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**Why So Many Americans Are Sicker and Die Younger than
Others?
Robert Wood Johnson Foundation
February 28, 2008**

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RISA LAVIZZO-MOUREY, M.D., M.B.A.: Good morning. I am Risa Lavizzo-Mourey, the president of the Robert Wood Johnson Foundation, and I am thrilled to welcome you all here. You know, as I watched Kenyan's story, I deeply appreciate the reason why we are here today and why it is so important that the Robert Wood Johnson Foundation is creating a commission to build a healthier America and one that will look beyond the health care system for first ways to improve the opportunities that everyone has to choose a healthy lifestyle; second, to get more out of the tremendous investment that America makes in health care and third, to address the vast differences that we see in health, one American compared to another.

Now, our thought process went something like this. Let's identify some of the smartest minds in the country, people who sometimes don't work at all in health care and let's challenge them to tackle a problem that most people can't define and if they can, they think it is so large and so encompassing that there is nothing that can be done about it and then we said we would give you less than two years to get actionable solutions. Now, as I say that out loud to you now, I realize that it took a lot of nerve to think something like that up but then think about Kenyan. Here is a young man, middle class person, who found himself on a road to chronic illness and one that would lead to ironically a lot of other

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illnesses. It was a road that his family was familiar with, his mother, his grandmother, his aunt all had diabetes and he had a grandfather who died of heart disease.

Now, the obstacles to good health for Kenyan were in many ways invisible but they were there nonetheless. The obstacles were there in the neighborhood he lived in that was dotted with fast food restaurants and corner stores that sold cheap liquor and cigarettes. They were there in the difficulty he had in getting healthy, fresh foods in his neighborhood and they were there in the education that he and his family received about making healthy choices.

So, Kenyan at 15 and almost 270 lb. as he said was facing a road that was not at all optimistic and what is worse is there are thousands of Kenyan's like him and a whole generation who have the potential to inherit and pass on the same unhealthy path.

What is hopeful in Kenyan's story is that it paints a vivid picture of the problem but also maps out a vision for the potential that this commission has because in his life, we see the opportunity to make a difference. We see that change can happen when people are educated about their health risks and when there are positive ways for them to make improvements like the program he talked about, students run Philly style. And that can be done without adding on to the burden of our medical care system. We see in his story how education plus local and

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effective programs can empower and enable people like Kenyan to make choices necessary to live a healthy life their whole life. The question we face is how do we do that and sustain it for the thousands of Kenyan's that are not in that video? So here we are after many months of planning for this commission and we have a national commission whose charge it is to look outside the medical system for practical, proven ways to improve health.

Now, in many ways this is exactly what the Robert Wood Johnson Foundation has been leading up to. We have invested and fostered in ways to make Americans healthier for almost three decades and next month the *Journal of Health Affairs* will be releasing a special edition that focuses on disparities that is funded by the foundation and this journal opens with two important influences, non medical influences that will be critical to the commission: neighborhoods and education.

In fact, what we want this commission to do is to knit together much of what we know about the variances in health and also what we know about common sense practical things that can be taken in an actionable way to improve health. We have come beyond the point where we can rely on more health care and more technology to solve all of our nation's health care problems. So, this newly empaneled commission to build a healthier America is being asked to explore some very important questions, questions like why are some Americans so much more

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healthy than others? And why as a nation are we not the healthiest nation in the world? And how does the context in which we live affect the health that we can all expect to have? And what can we do to change that context?

So to help get answers, the foundation produced a report to identify the dimensions of the problem that would be research based and would be a scientifically sound starting place for the commission. We wanted the commissioners to have the facts so that you could move quickly to solutions to help us become healthier and that is precisely why we have assembled a group of people who are as diverse as this commission is. We have economists, educators, doctors, journalists, business people, labor leaders; we have commissioners who are steeped in community building, in health policy both at the federal and state level in religion and in private sector development. I want to personally thank our cochairs, Mark McClellan and Alice Rivlin for agreeing to cochair this impressive panel. As we consider the work ahead I can think of no two people better suited to do this.

Now, this call to action goes beyond this group and beyond this room. It is going to involve organizations and groups all across the country and in every sector of our economy. It is going to require us to focus on issues like housing and education and make those groups see that their work is critically connected to health. It is going to require

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mobilizing partners that in every aspect of American life in order to truly change the trajectory of health in this nation. I am passionate about this and the foundation is deeply committed to it. We believe that the moment for action is now and there is one thing that I can promise to you, this is not going to be a commission that produces another report. We are poised for action and we demand action. At the foundation our mission is to improve health and health care. If we weren't taking this on, we would not be true to our mission.

So, that is why I am pleased that in addition to the stellar line up of commissioners, we have David Williams who is one of the foremost leaders in this area to be the staff director. He has been a great vision and inspiration as we have looked at the research and tried to define and design this commission so that it could indeed improve opportunities for everyone to make healthy choices, enable our country to get more out of its health care system, and to change our track record in the vast differences of health among Americans so David, I turn it over to you to tell us about this report and to launch this commission. The floor is yours. [Applause]

DAVID WILLIAMS, M.P.H., PH.D.: Thank you, Risa and good morning everyone. It is my pleasure to be here today and to welcome you as the Robert Wood Johnson Foundation Commission to build a healthier America begins its work. Over the next year and a half, the commission will investigate how to make

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all Americans healthier, not by examining how to improve hospitals or the medical care system but by looking at all of the things outside of that system that determines whether someone in America lives to be 55 or 75, whether they are overweight or in shape, or suffer unnecessarily bad asthma attacks or can breathe freely. This commission is going to reach out to communities and conduct regional field herons because we want to know what is working in communities now and making it easier for people to be healthier. We believe that in order to take this kind of unique and complex look at America's health we have to look beyond our typical comfort zone and break down the silos that have traditionally separated our areas of expertise.

To do that, we have assembled a phenomenal group of men and women who come from industry, academia, advocacy, and government. They are experts in education, economics, health policy, management, health disparities, finance and policy making. Led by our esteemed cochairs, Alice Rivlin and Mark McClellan, the commissioners who are present today with us are and as I call your name I will ask you to stand, Kate Baker, Angela Blackwell, Sheila Burke, Linda Dillman, Senator Bill Frist, Hugh Panera, Dennis Rivera, and Gay Warden. Commissioners who were unable to attend the launch today are Alan Goldston, Katie Haycock, Carol Simpson, and Jim Toui. Today we are grateful and excited to have such a distinguished

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group of national experts to serve on the commission and we thank all of you for being here and for taking on this charge of taking on this very difficult task.

Now it is my distinct pleasure to introduce commission cochair, Mark McClellan. Mark is both a physician and an economist. He is the former FDA commissioner and a former administrator for the centers for medicare and medicaid services. Dr. McClellan is current directing the Engelberg Center for Health Reform at Brookings Institution. He has dedicated his entire career to improving America's health and has wide range in expertise in health and economists that make him a natural fit for his leadership role with the commission. Dr. McClellan? [Applause]

MARK MCCLELLAN: David, thank you very much. It is a privilege to be here today with all of you and you know we have got a stretched goal for this commission. We have a stretched room to go along with it. For those of you who are standing, there are a number of seats down at this end, if you want to get in a few extra steps and also get more comfortable. There are plenty of seats down that way.

As I said, it is a privilege to be here today with David and Alice Rivlin to help launch a unique effort that I think can make a real difference in the lives and the health of all Americans. The commissioners who are serving with us in this effort are a truly distinguished group and I want to thank

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them in advance for a lot of hard work in a limited period of time to make a big difference. I am very confident that with their participation and leadership we will succeed. I also want to give a special thanks to Risa Lavizzo-Mourey and all of the staff of the Robert Wood Johnson Foundation. This is a foundation that knows how to change the agenda for this country. They played an important leadership role in helping to build a big collaboration behind raising awareness on other key health issues like the problems of the uninsured. I am confident that with their leadership here, we have an opportunity to bring another issue to the floor that is also extremely important along with improving health care to improving America's health and that is for reasons that don't appear to have much to do with health care.

There is a big gap between how healthy we are and how healthy we could be. Americans at every income and every education level could be significantly healthier than they are. You have got clear evidence of that in the report that the foundation is releasing today which shows huge gaps, huge lags affecting particularly Americans in lower socioeconomic and income groups. Something that I think is not as widely appreciated as well as it could be though is that in some respects even wealthy Americans are not doing so well. There are big gaps there as well. For example, in a number of important measures of health status, wealthy Americans appear

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to be less healthy than middle income citizens of England so clearly there is something more going on here. We need to find the right practical strategies to change it, to help all of Americans close the gap between how healthy we are and how healthy we could be.

Health care is very important and health reform is going to continue to be important but if we don't also make progress on these other major factors that are such important determinants of health and of our costs of disease it is going to be very hard to achieve the goals of health care reform and it is going to be impossible to get the goal of a healthier America so the commission is going to investigate practical strategies that are being developed and implemented around the country in the public and private sectors to strengthen our health and close the gap. The overcoming obstacles to health report being released today challenges all of us here in this room and all over the country to expand our focus beyond just the medical care system as we really want to improve health and enable America to reach its full health potential.

Only when we can make progress in addressing these broader issues can we improve the health of all and there is compelling evidence in the neighborhoods where we live, the quality of our children's education, our income, whether or not we exercise, eat right, feel connected to our communities, have the support of friends and family, all of these factors have a

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bigger impact on whether we stay healthy than doctor visits or insurance coverage.

You know, I experienced this myself. You heard from David I spent a lot of my career in health care and health policy as an internal medicine physician and I used to do stents in the emergency room and I saw a number of patients there where we come in and treat them for their heart failure, exacerbation of the diabetes that was out of control, give them medicines they need, get them stabilized, we know in talking to these people that this wasn't going to change, that they were going to be back, that we weren't really getting at the underlying problems that could help make them better for the longer term. The patients that I saw and millions of other Americans have more health problems and higher health care costs and will die much sooner because of their choices about how they live and because of the environment in which they live.

So, to improve health and not just health care for all Americans, we need to do a better job of improving the factors outside of the medical system that affect people's daily lives. How can we help all children get to three healthy meals a day? How can we get to more exercise? How can we get to more completion of effective education programs? How can we get to safer neighborhoods? All of these questions, as Risa said at the outset, sound like an enormous undertaking and of course

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everything starts with personal choices about health but I want to tell you based on the work that we did in setting up this commission, we have already seen many examples of innovative interventions around the country that are making a really difference at the local level, in the private sector in collaborations to help people get to better health. Some of these initiatives have been funded and nurtured by the Robert Wood Johnson Foundation already but there is much more than can be done.

Just to give you a few quick examples, a group of leading Minnesota businesses including Best Buy and Blue Cross/Blue Shield of Minnesota and Cargill have created a non profit foundation to invest in and test early innovative childhood education models, determine which ones lead to improved economic development opportunities and improve health along with it. This grew out of a study by the federal reserve bank of Minneapolis which found that cost effective interventions and high quality early education led to future local economic development and addressed some of the gaps that we have been talking about today.

Another example, in 1992 the Philadelphia Food Trust began to develop educational and marketing campaigns to increase consumer demands for nutritious foods and to promote farmer's markets and other community based nutrition education initiatives. The food trust is partnered with state and local

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governments to develop a program with government funding and matching private sector investment to finance the development of fresh food programs in grocery stores serving underserved communities.

Another example, in King County, Washington, a healthy homes pilot program funded by the National Institute of Environmental Health Sciences found that regular visits by community health workers, not health care workers, community health workers, designed to reduce children's exposure to conditions in their home that caused asthma led to both significant improvements in health and health care savings, not a traditional health care program, a change in the environment, a practical, feasible change in the environment that led to better health. We intend to explore real life examples, practical examples, like these and coupled with identifying concrete measures of making progress in our nation's health, we intend to have this commission make a real difference in improving opportunities for everyone to make healthier choices and in doing this we are going to depend on a lot of you in this room as well.

Many of you here have a lot of experience with not only influencing health care but thinking about health and health care in new and innovative ways. I personally think that as health care costs continue to rise there is going to be more and more emphasis on breaking down the barriers between what

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people have traditionally thought of as health care and other steps that we can take as communities, as groups working together in the public and private sector to improve our health and so we are going to need to call on all of your experience to help us make the most of this opportunity to change the way that people are thinking about these issues, and change the health of the nation.

I think the benefits of this kind of change can have some important big time effects on not only improving health from individuals but also affecting our businesses, affecting productivity and competitiveness as we heard from some of our commission members already, improving our communities, creating a better and stronger nation overall, so while many questions remain, we can start now to apply the new evidence on finding ways to strengthen all Americans' ability to make healthy choices, to remove the obstacles to improving health.

This kind of action is not going to be easy. It is a fresh way of thinking about some very long term difficult problems but reducing the large gaps and the big lags in health in this country is essential to our future and I am so glad to be part of this effort to take it on. So thank you Risa. Thank you to the Robert Wood Johnson Foundation. Thanks especially to all of you who are going to be part of leading this effort. We have got a lot of work ahead.

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I would like to turn now to my cochair, Alice Rivlin. I am pleased to have her as a partner in helping to address this important challenge. She has got a tremendous amount of experience from her work at CBO, her work in improving communities like Washington, D.C., and her general no nonsense approach to dealing with tough problems in a collaborative. Alice, thank you very much. [Applause]

ALICE RIVLIN: Thank you, Mark. I am delighted to have this opportunity to work with the Robert Wood Johnson Foundation and Mark and this great group of commissioners on this important topic.

As you now know, we want to build a healthier America but we won't focus on the health care system. This commission will try to answer the question: what can we do outside medical care delivery to help Americans make healthier choices?

Now it is not news that Americans are far less healthy than we could be. You all know that. We have a high level of chronic disease, diabetes, hypertension, heart disease. We face an epidemic of obesity including among the young. Information collected in the report to this commission documents dramatically that Americans with low income and lower levels of education are distressingly unhealthy but they are not the only ones. Middle income and even upper income Americans are not as healthy as they could be and it is not news that we spend more than every other country in relation to

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our income, every other country, and have less good health outcomes. This year we will spend about 17 percent of our gross domestic product on health and the latest projections show that proportion rising to 20 percent conservatively by 2017. That is \$1.05 going to health care but we don't have as healthy lives as many countries that spend less per person. Most other industrial countries are in the 10 to 12 percent of GDP range and they have better health outcomes. It is also not news that our expensive health care system doesn't cover the whole population, that some 47 million people do not have health insurance and that many do not have access to regular primary care or prevention.

And a lot of us including many people on the commission are spending time and energy to work on how to expand health care coverage and move toward more universal care and many of us are working hard on ways of improving the efficiency of our woefully inefficient health care system so that we get more health for the investment dollar but health is not just about medical care. If we suddenly had universal health care coverage and access to good care for everyone, America would not suddenly or even gradually become a healthy country. Most people have access to pretty good health care when they get sick now and they are far from as healthy as we could be.

So, our behaviors affect our health, good diet, regular exercise, avoiding tobacco and harmful drugs have a huge

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impact. Our neighborhoods affect our health and our ability to make healthy choices. Neighborhoods with polluted air and water, no grocery stores with fresh food, high crime and few open spaces are just not easy places to make healthy choices. And social interactions affect health, the atmosphere in the work place, the attitude of bosses and coworkers, and friends and family and neighbors can support and reinforce healthy choices or they can make them a lot more difficult.

The commission will document and publicize the influence of non medical factors on health but the big question we want to tackle is what do we do about it? How do we design and implement policies that will help Americans make healthier choices? That is what the commission will be spending our time and effort about.

We don't have the answers now, although as Mark pointed out we have some good examples. We will be sharing our experiences. We are not all academics. We have business people and union representatives and community organizers and people with political experience that have networks all over the country. We will be drawing on that experience and those networks and the research of the staff to identify practical examples of policies and programs that are working to make Americans healthier. We hope to have an impressive list and to be able to identify practical steps that can be taken by businesses, workers, communities, schools, faith based

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organizations, and government at all levels to get Americans on the track to better health. Thank you. [Applause]

FEMALE SPEAKER: This is Oak Hill, West Virginia, and I am not sure what our population is. I think we just added like 3500. Our family has been in the area for over, going back to my grandparents, 100 years I would say. [FILM CLIP 00:27:01 to 00:30:06]

DAVID WILLIAMS, M.P.H., PH.D.: Of all the things about the Elkins' story that affect me, I find that the way the Elkins' family have to struggle as working Americans just to reach average health, not good health but just to reach average health, the most disheartening part of their story, although as someone who has devoted most of his career to studying and understanding the differences in health between rich, middle class and poor, between Latino, black and white, between well educated and less educated, at another level it is not very surprising.

At this point, I would like to provide you an overview of the findings of a new report that is being released today. This report entitled overcoming obstacles to health was put together by our excellent research team at UCSF led by Dr. Paula Braveman. Dr. Paula Braveman, could you stand and be acknowledged for your hard work and the team that you work with? [Applause]

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This report gives us the status of the health of the American population. It confirms that there are enormous variations in the health of all Americans and that all Americans are not reaching their potential when it comes to health.

All Americans could be healthier than they are today. Millions of Americans die earlier than they should and far too many suffer from diseases that could be avoided. So the health of America the report concludes depends on the health of all Americans. A nation's health is one of its most precious assets and while America has seen great gains in improving health overall, some Americans face much more poorer prospects for good health and longer life than others.

This report reviews the overall health profile of the U.S. population. It presents new national evidence of differences in health across income and education groups and how very late the differences in health by race and ethnicity. It provides new evidence of the economic and human costs of social differences in health and it examines the role of both personal responsibility and societal responsibility for health within the context of where people live, work, and learn, which influence both the choices that people have and their ability to make healthy choices. The report also offers a framework for looking beyond the medical care system for proven ways to improve the health of all Americans.

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So what are some of the key findings? First, Americans are less healthy than people in many other countries. Despite its wealth and despite spending more on medical care than any other nation, the U.S. ranks at or near the bottom among industrialized countries on health and we are losing ground. The U.S. ranking on infant mortality slipped from 18th in 1980 to 25th in 2002. Despite improvements in life expectancy over the last quarter century, the U.S. has not had the same gains as other countries. From 1980 to 2003, the U.S. ranking on life expectancy fell from 14th to 23rd. In all social groups, health falls short of what it could be. Health differences across income and education groups are seen in a range of conditions from the beginning of life to old age.

For example, babies whose mothers have less than 12 years of schooling are nearly twice as likely to die before their first birthdays as babies who were born to mothers with a college degree or more education. More education the report finds is also linked with longer life. College graduates, men and women, may expect to live at least five years longer than people who have not completed high school. A similar pattern in life expectancy is seen for income with higher income men and women living longer than people with lower incomes. The percentage of individuals, reporting being in fair or poor health, increases as levels of income and education decrease.

For example, rates of poor health are about seven times

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higher among children in poor families than children in affluent families. Individuals with lower family incomes are more likely to have chronic disease that limits their activity. Nearly one in every three poor adults is limited by chronic illness and when people are sick they cannot do as well at school, at home or at work. Diabetes is twice as common among poor adults and heart disease 50 percent higher when compared to those in the highest income group.

These examples show that socioeconomic differences in health do not affect only the poorest or least educated groups while people in the most disadvantaged groups typically experience the poorest health, even middle class Americans are less healthy than Americans with greater advantages. The report also finds that socioeconomic and racial or ethnic differences are closely linked. Over the past several decades, research has also cumulated on the existence of large and avoidable differences in health according to race or ethnic group. Black Americans, American Indians, Hispanic Americans, Pacific Islanders, and some Asian American groups are disproportionately represented among the most socioeconomic disadvantaged groups in the U.S. But we find in our research that both race and economic status independently and in combination contribute to health inequalities in the United States.

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For example, fair or poor health is more common both among adults with lower incomes and among black and Hispanic adults. When income and racial or ethnic group are considered together, income gradients in fair or poor health are seen within each racial and ethnic group and racial and ethnic differences are seen at each level of income.

These patterns displayed here for health status but seen across a wide range of health conditions tell us that both income and race are important for health and health disparities. Geographic differences in health often mirror geographic differences in income, education, and racial or ethnic composition. There are dramatic geographic variations in the income and education levels of Americans across this great country. These differences in turn often correspond to striking geographic differences in health.

For example, this map shows how rates of death due to heart disease vary across U.S. counties. A 1998 study reveals that there are dramatic differences in life expectancy across U.S. counties.

For example, black men in the county with the shortest life expectancy for blacks live to only 58 years, well below the average life expectancy in many developing nations, while white men in the county with the longest life expectancy for whites could expect to live to age 78, that is a full two decades difference in life expectancy in the United States by

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geography. It is not difficult to understand why the poor would have worse health than people with greater incomes.

For centuries, poverty has been linked to ill health. You will see here that the United States has a higher proportion of its population and particularly of its children living in poverty than most affluent countries, but health shortfalls are an issue of concern for all Americans. Although the poor and the near poor are generally most affected, middle class people frequently have poorer health than the most affluent.

All of us, we are not realizing our potential as a nation. Even the affluent can improve their health. All of us could be doing better. This reducing health inequalities and improving health can benefit all Americans, the middle class and the poor, the affluent and persons from all racial or ethnic backgrounds. Social differences in health are costly in economic terms.

The most obvious cost results from ill health itself. Poor health limits the productivity of our citizens which can lower economic growth rates and over long term can affect the standard of living. The social conditions that cause health disparities also have hidden costs, reflecting profound effects in other sectors of society beyond health.

For example, inadequate education not only contributes to the social differences in health, it can also make workers

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less competitive for employment and less productive in the labor force. How large are the economic gains of a report deals with that and you can read the report and get some information on that.

What are the factors that influence health? How important are social factors? Well as we review the evidence, many factors influence health: Age, sex, genes clearly matter for health, but individuals have no control over their age or over their sex and genetic makeup with which they were born but where and how people live, learn, work, and play has a tremendous impact on health.

A great deal of attention is being paid to improving the effectiveness of medical care and increasing access to the medical care system. A report today presents compelling evidence that in neighborhoods where we live, the quality of our children's education, our income, whether or not we exercise, whether or not we eat right, whether or not we feel connected to our communities and have the support of friends and family have a bigger impact on whether we stay healthy than doctor visits or insurance coverage. Fortunately, many of these social factors can be substantially influenced by social policies and programs.

Health care is important but good diet, regular exercise, not smoking, avoiding drug and alcohol abuse, and adopting healthy lifestyles can have a huge impact on the

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health outcomes of Americans. The framework on the screen illustrates relationships among some of the key factors that influence health and thus represents potential opportunities for improving health and reducing health inequalities, although the relationships are far more complex than depicted in the diagram, this simplified framework highlights several important concepts.

First, living and working conditions shape individual behaviors and affect health in other important ways as well. It shows that behaviors are shaped by living and working conditions. The physical and social environments can be overtly hazardous.

For example, they can be polluted or crime infested. They can also severely limit choices and resources available to individuals. For example, an individual's ability and motivation to exercise and avoid smoking and excessive drinking can be diminished by living in neighborhoods that lack safe areas for exercise where intensive tobacco and alcohol advertising target poorer and minority youth and where liquor stores are plentiful and where healthy role models are scarce.

In addition, neighborhood socioeconomic conditions can affect whether its residents smoke, drink alcohol, have healthy diets, and pursue protective reproductive health behaviors. By the same token, aspects of living and work environments such as the presence of side walks and play grounds in neighborhoods,

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after school physical activity programs for children and youth, nutritional food services in schools and work places, and onsite facilities for breast feeding can promote health by encouraging healthy behaviors and making it easier to adapt and maintain them. Similarly people are more likely to receive recommended medical care when facilities are accessible from where they live, work, or study.

Now, no one would deny that individuals make choices for themselves and their children that have health consequences. Ultimately not only individuals and their families but in many cases society will bear the consequences of some of these choices. That is why it is important to look for ways to help people choose health. We can do this by strengthening the ability to make healthy decisions, by removing obstacles to healthy choices, and by creating more opportunities to be healthy, particularly for those groups of people whose options have been most limited.

Research has shown how family income in one generation shapes family income in the next. Obstacles children encounter early in life can create a negative chain of events that is often difficult to break and can transcend generations. Effectively improving health and addressing health disparities will require expanding the focus of discussion beyond medical care and personal behavior to the broadest social and economic context. We need to give consideration to new strategies for

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expanding opportunities to healthy futures for all. Knowledge based directions to explore include a range of community based initiatives that can lead to healthier communities both by attracting additional resources and by building and developing on community strengths, programs to improve development in early childhood, leading to higher educational attainment which in turn can improve adult health, youth development programs targeting youth in disadvantaged communities, strengthening community colleges and increasing financial access to college for low income students.

Other evidence also documents in the report the effectiveness of interventions with potential to improve health and reduce inequalities. These include decreasing teenage smoking by engaging high school students in community advocacy activities that address influences on smoking and increasing exercise by creating or enhancing places for physical activity or enhancing the length or intensity of school physical education programs.

This is a timely moment to seek solutions. Solutions to the complex problem of improving health and reducing health disparities will not be simple as our cochairs have indicated but this is an opportune time. There is widespread recognition by business, government and the general public that medical care costs must be brought under control that creates a sense of urgency for action. Pervasive concerns about global

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economic competitiveness add to pressures not only to reduce health care costs but to have a healthier and thus a more economically productive work force.

Debates about health policy in this country rarely have focused on the powerful influence of social factors, these factors outside of the health care system that we are talking about. This is the moment to bring the attention of policy makers and the public to these influences in part because of the accumulation of scientific knowledge about health but because this is also a time to make decisive actions. The health of America depends on the health of all Americans. All of us can be healthier and it is the time to act.

Perhaps the most important reason to act now is the shared American ideal for fair opportunity for every American to pursue life, liberty, and happiness, all of which depends on good health. This is a timely moment to seek better ways to help people choose health, to strengthen individuals' abilities and resources to make healthy choices and to remove the avoidable obstacles that deter too many Americans on the road to leading a long, healthy, productive and fulfilling life and Americans agree that the time has come for something to be done.

To shed light on how every day Americans understand and react to the findings in the report, we have Anna Greenberg of Greenberg Quinlan and Rosner Research and Bill McInturff of

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Public Opinion Strategies to share some research findings with us. [Applause]

BILL MCINTURFF: Hello, hi, Bill McInturff of Public Opinion Strategies and Dr. Greenberg will wrap up before Q&A with observations that put this into a perspective about timely solutions.

Let me tell you a little bit more about the work that we did for Robert Wood Johnson, if you can move on to the next slide. We did a very large national study and that study was 1,000 adults plus but we also did sub samples with 250 African Americans, 250 Latinos, 250 of what we labeled vulnerable adults, these adults are people who have less than a college degree, household income below \$50,000, 18-64 years old, and then their demographic counterparts in some ways, people 18-64 who have college graduates or better and \$50,000 plus and you will see in a minute how profoundly those different perspectives are, and what you will also see I think and what is so compelling about this research is the way that real people reflect the observations and findings of these statistical reports in what they report.

Number one, as we move on, the majority of Americans say in terms of what is the personal importance to them that it is important to them on this scale of 1-10 that we as a country try to reduce health differences due to social factors and compellingly when we ask not what is of importance to their

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country but what is important to you, that number overall matched the resolution and want to see a resolution in the war in Iraq.

Another way to measure this, 70 percent of the country agreed in a very strong number, 52 percent strongly agree in this one statement. We can move on to the next slide, please. It is important to make sure health differences between groups of people in this country no longer exist because of factors such as income and education.

Now, moving on to the next slide. What is also true is that people in this country recognize, this is one of the things we try to do in this survey which is do people accept the basic premises behind this new Robert Wood Johnson Foundation commission? And as we move on, we gave people to the next slide please, we gave people this set of factors and we said to the people does this have a positive influence in your health? A negative influence or does it not make a difference one way or the other?

So, the point we are making here is by asking people and telling people you can say it doesn't make a difference, they had to kind of pick these factors and what you are saying is 82 percent of Americans say sure, it makes a positive influence whether you live in a safe neighborhood; 67 percent say it makes a positive influence in terms of having higher education achievement; and 68 percent say it is a negative

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influence having low income. Throughout this world, people are very, very responsive to believe there is a strong relationship between poverty and health in terms of what they recognize and see.

Now, point number three, we asked people about their own health. How do they see themselves? And again, people self report near these findings, so we move onto the next slide. On a five point scale, we said are you in excellent health, very good health, good, and then are you at only fair or poor?

And so we looked just at the top two and the bottom two punches so that overall the majority of Americans say they are in excellent or good health and 16 percent say that they are only at fair or poor health but what happens? African Americans, Latinos, and vulnerable adults, these people have lower income, lower education, are much more likely, and this is what I want to just take one minute.

I want you to remember that all these people in our vulnerable adults of opinion leads are all under 65, so people with the highest age brackets are not in this category. The only difference between vulnerable adults and opinion leads is their education income. The highest education income people, 71 percent, I am in excellent or good health; only 7 percent fair or poor. Their demographic counterparts, same age, just lower education and lower income, 42 percent I am in excellent

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or good health; 23 percent I am in fair or poor health and by the way we have tons of data over the years with Robert Wood Johnson in other studies that show your self report about your health is very accurate. People certainly know their own health and that is a huge extraordinary difference.

Number four, as well, people who are the most vulnerable say that they have less of an ability to control their own health. Number five, and as I said something that I think Dr. Greenberg will hit on as well that people do in this country see a strong correlation between socioeconomic differences in the health of individuals so for example moving on, 91 percent say that it is believable that if you live in poverty or economic stress that you have a higher risk of poor health and almost three quarters believe that people who have less education are at risk of having poor health.

Moving on, and on the positive side, this is kind of I think the advocacy effort where Robert Wood Johnson would like to lead, that 92 percent agree and these are very strong agree numbers that it is important to increase the education level because it not only improves a person's quality of life but will also improve their health and it is important to improve housing and neighborhood conditions because it will not only improve a person's quality of life but also improve their health.

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Now, one thing that people do not believe and this is a statement about our government is they do not believe moving on, they do not believe the current government policies are working to reduce health differences so for example we gave people a positive advocacy statement, if you go to the next slide please. We said do you agree or disagree with this premise? This premise is current government policies aimed at reducing health differences between groups of people in this country are working.

Here, people don't agree; 60 percent disagree with that statement; 36 percent strongly disagree, so it tells us that although we are looking for individual responsibility in what businesses can do, in what we all need to do, the government clearly has a role and in this regard, moving on, people do think there is a role for government as part of the response to this solution so moving on to the next slide.

We gave people a set of choices between individuals, businesses, people themselves, and as well as the federal government. The majority of people said the federal government has a responsibility to intervene in this area, but what do we see is the same pattern? Those people most at risk, African Americans, vulnerable adults, and Latinos are all substantially more likely to be looking for a response from the government.

Now, moving on, this is a statement that I think and I think you can see as well, these standards of individual

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responsibility in today's presentation, people do have a responsibility for themselves, that is another value that is clearly reflected in this research but when you remind people and you tell people, people have this responsibility, but we say you know some things are beyond our control that can negatively affect our health.

It is important to make sure health differences between groups of people in this country no longer exist because of factors such as income and education. Now this is not a hard premise to agree with people, but still what strikes us as researchers is 60 percent strongly agree; 85 percent agree, and part of what we do in our other work is to try to work with folks to say what is a premise that if you say it out loud and you are talking to groups of people, other people started nodding and said I agree with that, and what we are telling our friends here, this is a premise that essentially that our country broadly accepts and wants to see as a goal and then as a last observation before Dr. Greenberg, more than six out of ten people do agree that this is an issue that affects us.

One of the things that you are going to hear today is this kind of repeated line which we liked and we incorporated in the research, we wanted to test, which is the health of all America depends on the health of all Americans, yet many Americans with less education and lower incomes are sicker and dying younger than they should, resulting in human and economic

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toll for our nation and again roughly two thirds of the country agree with that premise, so it tells you in some ways that lots of the core premises of this commission are already accepted by the public in a way that I do think sets the framework for an interest and a commitment to see what can be done to resolve this issue and to improve this issue. And with that, Dr. Greenberg is going to provide just a little more context as with David about this timely moment. Thank you. [Applause]

ANNA GREENBERG, PH.D.: Thank you. I want to thank the Robert Wood Johnson Foundation for allowing me to be involved in this project, looking at one of the most important overlooked aspects of our country's health.

When you think about the last 15 years and the debates we have had about health and health care, in the early 90's we had a debate that was not dominated by issues of coverage and of the same issue that is with us today as Dr. Rivlin pointed out, and I would say in the last ten years or so an intense debate, particularly post the early recession in early 2000-2001, the costs of health care premiums, co-pays, those kinds of issues, but what we have not seen is a focus on these profound differences in people's health that come from race, class, context, neighborhood, differences that exist as many people have noted regardless of whether or not people have health care coverage.

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I would argue that we are in a critical moment to have this debate, a critical moment to even redirect the debate to some degree, an agenda setting moment. We don't have them very often. I would argue that '91 and '92 was an agenda setting moment, that presidential election around having a debate about health care. We are in another one of those moments and so the timing of this commission could not be better in thinking about how to set this agenda.

The research that Bill and I did suggests that the American public recognizes that this is a problem, that social factors produce differences in health in this country and we believe that and this is actually consistent with what we saw in the report the commission has put out already that in fact that middle class Americans have different experiences of medical treatment, have different experiences of life expectancy, have different experiences of infant mortality, and they also understand that social factors contribute to these health differences, that the context that you are born into that you have no control over, your neighborhood, your social networks, your income, your education, at least in terms of the family you are born into that you have no control over these aspects but there are some other parts that are equally important.

In thinking about how you live, stress— and I think that stress is an incredibly important issue. When we asked

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people in this poll about negative influences on health, after smoking which is obvious, stress was the second most important negative impact on people's health. In other work that I have done on stress, we asked people about the biggest sources of stress in their lives and I was actually a little bit surprised. In the end though, it was completely understandable.

The biggest source of stress came from work, not family, not neighborhood, but work. What aspect of work? How much money you make. Not your ability to get promoted or your relationship with your coworkers, your boss, but literally how much money you make, how much money you actually have, so you think about the kinds of health differences we are talking about today and the kind of differences around income and education level. This is not just because you have different kinds of access to healthy food, medical treatment, it is because literally causes an enormous amount of stress and we know as a mental health issue, stress in an incredibly important issue for people.

Now, people also understand as this poll shows that people's health is to some degree outside of people's individual control and to me one of the most profound and in some sense disturbing aspects of what we found was that the most vulnerable populations are much more likely to believe that their health is outside of their control, so one of the

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things that I think this commission taps into so well and actually it was the last slide in Dr. Williams' presentation was the notion that there is I believe, people believe that a core American value is an equal opportunity, you know, life, liberty, the pursuit of happiness, but predicated on equal opportunity to be in good health.

Now, as Bill pointed out at the end of his presentation, people strongly believe in a personal responsibility to take care of one's own health. Just because people know that people's health is driven by the context you are born into and somewhat outside of your control, people still have a personal responsibility and in fact I think the opening story on Kenyan was really an amazing illustration of how one can be self determined in this and seek control over your own health.

No doubt government has a role to play. We saw a very strong belief that governments, policies, are not working and there is a belief that government has a role to play in this but individuals have a responsibility as well. Government can give people the tools to be healthier and take control of the health in their lives.

So to conclude, Americans do believe that and this was the last slide that Bill showed, that this takes a moral and economic toll on our nation and I go back to where I started that we are at a critical agenda setting moment. This

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commission could not be launched at a better time politically. We are having a national debate. We have been and will for the rest of this year about health care in our presidential election. It is an agenda setting. We have states of Massachusetts and California innovating around trying to figure out that is an issue of health insurance but we still have innovation bubbling up from the bottom. We have awareness on the part of the American public that these differences exist, a belief that it is important, a belief that it is unacceptable, and there is a role to play for this commission to help bring about this profound change. Thank you. [Applause]

DAVID WILLIAMS, M.P.H., PH.D.: Thanks, Bill and Anna. So to recap, we have shown you we have a problem and we have shown you that the American public is ready for us to address the problem and we have assembled an outstanding commission to do that.

We are going to take your questions in just a moment but before we do that I would like to point out that we are launching this commission here in Washington, D.C. because this commission is focused on solutions and making change happen, and where better to do that than in Washington, D.C.? Now this isn't to say that the commission will be advocating for any big government programs.

We will be looking at solutions, large and small, from the private sector, the non profit community, and state, local

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and federal government. But being here especially here at Union Station, puts us in a place that very clearly and very starkly illustrates our point.

In your folders, there is a metro map and you will notice that those of you who got on the metro in Rockville or Bethesda are likely to live six years longer than someone who got on the metro in Columbia Heights. And if you got on in Rosalind, you are likely to live almost five years longer, and that is simply unacceptable in Washington, D.C., and anywhere in the United States. We can and we must do better.

At this point I would like to open the floor to questions. There will be some roving microphones and when you ask a question please tell me your name and organization you are with. See the microphones over here, there is a microphone over here, a microphone over here.

LYNN SNIDER: Good morning. Lynn Snider, National Energy Assistance Director's Association. It is very exciting to see this commission begin its work. In looking through the materials and listening to the presentation, there was discussion about intergenerational legacy of health and conditions to succeed. I was wondering to what extent the commission will be looking at policies and practices regarding our aging population, folks over age 65, and some of the conditions that they need to improve the quality of life, particularly as people live longer and longer lives?

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DAVID WILLIAMS, M.P.H., PH.D.: I think our commission would like to be comprehensive in its approach and look at strategies at multiple age groups including our older population which is a fast growing demographic subgroup of our population but we are also thinking of what we can do to put the next generation on a sound footing and so we also want to begin early and invest in our children. So I think we would like to do both.

SALLY ATWATER: I am Sally Atwater and I serve as executive director of the president's committee for people with intellectual disabilities, it is formerly mental retardation, did you include in your studies or going to focus on people with disabilities including cognitive and intellectual disabilities, physical disability? I did hear the mention of autism.

DAVID WILLIAMS, M.P.H., PH.D.: The commission at this stage would like to be comprehensive in our approach. We also realize we are not able to do anything but we have already had internal discussions in our commission about importance of disability as a factor that should be considered.

But I do want to emphasize a point of which was made that we are looking for you to assist us with not just in identifying problems which is important but also in helping us identify solutions that are working on the ground that we can take a look at and potentially recommend.

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ELLEN ROSCOMB, M.D.: Good morning. I am Dr. Ellen Roscomb. I am a policy scholar at the Woodrow Wilson International Center for Scholars, I want to hail and commend you so much for undertaking this tremendous effort toward building what is really needed as a good society in America.

One of the areas, I understood a couple of people mention were work and the stress factors in the work place but I think that one of the major gaps that hasn't been mentioned by any of the speakers that is a major contributing factor to the body, the epidemic of chronic disease particularly cardiovascular disease, stroke, depression, and diabetes in America is job strain. The impacts of the work place, especially the changes over the last 20 years, the introduction of new work technologies combined with less social and economic security, we have a large body of rich data that show this and March 5th next week we are holding a seminar at the Wilson Center. You are all invited and a press conference after to present all of this new data in a global context. Thank you.

DAVID WILLIAMS, M.P.H., PH.D.: Thank you. We would include work strain as part of stress, work stress, and we identified that the American public is saying that work is a major source of stress. Yes?

CATHERINE CAPPS: Hi, I am Catherine Capps, the President of Health Resources, I was delighted to hear that you referenced where they live, work and study, and I am interested

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in finding out based on what corporate America is doing right now which is investing quite a lot into corporate health, lifestyle, risk reduction, what you see as the role of corporate America in this since as you know Americans spend on the average 2,080 hours at the work place a year so has that been defined yet or is that the next step?

DAVID WILLIAMS, M.P.H., PH.D.: I think we have been trying to be consistently clear that although this event is in Washington, D.C., we are not looking to the federal government alone as a source of solutions. We want to partner with every sector of the American society to see what each can contribute to improving healthy environments which includes work environments for the population so yes we are certainly interested in initiatives that will come from the private sector including corporate America.

ALICE RIVLIN: David, do you want to ask some of our corporate commissioners to comment on that?

DAVID WILLIAMS, M.P.H., PH.D.: They are certainly welcome to, if they would like to. [Laughter]

ALICE RIVLIN: Like Linda?

LINDA DILLAN: I guess that was a cue for me. I am Linda Dillan with Wal-Mart, and I think absolutely corporate America has to play a role. The health of not only our employees, our associates and their families, is important to our continued success but also the health of our customers is

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important to our success and we have a vested interest in this so I think we are all interested in playing a role.

DAVID WILLIAMS, M.P.H., PH.D.: Thank you. I think I will go over here next.

CARL HALEY: Hi, I am Carl Haley with Baltimore Examiner. I am a health and science reporter, there is a lot of focus on changes that take place at the community level, access to safe places to exercise, safe choices, healthier choices in food, is there any particular model or models that you have looked at that could be expanded to bring more of these choices to some neighborhoods that don't have them?

DAVID WILLIAMS, M.P.H., PH.D.: Do one of you want to take that question?

ALICE RIVLIN: That is pretty much what the commission is addressing from here on. We had a good deal of outreach to find some models but we just met for the first time yesterday and so we are not prepared to give you models at the moment. We certainly have commissioners that have experience in communities all over the country and I don't know whether Angela Blackwell might want to say a word or two about what they are finding.

MARK MCCLELLAN: While Angela is getting a microphone there are a lot of programs that are making a difference in communities. I mentioned in my remarks a program in Philadelphia that is bringing more nutritional food choices,

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fresh fruits and the like to neighborhoods that have had limited access, lots of programs like that, that are going on, and Angela has had a tremendous amount of experience with.

ANGELA BLACKWELL: Yes I would site Philadelphia and Pennsylvania at large, really focusing on this issue of how to make sure that fresh fruits and vegetables are available in low income communities but there are literally hundreds of examples like that across the country where people have taken this notion of where you live impacting your health and well being.

Also around the issue of exercise, there are groups that are working with young people to try to bring more opportunities and more focus into exercising into the community life and also parks.

One of the things that is true, many low income communities do not have access to safe parks, parks that are attractive, parts that are safe, parks that are accessible, so there are lots of community groups and government agencies that have been working on that and those are the sorts of things we are going to be looking at and trying to lift up the lessons from.

DAVID WILLIAMS, M.P.H., PH.D.: Thank you. Yes?

DAVID RAVEN: David Raven, Georgetown, I think the concept is sound and the presentations today excellent. But beginning 30 years ago in Canada, there was national programs to identify social discrepancies and to try to act up on them.

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Great Britain as a nation has had commissions and governments that have indicated to different ministries that they should be attentive to the health effects of their policies and we since 1990 have had healthy American programs focusing on these aspects.

How hopeful are you that in reality you will be able to have an impact over time on these discrepancies and health?

In Canada they have acknowledged that their program for healthy Canada was looked at retrospectively ineffective. Great Britain there are continuing discrepancies by social class and health and as you have shown very dramatically with figures, we have gotten worse relative to others, maintained differences by social class in health status.

DAVID WILLIAMS, M.P.H., PH.D.: The hard questions I will give them to Mark. [Laughter]

MARK MCCLELLAN: I'm happy to help and I know Alice and our commissioners have views on this, too. This is actually been a subject of a lot of already intensive discussion on the commission and there are different models for commissions out there. There is I think a consensus within our group that we are going to try to do at least two things to make sure that we do have a concrete measurable impact on the problems and challenges identified today.

One is this emphasis on practical feasible steps that can address the problems. These are big challenges. They have

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been around for a long time. They are not going to go away over night but there are also as you have heard already a number of programs in the private sector, the public sector, in local communities around the country that are making a difference and we are going to identify those and do a better job of highlighting them and finding ways to support them. We are going to couple that with an emphasis on concrete impact so how can we measure progress on these key issues?

There have been a number of commissions that have been set up and succeeded in actually having a real measurable impact on a difference, an important, difficult public health problem and difficult public policy problems that have followed these principles. We need some input from all of you to make sure that we are carrying out this mission and that we are going to get to some accountable results at the end of this less than two year period that we will be able to say you are going to make a difference.

DAVID WILLIAMS, M.P.H., PH.D.: Thank you.

NANCY PALLISON: Thank you, Dr. Williams, my name is Nancy Pallison. I am the Executive Director of local Arlington free clinic but I also represent the national association of free clinics and we certainly deal everyday with the vulnerable populations and I was stricken when I saw the figures up there but not surprised.

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I would just like to say that I do hope that some of your research does focus on the vulnerable populations because I think the need in order to accomplish what you want to accomplish are going to be more difficult in the communities of those populations but I would also like to offer that the national association would certainly like to be a conduit of information out to many hundreds and hundreds of communities across the country to implement some of the recommendations that you come up with. Thank you.

DAVID WILLIAMS, M.P.H., PH.D.: Thank you. I think we agree with your comment and we are looking at vulnerable populations so yes all of Americans need to do better. Some have an even longer journey to go. Thank you. I see a long line here. Let me go back on this side and come back to this side.

RUTH PEROW: Yes, hello, I am Ruth Perow, Summit Health Institute for Research and Education and also out of Many One, a multicultural advocacy coalition. I want to thank the commission and Robert Wood Johnson particularly for acknowledging that if all of America has a cold, certain communities, communities of color in particular, have pneumonia. I wanted to ask what is the process for consultation that the commission has in mind to talk to communities of color and other vulnerable populations and

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representatives so that we might suggest not only solutions but also recommendations?

DAVID WILLIAMS, M.P.H., PH.D.: That is a really good question. One of the things the commission will do will have regional field herons in different parts of the country. Our website, as I will talk about in a minute, is going to be a source of information and updates not only new information but announcements of the activities of the commission so there would be a mechanism where we would want to actually go on the road and listen to communities and what they have to say and especially learn not only about the problem but about things that communities are doing right now to make a difference so we certainly want to build on the strength and knowledge that exists in communities.

BOB ROAR: I'm Bob Roar, at BMJ. The overwhelming amount of health care dollars are being spent on cure and not on prevention, how do you change the paradigm of incentives to emphasize preventive medicine as opposed to the heroic intervention of saving people at the last hour? How do you do that?

MARK MCCLELLAN: Part of the commission's focus is to move our emphasis on doing something to improve health and close the health gaps away from an emphasis on health care and you are absolutely right that medicine in this country and else where has traditionally focused on dealing with health problems

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after they happen, I mean, cures for diseases after they have progressed and our initial focus is going to be away from health care for that reason to put front and center all of these non medical factors that clearly can and do have an impact on choices and on health.

Also, implicit in your question is some concerns about health care reform and this is not a health care reform commission but as I mentioned earlier I do see some convergence coming down the road. What we are learning and by medical science is that there is more and more that we can do to influence the course of diseases and influence their progression or to preempt them before they happen in the first place but a lot of the steps to do that are going to turn out not so very much like traditional medical care.

So, down the road I see more of a convergence between what we are focusing on today which is the non-medical factors that can and do have a big impact on our health and the health care reform factors are continuing to be an important public policy issue in this country.

But, I think in the longer term given where science is headed, given where the limited fiscal and financial resources are that we have available for our health care system, we are going to have to find a way to put these together, more of a unified emphasis on keeping people healthy and staying well, living longer, living better lives at a lower medical cost.

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So, I think it can come together in the end but right now we are really focused on the non-medical factors that can have a big impact.

BOB GRIS: Bob Gris with the Institute of Social Medicine and Community Health. The evidence is that inequalities produce poor health and influence our health care spending, so presumably by reducing inequalities we can save money in the health care delivery system but a lot of these social problems cost money to solve. Will the commission look at how savings in the health care delivery system can be used to address the social determinants of health that we have long recognized cost money to eliminate?

DAVID WILLIAMS, M.P.H., PH.D.: Alice do you want to take that?

ALICE RIVLIN: I think the answer, the honest answer to that is no, this is not the job of this particular commission. Some of us are working hard on how do you make the health care system more efficient and how do you slow the rate of growth of health care spending? But that is not what this is about. This is about the non medical factor. You can't do everything in one commission.

GWEN MCKINNEY: I join the legions to commend you on this commission. My name is Gwen McKinney and I am with McKinney and Associates and we are heading the communications effort for a new series. This is a plug, not a question, if

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you don't mind. [Laughter] Is inequality, unnatural causes, in inequality making us sick? Which will premiere March 27th nationally on PBS for four consecutive weeks and I think the thing that is so exciting about this initiative and the timing of it is that the film series is a tool that is much bigger than the small screen or an air date so I just want to thank all of you for the work that you have done up to this point to make the documentary and the content real and something that is very viable for us to promote.

DAVID WILLIAMS, M.P.H., PH.D.: Thank you. I will go right over to the far—

JOSH GORDON: My name is Josh Gordon with the Concord Coalition, are you going to be able to confront the link between agricultural subsidies and food prices and how that encourages different food choices once you get to the super market?

And also I know this is becoming an issue because the ethanol debate has been connected to the increase in food prices and are you going to be able to deal with any of that or is that too macro level?

MARK MCCLELLAN: Non-medical factors are on the table for this effort. I think you have heard from us that there is a big emphasis on— there seems to be some evidence that better nutrition can have a positive impact on health and stuff to make fresh fruits and vegetables available, some of the

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community based programs we have talked about can make a difference so that general area of issue is definitely on the table with this commission.

DAVID WILLIAMS, M.P.H., PH.D.: The important point for everyone to keep in mind, the commission is being launched today [laughter] so we have no— you have gotten the report of the foundation to the commission so that is the charge to the commission of its work so we are just beginning our work and that is why we are really very serious when we say in order for us to be successful we need your input and your knowledge and your expertise to feed to us, to help us both to identify solutions and promise some levers for intervention.

RICHARD HOFRICTER: Richard Hofrichter, senior analyst for health equity at the National Association of County and City Health Officials, again I would like to commend the commission for its work.

My question is independent of direct connection with lifestyles and behavior and so forth and programs to deal with the consequences of what you are talking about, will you be focusing on in terms of these social factors things like the targeting of toxic waste in low income and people of color communities of redlining by banks, segregation and land use policies, and other forces of that type that are not really— that have their own direct impact independent of behavior and life style.

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ALICE RIVLIN: I think the pollution problems and toxic waste are certainly part of our purview. The last several questions have really said are you going to take on all the hard problems that face America at the moment? And we have a lot of will to do that but it wouldn't make sense. We have got to focus on the non medical factors that affect health and the ones that are most susceptible to change. We will talk a lot about the nutrition program.

I didn't notice Senator Frist leaping to his feet when we talked— when somebody mentioned getting rid of agricultural subsidies. [Laughter] There are lots of things that probably ought to be done but I don't think you can expect this commission to do all of them.

MARK MCCLELLAN: I want to go back to the point that I made earlier, we are looking for concrete feasible steps where we can expect to achieve a measurable impact on health within the scope of our commission's activities and we are going to be doing a lot of work over the coming months to find what exactly that means.

DAVID WILLIAMS, M.P.H., PH.D.: And remember part of our task of raising awareness levels is also changing the conversation in this country when it comes to health and we are not naïve to think that in a two year span the commission is going to solve every problem in the United States but we can

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certainly change the conversation, make progress and point in the way that future efforts can continue to build on.

BARBARA KRINGLE: Barbara Kringle, the Director of Kellogg Health Scholar's Program at the Center for the Advancement of Health in Washington, D.C. I also commend the foundation for convening this commission. My question is given that we see very strong impacts between income and health and education and health, I wonder whether it will be in your purview to consider programs such as the earned income tax credit that have made so much difference in incomes of working families and programs like Head Start that provide quality, early childhood education which makes such a difference in the health and development of children across the life span.

ALICE RIVLIN: I think we want to keep the focus on things that have the most direct influence on health. No your mention of Head Start in early childhood is certainly in that category and there is evidence that early childhood programs do affect the future health of those children. We have a dilemma I think on general measures to reduce inequality like the earned income tax credit. This is not a commission on how to reduce poverty in any quality.

Angela cochaired such a commission that I served on a couple of years ago and we came out strong for raising the minimum wage and increasing the ITC but I think if we do that we will dissipate the impact. We want to focus quite

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specifically on things that lead pretty directly on the evidence to improvements in health.

DAVID WILLIAMS, M.P.H., PH.D.: Question on this side.

ANNE MARIE O'KEEFE: I am Anne Marie O'Keefe with the School of Community Health at Morgan State University, I think the good news and the best outcome of this commission is your focus on neighborhoods, peer to peer learning, and your single minded focus on the consumer as the centerpiece for what we have got to do to improve people's health; but you are bucking a biomedical system that presumes knowledge flows from the top. I mean the entire NIH complex is set up to study problems, not provide solutions. Do you think you can affect that?

DAVID WILLIAMS, M.P.H., PH.D.: We will turn to Mark.
[Laughter] Our physician.

MARK MCCLELLAN: I certainly take your point about a focus on helping individuals with their choices. These individual choices do matter. As our biomedical knowledge expands we are finding that personal factors are more and more important and individual circumstances and specific conditions do matter a lot and we are keeping that focus on helping improve individual choices.

I don't think this is just us though. I think this is some thing that is part of where biomedical knowledge is headed generally, part of where our society in the 21st century is headed, towards more potential if we get it right, to support

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individual choices and help people make decisions that improve their lives and I think we are actually catching some important and potentially historic trends and that is one reasons I think this commission is going to have such a lasting impact.

NOAH BARTILUCHI: My name is Noah Bartiluchi and I am with the Aspen Institute. I thank you again to the foundation and its partners, clearly a tremendous effort to improve population health in our country.

My question is this. I am wondering to what extent the commission envisions itself approaching government and in particular encouraging an approach of health in all policies because of the extent to which all policies have a health footprint, you know, be it regarding built environments or agriculture or the environment itself.

MARK MCCLELLAN: Well, health does seem to have an impact everywhere, you know, we talked, this terrific session of questions and answers about a huge range of factors that can potentially influence health.

One of the challenges though is making sure we understand that direct connection. That is why we have emphasized in the work we are doing so far measurable impact so while there may be a large number of programs where you could pause it if there is some kind of health connection, long term or indirectly.

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What we would really like to do is be able to hone in on a better way of measuring what those connections are and a better way of focusing our efforts and the efforts of policy makers on programs that are going to have a measurable impact and I think it gets back to the point that Alice was making as well about the need to keep in mind that this commission isn't going to solve every social problem, it may have some connection to health but we are going to get this issue of the non medical factors that influence health front and center and we are going to take some real steps to make concrete progress, measurable progress on addressing those problems.

LAUREN GORDON: Hi, my name is Lauren Gordon, representing USCPA; I was wondering are there any specific environmental factors that will be addressed in your research? And if so, will you engage with experts in the environmental health field?

DAVID WILLIAMS, M.P.H., PH.D.: I think we are certainly interested in engaging with experts in any field that we identify as really important determinant of health where again practical, feasible solutions exist. Our report is comprehensive in terms of laying out the charge.

We haven't again, the first day, today is the first day of the life of the commission so we haven't identified what our priorities will be but we are certainly taking a broad net

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looking at what is out there and what is working and what can make a difference.

KATHLEEN MALLOY: Yes, my name is Kathleen Malloy, I completely appreciate the comments from the commissioners in terms of the short duration of the commission and that you can't take on enormous challenges. But, I probably would ask that the commission still reference the context of particularly economic inequities which really are going to be an underlying factor for any attempt to improve for example quickly improved nutrition, putting supermarkets in poor neighborhoods, the ability of lower income people to purchase them, the ability of people working two or three jobs to prepare meals.

So, I think these larger factors have to be although you are not out to increase the minimum wage, for example, or promote economic investment in communities, these things must happen if some of the more specific programs have a chance of being successful.

And the risk of not including that reference means that you put a specific program in place and you may not see some of the positive outcomes that you expect so I think and again this it the literature is documented for years and years.

This is not an original thought but I think maybe a lot of the questioners here understand that as well and that the commission with its power and leverage and prestige can draw

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attention to this larger issue, let's say raising the minimum wage. Thank you.

DAVID WILLIAMS, M.P.H., PH.D.: Thanks for your comment. I think if you look at the report, the report does situate issues within the broader context so thanks for the comment. We probably have time for two more questions so I will take the last two. Yes, one on this side?

MARIAN DANAS: Hi, I am Marian Danas from the Clinical Center at the National Institutes of Health. [Laughter]

And, I wanted to take on the challenge that was mentioned about the NIH and I really want to say that we would be thrilled and I work with the National Center for Minority Health and Health Disparities and I think this is a great challenge to say that we should partner and that the NIH does bear responsibility for thinking about the translation of what is done in science and we would be thrilled to work together and I do think that there are some very interesting challenges in expanding the way we think about the influences on health.

And I am struck that a lot of the questions were about how do we deal with health in a very scientifically complex world and our society isn't organized necessarily in the way that is best suited to address it. We need to think more intersectorially and thinking about economics and their influence on health is something that we ought to take on and work with you on.

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DAVID WILLIAMS, M.P.H., PH.D.: Thank you. I think that is more of a comment than a question so we have the last question.

RAVY SONIC: I swear we didn't conspire. I am Ravy Sonic from the NIH Office of Science Policy. [Laughter] So I got your back over there. But, my question actually was totally different.

Beyond the health disparities some of you mentioned the huge difference in health between the United States and other nations, like a little girl born in the United States right now is expected to live a life four years shorter than a little girl born in France or rich, white, educated Americans tend to have 30 percent more heart disease, cancer, strokes, and diabetes than their English counterparts.

So these are people that have good health care. They live in safe neighborhoods. They probably have grocery stores with healthy foods so besides being a national disgrace it seems like a great opportunity also. So, I was wondering do you have international partners in England, France, other countries to see what they are doing that we aren't?

DAVID WILLIAMS, M.P.H., PH.D.: We are certainly focused and I am glad this is a good question to end on, remember the name of the commission. It is the commission to build a healthy America. We believe that the health of every single American can improve. Yes, we understand that there are

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disparities in health and we think that some Americans have an even longer way to go than others but there are opportunities for all.

We are interested in all examples of actionable solutions that are out there that can make a difference, so certainly seeing what other countries are doing and what is possible and how that can apply to the U.S. situation is important so I want to encourage all of you to provide the input and help us as we make this journey.

I want to conclude by saying that I want to thank all of you for joining us here today. I would like to thank our entire panel, all of our commissioners and the Robert Wood Johnson Foundation for their visionary leadership in creating the commission. Over the last two hours we have given you a lot of information, a lot of data, and a lot of facts, and we have heard from you that you are interested in what we are doing and have an agenda for us to pursue but I hope that with great thanks to the Elkins family and to Kenyan, that we have also given you a taste of what the problem looks like and means to average American families and we will be bringing you more of these stories on a regular basis on the commission's website.

Please do visit the commission website. It is www.commissiononhealth.org. Commission on health dot org. We promise you that this site will be interactive and a continual

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source of current information on trends in the field as well as of the commission's activities. Very soon we plan to hold our first field heron and the commission website will have more details on that. We are looking forward to the commission pointing us to a future where the way America protects and promotes health builds a healthier America for all and may even go further to set a standard for the world on how we can promote health.

And to conclude, I hope you walk away from this morning with a better understanding of how much there is to health and that there is more to health than health care and with the confidence that this commission will identify ways to improve the health of all Americans so that our country and all of its people can live up to its full potential. Thank you for being here and continue to work with us. Thank you. [Applause]

[END RECORDING]

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