like a pandemic influenza, where people will be—if they don't have healthcare and if they don't have sick leave, they will be disincentivized from seeking the care and doing sort of the self-isolation that is going to be necessary to contain a major infectious disease outbreak.

Senator DODD. As the father of a 3-year-old and a 7-year-old, I am painfully aware about that.

Mr. LEVI. You could be in perpetual isolation.

Senator DODD. I know. I know. Permanent family medical leave. [Laughter.]

Let me just mention two other quick things. This Guide for Clinical Preventive Services is very, very good. But there are recommendations in here for clinical prevention services. There are just 10 recommendations for children while there are more than 50 for adults.

As the author, along with Tom, of several pieces of legislation designed to ensure that medications and medical devices have been tested for safety in children, this is somewhat concerning to me that we have so few recommendations for children in this.

Again, talking about prevention, obviously we learned—going back to obesity, we know if you want to really reduce costs in the long run to the extent we are able to make a difference in the child's life early on, then obviously the cost later declines substantially.

Any comments on that at all? Is there a need for more coordinated Federal work in this area?

Mr. LEVI. Well, I think the clinical guide is an incredibly valuable tool, but I think it has the limitations that you mentioned. There is a similar effort to have a community guide for community-based interventions. That is a much smaller-scale effort, and actually, one of the recommendations we make in our written testimony is to have a much broader investment in being able to provide for communities, for health departments, for clinicians, for health plans much more systematic evidence about what works, what might be cost effective, both in terms of community interventions and clinical interventions.

We don't do, particularly on the community side, that kind of evidence gathering in as robust a way as we might on the clinical side.

Senator DODD. Well, I presume there will be updates to this and, again, coming up this year. I would really strongly recommend that we put at least as much attention on this area because I think it goes right to the heart of the prevention issue with children.

Last, Dr. Mahoney, in your oral testimony, you talked about how Pitney Bowes has had to change health insurers many times due to the fact that the company has such a comprehensive view on what the insurance benefit package should be. I wonder if you could talk briefly about this, and do you think the company has had an influence on the private health insurance benefit design market as a result of the changes that have had to occur?

Dr. MAHONEY. The best way to answer that I think is to give a little bit of history, and that is we started down this pathway, as I said in the testimony, we used a standardized instrument that is called eValu8—little e, big V, and the number 8. It was developed by the National Business Coalition on Healthcare.

We participate with 350 other employers in this standardized assessment of quality metrics from health plans, and we have made decisions over the years looking at the quality of the plan, performance in given areas, and improvement in quality as our benchmark of continuing the relationship.

I would say that this is a very powerful instrument because what happens is after the assessment is made, after the health plan completes the process—and it is an extensive process—then the health plan gets to meet with the employers who are involved in the specific business coalition. For example, we belong to the New York Business Group on Health and also the Pacific Business Group on Health.

We have an opportunity to meet with the health plan, articulate where our issues are—not only us, but the other employers—and set some expectations for improvement. Probably the best example I can give you is in New York many years ago. We benchmarked behavioral healthcare services among all of the health plans, and the performance was not that wonderful. Over the years, we have seen steady improvement in delivery of behavioral healthcare services.

So, I think that if you set an expectation, the marketplace begins to respond to you. And frankly, on an individual basis, we have had

to make the decision that maybe sometimes we could do better with another health plan.

Senator DODD. That is great. That is good to know as well.

Mr. LEVI. If I could add one point to that——

Senator DODD. Sure.

Mr. LEVI [continuing]. Which is the Federal Government is a huge purchaser of private health insurance, and the kind of standards that Dr. Mahoney was talking about and thinking about a comprehensive wellness approach for Federal employees would dramatically change the insurance market.

Senator DODD. Well, I think the fact you do this in a group setting has to be a dynamic in itself. A one-on-one with that company, things may slip. But the fact that there are a number of people sitting around, you take note if you are that insurer, and that is of value.

Ms. Hibbs, I apologize. I don't have a question, but I want to thank you and I spent a little time in Iowa in the last year or so. Enjoyed Marshalltown very much, a nice town to be in.

Ms. HIBBS. Thank you.

Senator DODD. Thank you for what you are doing with the Y. They do a great job as well.

Thank you, Mr. Chairman.

Senator HARKIN. Thank you, Senator Dodd.

Just a few follow-ups on this. Dr. Mahoney, Pitney Bowes is 27,000 people, big company. And again, you were able to do this because you had good executive leadership. I understand that. But I am concerned about all of the small businesses out there. Businesses that employ 50 people or 25 people, and what they can do to implement wellness policies.

In many cases, they don't have the wherewithal to implement big things. When you go to your healthcare plans, and you have 27,000 employees, they listen. If you have 25 or 30 employees, they say take it or leave it.

I am interested in how we take these kinds of models and apply them to the small businesses around America, and do you have any thoughts on that?

Dr. MAHONEY. Yes. Actually, subsequent to retiring from Pitney Bowes, I have worked with a number of regional healthcare coalitions. And Senator Dodd is right on in the comments. It is very powerful when a group sits down with a health plan to negotiate and implement as opposed to individually.

I would have to say that I have been amazed at the creativity of small businesses in looking at wellness and health improvement, and I think it is because they are more acutely aware both of the direct costs, the hit on their healthcare premium, but moreover, the indirect cost. Because if you are a small company of 20 people and you have 2 people out ill due to a preventable condition, it hits home to the entire organization.

I have seen great creativity there. I think that the stumbling block has then been how do you create this environment? They might not have all of the resources. So I applaud any of the efforts that can be done on a community basis.

And just by way of comment, you know I mentioned we have very small work groups. We have incredibly small work groups in

areas that we can't reach. However, by providing the incentive through our Healthcare University and then directing them to community resources, people can participate in those programs.

I think small businesses can make progress there. The difficult part is changing the health plan environment, if you will. But there is a way to do that, and that is through the group action.

Senator HARKIN. OK. The other thing is I have seen a lot of fairly large businesses that have put a wellness center in their business. They hire a nutritionist or a dietician, plus a physical exercise person, and they get their people signed up, and they have wonderful gyms and things like that. They have all kinds of incentives, are open on the weekends and stuff.

Any time a business does that, that is all tax deductible. For a big business, that is a tax-deductible expense. Not only is it tax deductible to the business, it is not a taxable event to the employee.

However, if a small business employs 50 people or 100 people or 200 people, they can't do that. But if they wanted to, let us say, purchase a membership in the local Y and have them go to the Y and enroll in a plan for weight reduction, smoking cessation, on and on and on, if they do that, that is not tax deductible for the business. And if they were to do that, it is a taxable event to the employee. Just again, that is one of those disincentives that is in our taxing system that needs to be corrected.

It seems to me that there is a great opportunity in our communities, as evidenced by what Marshalltown is doing and a lot of others, where they are utilizing their Ys and others to reach out to people to get them into these kinds of classes and smoking cessation, weight reduction/control, diet-related information.

We have to somehow help our small businesses be able to access that, and perhaps this is just another thing that we can do, and that is changing the tax code. But we have to keep the employees somehow incentivized in this.

I don't know exactly how you do this through your vast network. I mean you are all over the United States. I don't know exactly how you do that, but somehow you must keep them incentivized in this?

Dr. MAHONEY. Well, part of the issue, if I may, is keeping the program fresh and constantly re-inventing the program. The other is to keep it simple so that people can actually participate in it.

Our current program is called Count Your Way to Health. And it is built around simple numbers—0, 1, 5, 25, 30, and 100. Zero smoking. Floss your teeth once a day. Five fruits and vegetable a day. Maintain your body mass index at 25. Exercise for 30 minutes a day. Wear your seatbelts 100 percent of the time.

Those are all things that you can do without a fitness facility. You really don't need a nutritionist. It is just providing both the incentive for people to do it, and we do that through a self-assessment that people can take. Again, they get a financial reward. And we also give them access to a program.

But the key to it was keeping it simple so that if they are in an area—a rural area or a small town or even a large town—where we don't have a presence, they can go to a facility and actually avail themselves of that and report back to us on their progress.

Senator HARKIN. Dr. Thorpe, you mentioned before the North Carolina community situation. I don't know a lot about that. Could you help me out? Tell me more about that North Carolina model in terms of what you called a community care team?

Mr. THORPE. Right. The community health teams.

Senator HARKIN. What is that?

Mr. THORPE. There are really three States doing this now—North Carolina, Pennsylvania, and Vermont. What they are, are teams of community health workers. So they do link people up to community resources, like working with YMCAs, nurse practitioners, nutritionists, social and health behavior change workers. They are basically care coordinators.

Senator HARKIN. Who set this up, the State or what?

Mr. THORPE. The State set this up in North Carolina. It was originally done through the Medicaid program, recognizing that it is a different way of doing population health in managed care.

They work with small physician practices, groups of one and two and three, that don't: (A), get paid to do the care coordination and prevention; and (B), don't have the capacity in their offices to do it. It was a very effective way of really integrating physician practices with care coordination and paying for it in a way that was far less expensive than how we do managed care within the Medicare program, for example.

Their results have been very spectacular. Depending on the year you want to look at, they saved $100 million, $200 million in terms of preventable admissions to the hospital, preventable re-admissions to the hospital.

The concept really integrates population health and prevention with treatment in the same setting. So it doesn't break it apart. It does the whole continuum of population health to prevention to treatment.

I think that several States have seen the value in this. I was suggesting that the Federal Government could accelerate the development of those types of programs in the Medicare program, which our big challenge is what do we do to manage chronic disease for the 80 percent of the population in Medicare that we are really not doing a very good job of managing right now?

That would be one approach that we could do very quickly by working with the States to have them set these community care teams up to work with smaller physician practices to do prevention and treatment of Medicare patients, Medicaid. I would presume that a lot of self-funded, self-insured companies would be very interested in participating in that type of model as well.

In the North Carolina example, it started with Medicaid, but the private sector is now starting to participate in it as well because they see it as a more effective way of preventing and managing disease than the way that they have been doing it in the past.

Ms. HIBBS. May I add something to that?

Senator HARKIN. Sure, Carol.

Ms. HIBBS. You talked about incentivizing workers. Well, in the Pioneering Healthier Communities initiative, we have looked at a lot of ways to do that. We look at build environment in our community. We look at policies that keep people from doing things.

But we also have an internal program through the Activate America Program that focuses on the health seeker population. And what that tells us is that the majority of the population need a supportive environment to make the changes and to stay incentivized. And so, the Y is working on creating that supportive environment so that people can make the changes that are very difficult for most of the population to make.

Senator HARKIN. What are some of the biggest obstacles that you had in Marshalltown? I mean, you had to work with the city council and city manager and all that kind of thing and the school districts.

In trying to do what you did in Marshalltown, what are some of the barriers or some of the things that we might be able to look at if we are going to do a stimulus bill? Maybe I would even further enlarge the question to say what would you want, what would you like to see in that stimulus bill that would lend itself to Healthier Communities?

Ms. HIBBS. Well, one of the things that has been successful for us is we have engaged decisionmakers from all sectors of our community, from business, economic development, public health, and city government, as you mentioned. The barriers for our citizens are, who is going to pay for it?

We need more than $1 million in sidewalks. That is what our sidewalk task force says. Now we cannot pay for $1 million in sidewalks right now. So how do we get the resources to make sure that areas of our communities, especially those near schools, have sidewalks. That is a big barrier for us.

Also, we are trying to make our bike and walking trails connect throughout the community. And to do that, we are also seeking out other resources.

Senator HARKIN. I am going to think about this in that stimulus bill in terms of getting money directly to communities for things like this. We ought to really seriously think about this.

Ms. HIBBS. Well, it may even be as simple as making sure that our crosswalks and our intersections have the countdown timers and the crosswalk markings that children need to cross a busy street safely to get to school.

Senator DODD. One of the things we could do—and just last spring and summer, and Senator Harkin was tremendously helpful, we tried to pass a housing bill to make a difference on litigation on foreclosure—we wrote a community development block grant of almost $5 billion targeted to dealing with foreclosure. To buy foreclosed properties, to be able to maintain them, to put them back on the market so you would have property taxes coming back in. It was a local initiative that has been very, very important to local communities to be able to do that.

I think by talking about a community development block grant, where money goes directly to communities, where you are targeting it for health prevention and so allowing communities then, whether it is in Marshalltown for sidewalks or someplace else, for something else. But giving some latitude.

I have found, we have done this with fire grants, local people do a pretty good job. We have given out 30,000 grants to fire departments across the country. I hesitate to say this because it will

probably change tomorrow. We have yet to have a single case where people have pointed up to fraud or waste in these things. They are pretty good and careful about it.

Now, as I said, I will probably hear a story tomorrow of something to the contrary, but it works. I think if you defined it in some way so it gives you the latitude to address these questions without trying to pinpoint it in a way that makes it difficult for some community that has a different need or sees a way for it to make a significant contribution to exactly what you are talking about, we ought to be able to find a part of that money, that stimulus, for these kind of public works projects that will put people to work and address specifically, prevention areas.

So that worked with the housing——

Ms. HIBBS. Well, one of the nice things about the Pioneering Healthier Communities model is that it involves all sectors of the community, and so it allows the community then to decide what they need and what works best for them.

Mr. LEVI. But I think one other thing to point out here is that here are communities across the country that have plans on the shelf. It is not just the highway builders who have plans on the shelf that could be implemented immediately. There are—it is Pioneering Healthier Communities. There are other CDC programs, California Endowment and the Robert Wood Johnson Foundation have supported these kinds of planning efforts as well.

So there are communities across the country who have the plans, know what is needed, and, if the resources came, could begin to implement them immediately.

Senator HARKIN. Well, we ought to look at that. We ought to really work on that because that thing is going to be coming down in January.

I don't mean to prolong this, but again, thinking about incentives. All of the incentives in our health system are on patching, fixing, and mending. Let us be honest about that. That is where the incentives are. We have to move these incentives forward.

Now, fortunately, we have some good companies out there doing things. But incentives. I am thinking of a company in Des Moines that a long time ago, back in the 1980s—Townsend Engineering. Ray Townsend had had a heart attack and decided to quit smoking. Then he noticed all the people working for him smoking, and he decided to implement a big wellness policy.

This was back in the 1980s. I was very intrigued by that at the time. And in the 1990s, when I first became aware of it, it was a manufacturing plant, employs maybe 300 people, 200 and some people. But the incentives he put in there were tremendous.

Not only did he build a wellness center for his employees, he signed them up in comprehensive wellness programs. He hired a full-time nutritionist and a physical exercise person. Then he gave incentives to his employees that if you sign up and do these things, you get certain things. Like if you do this and this, you will get a day off, an extra day off, for example.

The biggest one, I remember, is that he went on a smoking crusade. Now I could be off on this. I have to check my records on this. But it was like if you quit smoking for 6 months, you got a certain thing. If you quit smoking for a year, you got something.

I think it was if you could show that you went either a year or 18 months or 2 years, something like that, without smoking, he gave you, for you and your spouse, a paid round trip ticket to Hawaii in the middle of the Iowa winter. That is a big incentive.

[Laughter.]

Ms. HIBBS. That is a big incentive.

Senator HARKIN. And two things on that. I asked him, I said, "How could you do that?" And he said, "Well, you understand I own the business. I don't have to answer to a board of directors. So I can do this on my own. I don't have to answer to the board on the bottom line. My bottom line may not have looked that good that year, but I knew it was going to be better the next year."

And second, I said what has been the outcome of this? And the outcome was that in this plant—I will tell you, I have visited since. No one ever leaves work. They love these jobs. His productivity has shot through the roof. He just has a very healthy workforce and his productivity is great, like I said, is great.

He was concerned because his healthcare costs, his plans that he was able to get, the health plans didn't really reward him that much. But he could show the bottom line in terms of how much money his company was making and no absenteeism. No one was taking time off because they were sick.

He worked two shifts, and he said it used to be that 15 minutes or 20 minutes before the shift change you really didn't get any work out of anybody because they were sort of heading out the door. He said now people stay, and they clean up their equipment and they take care of things. He said it was just an amazing transformation of the workforce in his plant. So, again, thinking about incentives.

Now, again, he received not one tax break for this. Why shouldn't he? Why shouldn't a small business or someone that does something like this, why shouldn't this be some kind of a tax credit or a tax deduction or something for them—if they can show these kinds of things, why shouldn't they get these incentives?

So I keep thinking about how we incentivize this—workplace incentives, community incentives, things like that. How do we build in extra bonuses for communities? If they do things like that, would their community development block grant be a little bit more? Or something that would entice people to get involved—yes?

Ms. HIBBS. May I add a comment? Incentivizing workers to reimburse them for physical activity and good nutrition programs participation is a great idea for companies, and we actually work with a company in Marshalltown—Fisher Controls, part of Emerson. They do that in their wellness program. They have incentives for their employees, and we help them track that.

That is a great way to do it. There are other programs that are possible and being done at Ys around the country that also can help increase physical activity and improve nutrition and reverse the effects of pre-diabetes.

There is a great model in Indiana for that, and they have reduced the cost from the original study that was done, which was $1,400 a person, down to $275 a person.

Senator HARKIN. Say that again, Carol. What? I heard about this Indiana thing, but what is it now?

Ms. HIBBS. Well, there is a Y in Indiana that replicated a study done by the NIH. The NIH study showed that people with pre-diabetes conditions, if they were on a program of increased physical activity and improved nutrition that they could reverse the pre-diabetes conditions. It figured out to cost about $1,400 a person.

Now those same people came to the Y in Indiana and replicated that study with the health and wellness staff of the Y, and they did it for about $275 a person.

Senator HARKIN. Amazing. The Ys around this country are now playing and are going to play a much bigger role in this. I am just so thankful for what the Ys are doing right now.

Mr. LEVI. If I could add just one thought or two thoughts, actually? One is, part of what this program was about is that very small changes can result in very big savings and big changes in healthcare and health outcomes. And so, we need to be clear about those kinds of goals.

I think the second part, and I would defer to Dr. Thorpe to actually confirm this assumption, but I think we do see some data showing that there is a Federal benefit to these kinds of workforce wellness programs and having our population get as healthy as it can be. So that when it enters Medicare, it is healthier.

If we have fewer people entering the Medicare system with chronic diseases, then the Medicare costs are going to be lower. And we have to start thinking about who benefits from these prevention programs. That is one of the things that our report looked at, which was Medicare benefits, Medicaid benefits, private insurers benefit. How can we make sure that those who are benefiting from these prevention programs actually contribute to that investment?

One way of thinking about that is, for example, the Medicare program to be targeting the pre-Medicare population, 55 to 64, and doing work with them and community prevention efforts that are relatively inexpensive so that when they enter the Medicare program, they are as healthy as possible.

Senator DODD. Yes, that idea of going back to the notion of the physical exam as a precondition of getting Medicare 5 years before would be—what you could discover and change habits 5 years out in terms of the cost of that person at age 65 is phenomenal.

Senator HARKIN. You said, Doctor, I wrote it down, 95 percent of Medicare is for chronic illnesses?

Mr. THORPE. Right, and I think to follow up, one of the reasons I was suggesting to look seriously even as part of a stimulus package of a universal wellness plan for the uninsured right now is that anything we can do to change the incoming health trajectory of people into Medicare is going to save money long-term.

I mean, the statistic that I threw out was that if you look at lifetime spending of a person at age 65 who is normal weight, no chronic disease, versus that same person who is obese that has one or more chronic conditions, it is 15 to 40 percent less over their lifetime Medicare spent on healthcare.

Senator DODD. What is the number on chronic illness, the number that I have used over the years? Every time I have said it, I wait for someone to jump up and tell me I am just wrong. But the

amount of Medicare money that is spent in the last 20 days of a person's life for intensive care, for instance?

Mr. THORPE. Well, the data we have—the best data we have is really more on the last year of life, when we spend about 28 percent of spending is on the last year of life. And I think the challenge there, too, is that the variation in spending in terms of how much we spend in the last 6 months and year of life is really dramatic.

So the whole area of palliative care models and really looking at some of those models and what accounts for some of the variation and getting into issues of informed consent is another area that would be fruitful to look at.

Senator DODD. I apologize. I didn't mean to interrupt. You were asking a question?

Senator HARKIN. No, no. Go ahead.

Senator DODD. I have to ask Dr. Mahoney one question. I can't resist. I love the numbers that you have and keeping it simple. And also nothing succeeds like success, giving people things they can actually do.

If you come up with too long a list, then you don't do anything. It is like too many warnings on a label on something. It is just so dizzying you don't pay any attention to it.

Flossing. Are you drawing a conclusion about flossing that it is dental care, or do you correlate the relationship between plaque and heart conditions?

Dr. MAHONEY. It is the latter, the plaque and heart conditions. And frankly, given some of our covered population, just plain dental care, just putting the focus on it.

If I could comment just a little bit? We don't, obviously, have a large population into retiree medical, but we have a reasonable population. What we are seeing is very interesting. The investment that we have made in the active population while people are actively employed at the company is carrying over into the pre-65 retiree group and also into the post-65.

So we don't have as robust a mechanism to benchmark this, but we know that our costs per retiree are lower in that group. We can only think that that has to be a carryover from the habits that we were able to change earlier, especially in management of the chronic conditions.

Senator HARKIN. Anything else that anybody wants to proffer here before we call it to a close?

Senator DODD. Could we leave the record open?

Senator HARKIN. Yes, I said that for 10 days.

Senator DODD. Oh, good. Good.

Senator HARKIN. I left the record open for 10 days.

Anybody else?

Mr. THORPE. I would just end up by saying on the leadership side that the leadership in terms of prevention innovation really is coming from the business community because they see the results directly in their businesses. And I think that we could help them by really looking at some leadership in the Medicare program as well, or even the Federal employees program on two fronts.

One is that, as it is currently designed, we really discourage prevention in Medicare. If we have a welcome to Medicare physical, we charge you for it.

If you really are looking at incentives to have a clinical preventive package in Medicare, well, let us put it out there the same way the business sector has done in terms of let us make it so that you don't discourage people from availing themselves of clinical preventive services. I think that that is one issue.

The second issue is that Medicare has to think earlier on. By the time people come into Medicare, it is almost too late. I think to the extent that we are reaching out earlier with focusing on primary prevention and getting people into the system faster in terms of health risk appraisals and physicals and treating them, if they have diagnosed disease, get them treatment right now.

We have a model that does that in the breast and cervical cancer world. This would expand that to other chronic diseases. I think if we treat them earlier, we diagnose earlier, we are going to get better outcomes at lower cost.

The final point I would raise is on the 95 percent figure, the long-term future of the Medicare program really is going to depend on our ability to prevent the explosion of chronic disease coming into the program. If you reach out earlier you can do that, but also how do you manage chronic disease in the program today? And the Medicare program, as it is currently constructed, is ill-equipped to do it.

So that is going back to your question about the community health teams in North Carolina, that model of building the capacity to really manage patients at home. Do the prevention, track them in and out of the hospital, to work collaboratively with the primary care physician practices to prevent things that should never happen—the admission into the hospital for a diabetic patient, the readmission into the hospital for somebody with pulmonary disease. I mean, MedPAC alone has commented that at least $20 billion or so in savings could be had if we were managing these patients with chronic illnesses more effectively.

I think that those are three areas that would all be fruitful perhaps as part of a stimulus package, but certainly as a centerpiece of the healthcare reform debate. I just think that they are common sense things to do.

Senator DODD. Yes. My last comment as many of you may know, I know Tom knows, I have been deeply involved over the last several days in this automobile issue in deciding whether or not we are going to be able to restructure these three automobile companies in a way that they can survive. And obviously, it has just consumed a tremendous amount of time over the last 2 weeks of trying to fashion some way to get there between now and then.

Obviously, a lot of what is going on in the financial community today and so forth is affecting all of this, and clearly decisions made by the industry itself have brought us to this point as well. There are a lot of factors. But one of them is this issue we are talking about, healthcare.

You look at the cost of a foreign-produced automobile. The healthcare cost per automobile is a fraction of what it is here. I think it is roughly $2,000 per automobile as a healthcare cost in

that car, something like that. Very close to that number. I think it is $150 or $200 per car, for a Toyota, someone told me the other day.

These issues, your point, Dr. Thorpe, made me think of it here that, obviously, from a business standpoint, I don't recall back in 1993, by the way, the automobile industry running up around here talking about universal healthcare and reducing the costs. In fact, quite the opposite.

At a time when we might have been able to do something years ago on this issue, there was quite the opposite view. That has dramatically changed, obviously, I think, and we are seeing that in contracts and so forth.

But it is one of the factors that we have to grapple with in all of this, and this is a classic example right now. Not the only cause of all of this or the problem, but it is a major piece of it as well. So it is a very worthwhile point.

Thank you.

Senator HARKIN. Thank you, Senator Dodd.

Thank you all very much.

This has been an enlightening last couple of hours, and you are all recognized leaders in this field of prevention and wellness, and I encourage you to continue to give us the benefit of your insight and your suggestions as we move ahead.

I just said, Jenelle, get Dr. Thorpe's three things for me because I want those. Did you say the same thing?

[Laughter.]

Because we have to move on this. We are going to be really talking about this very soon.

We progress on this, we will be having obviously more hearings involving more parts of our society in this process. I just invite you to continue to follow this—I know you will—and give us your insight, your suggestions, and advice as we move along.

I would just close up by saying, I will just end it where I started. If we don't, I said at the beginning, Chris, I said I will lay down a marker in this whole healthcare reform debate. And it is this.

If all we do is address how we pay the bills, but we don't make prevention and wellness the centerpiece of our reform movement, then we will have failed, because we will just keep paying more bills. We will rearrange how we pay it perhaps, but we will just keep paying more bills.

Somehow we have to just quit making prevention kind of a footnote as a feel-good kind of thing. Oh, everybody likes to talk about it, but it is too hard to do. It is kind of soft. It is not hard. The payback period is 20 or 30 years. Trust for America's Health just showed that the payback period is a lot sooner than that, and I appreciate that. So somehow we have to make this work.

Senator DODD. Senator Coburn, before he left, I think made a point in, again, predicting where this would all end up. But if you look at the various areas and where are the flashpoints, this isn't one of them.

There will be flashpoints, and we know where they are. But this is one where you hear people who have argued for years about what ought to be done in healthcare don't argue about this.

We have a wonderful opportunity to begin on something where there is a lot, I think, of commonality of purpose and interest, and I am very, very hopeful that would be a major, major part, as it should be, if we are really going to address the long-term need.

And so, I welcome Senator Coburn's comments as saying this was an area where he really looked for a tremendous amount of cooperation as well.

Senator HARKIN. Well, thank you very much, Senator Dodd. Thank you all for being here.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF SENATOR ENZI

Thank you for holding this hearing and providing us with an opportunity to discuss a vital aspect of our work on healthcare reform—prevention. The information we will receive today from our witnesses will provide us with a much needed perspective on that matter that will help us to incorporate this important component in our health care system in a much more effective manner.

We are fortunate to have a panel at this hearing that is made up of individuals and representatives of organizations with a great deal of practical experience in this area. I am looking forward to their insights and observations on how we can more innovatively and creatively integrate successful prevention interventions. They will have a great deal to say, I am certain, about how to craft the message of prevention so that it receives the attention and focus of all Americans in their day to day lives.

We all know that any successful reform effort must focus on reducing health care costs to make the system work more efficiently and effectively. If providing the best care at the best price is our goal, we will need to make prevention a key component of any reform measure. There is no question that the high cost of health care is directly related to the increased incidence of chronic diseases. The more we direct our efforts to preventing the onset of these diseases, the less we will need to spend on treating them in their advanced stages.

Unfortunately, we are still not doing a good job of educating Americans on how they can prevent the onset of chronic illnesses. Instead, we have directed our efforts at treating these diseases after they have already developed.

The statistics are alarming and we ought to be more concerned. Chronic diseases like heart disease, diabetes and cancer currently account for 1.7 million deaths in the United States each year. Although these and other chronic diseases are among the most common, costly and deadly, current medical data makes it clear that they are also the most preventable, mostly by making lifestyle changes that are really just common sense. With a little willpower, these changes can be put into practice and the results that can be achieved would have a great impact on our personal health as well as on our health care system as a whole.

If Americans would make primary prevention interventions a part of their daily lives, our healthcare system would, over time, change dramatically. Primary prevention includes regular exercise, eating balanced and nutritious meals and eliminating risky behaviors, like quitting smoking. With all of the information out there about how successful these primary prevention interventions would be if they were put into practice, it is a great disappointment to see how few Americans have taken advantage of the information many of them are well aware of and made these changes a part of their daily routine.

Americans also need to be better informed and made more aware of the price and quality of the healthcare services they receive. If people had better access to comparative information on prices and

quality, they would take more control over their health and make the kind of choices that would improve the quality of their lives.

Secondary prevention interventions are another important component we must improve if we are to make the system better as a whole. Having regular check-ups and frequent contact and interaction with a primary care physician will make patients more aware of their health risks. It is also important for patients to get the appropriate screenings for diseases that can be prevented if detected in their early stages. Cancer is an example of a disease that can be controlled or cured with regular screenings. Early detection leads to a 98 percent survival rate for breast cancer and a 92 percent survival rate for cervical cancer.

In my Ten Steps to Transform Health Care in America legislation, prevention is number six on my list, but when it comes to those things we can all do as individuals to improve our own health, prevention ranks right up at the top. In my proposal I emphasize the importance of preventive benefits and the need to provide assistance to individuals with chronic diseases so they can better manage their treatment and care. I believe that any plan purchased with a tax subsidy must include basic preventive services and a medical self-management component. This is critically important if we are to prevent disease, and not just treat its symptoms after it has already begun to take its toll.

Prevention works and it is time for all Americans to make it a priority. I have no doubt they will do so if we ensure they have the information they will need to continue to make the changes that will make their lives happier and healthier—and longer. The more we are able to increase the awareness of prevention programs and the role they must play in our healthcare reform effort, the better we will be able to encourage all Americans to take better control of their lives and promote the behaviors that will lead to better health. It is time to change our healthcare system from one that is centered on sick care to one that is more directed toward preventing illnesses and promoting health which will ultimately make it possible for us to reduce costs and increase availability.

I want to thank the witnesses again for their time, their knowledge and their willingness to join us for this important discussion. Their expertise will prove to be very useful as Congress continues to consider the reform of our health care system.

PREPARED STATEMENT OF SENATOR HATCH

I thank our expert panel for being here today as we examine the benefits of prevention and health promotion. It has been estimated that the United States spends annually $2 trillion on its health care system. As we in Congress engage the topic of health care reform, the financing of health insurance coverage and access to care will likely be at the top of debate. It is easy to understand that if people are healthier, health care costs are less to both the individual and the system as a whole. Preventive health services reduce hospital stays, emergency room visits, and long term disability. Simply put, disease is expensive; and prevention can save people's lives and money.

According to the Center for Disease Control's (CDC's) National Center for Chronic Disease Prevention and Health Promotion

(NCCDPHP), chronic diseases like diabetes, cancer, and heart disease are the leading causes of death and disability in this country. Accounting for 70 percent of all deaths in the United States, chronic diseases are among the most common and costly health problems. They are also among the most preventable. Better nutrition, being physically active, avoiding tobacco and alcohol use, and other healthy practices can prevent or control the destructive effects of these and other diseases. Yet it has been estimated that less than half of the most effective preventive services are being delivered to the people they could help.

Delivering preventive services that are proven to be effective is essential to improving America's health, and linking clinical and community preventive services should be explored as part of the health care reform debate. Clinical preventive services provided by a healthcare professional, such as counseling, screening, and immunizations, have helped to improve the health and lives of millions of Americans; however, the community components of health promotion should not go overlooked. We will get a greater return on our investment if we do not limit focus to the traditional healthcare arena. Many of the most significant advances in health are the result of policies aimed at health risks that are not typically addressed in traditional healthcare settings—such as food safety and restaurant inspections, clean water and air, speed limits and seat belt use, fire prevention and building standards, and so on.

We must also examine other methods of prevention, such as workplace wellness programs. Employer-sponsored wellness programs are a good idea because everyone benefits. Healthy employees are more productive; and healthier people also reduce the burden on the health care system as a whole. Employers benefit from lower plan costs and higher productivity. Studies have shown that health care costs for workers who participate in wellness programs run below costs for nonparticipating employees, and that consumer-directed health plans can lower annual claims-cost increases.

Throughout my Senate career, I have been a strong proponent for preventive health measures and have helped to create many of the Federal prevention programs and initiatives that have been successful in helping States and local communities to implement prevention and wellness programs. The benefits of prevention are significant, and spending more on treatment alone will not bring about the substantial improvements in that health we seek. We must evaluate the whole picture. Once again, I thank our panel witnesses for joining us here today to share their expert testimony as we consider the important role of prevention and health promotion in health care reform and how preventive services and programs can save lives, money, and make people healthier.

QUESTION OF SENATOR CLINTON FOR JEFFREY LEVI

Question. In your testimony, you mention the critical importance of investment in community and clinical prevention, as well as stable and reliable funding for public health programs. Can you please discuss the ways in which the establishment of a Wellness Trust within the Centers for Disease Control and Prevention would help to meet these goals?

[Editor's Note: The response was not available at time of print.]

The committee will stand adjourned subject to the call of the Chair.

Thank you all very much.

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