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**NIH Summit: The Science of Eliminating Health Disparities –
Day 3
National Center on Minority Health and Health Disparities
December 18, 2008**

[START RECORDING]

JOYCE: - to introduce to you Dr. Evelyn Lewis

[applause].

EVELYN LEWIS: Good morning. I want to thank her for that introduction but because of the fire alarm that we had a few minutes ago and the need now to sort of cut the time, I told her she could just say here's that one [laughter]. She said she'd never use that phrase. I was like why not? Look who that one is.

So again I say thank you for this opportunity to speak with you this morning. While I do, within the slides I wanted to show and share with you, have some information that's sort of hot off the press. I didn't anticipate it would set off the alarm but nonetheless we will move ahead here and there will be some that I'll skip over so that I can ensure to keep Dr. Ruffin in this relaxed mode so that he doesn't feel like we're going to go over too much.

In any event, starting off, what I want to just sort of share with you this morning is really what Pfizer does, who we are in respect to this summit and what it stands for and what it means.

As you can see from the first slide here, starting off with what the commitment of the company is around this issue and it speaks to our commitment to taking action against health and healthcare disparities because those with the tools, the

talent and resources and the will to build these bridges that we've been talking about throughout these past few days have a most urgent need to do so.

We must all remember that because the need is indeed urgent. I'm sure that you all have felt that same sort of compelling need to get going and to do the kinds of things that we need to do so that we can get this work advanced as quickly as possible.

Again when we look at some of those commitments in terms of the company, you can see the kinds of things that we look to do and that is to be number one, number one in terms of the production of the best medicines, making them available to people who need them, delivering sort of the best lifesaving modalities also around the different medications that we develop, and contributing to the poor, those who cannot afford those medications at the prices that they sell for but ensuring that they too have access to those therapies and being sort of the number one in terms of the philanthropy of companies that are providing that.

We also look at again while discovering and developing these medical innovations, in the way of advancing the promise of health, we recognize that the innovations that remain inaccessible to all, that the need for them promises that remain unkept. It essentially means to us that if we have the

ability to do something then we need to do it and we need to do it now with that sense of urgency that I mentioned earlier.

So as we talk about providing solutions, this was sort of an overall view that the Institute of Medicine Report gave us several years ago. They offered a number of interventions and solutions around this whole healthcare disparities issue. Many of us know that as sort of the Bible, if you will, directive on this issue of healthcare disparities.

They mentioned a number of things, as you can see here. They talked about increasing awareness, health system interventions, data collection and monitoring, and patient and provider education. Throughout the course of this summit, much of that has been talked about in a number of different presentations that we've all had.

Then we look at what companies like a Pfizer or other corporate entities can do as it relates to this issue of healthcare disparities. We look at things like collecting and distributing data about their employees as it relates to the issues that we're talking about.

Development and implementation of prevention programs, you'll hear me talk a little bit more about prevention later because that has not necessarily been the focus of what we call our healthcare system, also improving adherence to therapies and implementation of cultural competency training and we've had numerous presentations and sessions on that issue alone.

So as we've talked about what the Institute of Medicine put out as some of the interventions that could possibly be done, what some companies at this level should be doing, now I'm going to focus a little bit more on exactly what it is that Pfizer has done, is doing, and sort of looks ahead to do.

When we talk about collecting and distributing data, Pfizer has a series of publications called Pfizer Facts. We have worked with the National Medical Association, the Hispanic Medical Association in terms of publishing these as we talk about these issues in their relationship to minority populations.

We also looked at partnering with others to deliver prevention programs. Again that key word there is prevention because our healthcare system or you'll see in another slide where, it's clearly referred to as a sick care system, does not necessarily promote wellness and prevention. So we look at how we partner with communities, employers, schools, et cetera to carry that message and move that message forward.

Also looking at promoting physician and patient relationship, one of the sessions I was in yesterday talked in-depth about that particular role there. A lot of the cultural competency or cultural proficiency issues that we talk about play prominently in that particular section.

Providing access to medicines, again you heard me say how Pfizer has a number of different programs that are focused

primarily on doing that. We'll see some more of those too as we move along here.

Collecting and distributing data, again the Pfizer Facts that I've talked about earlier, these are just a sampling of some of them. The one on cancer was again partnership with one of the NMA members and then we did racial and differences in cardiovascular diseases. We've had a couple of new ones that will be coming off of the press here in the next few weeks. That should be available for you all to also see.

Partnering with others to deliver prevention programs, again talking about communities, employers, et cetera, these are just a sampling of some of the programs that we are partners with. One is the Church of God and Christ. They had a huge sort of awareness program looking at the community health initiative.

As you can see, that's a large organization. It's about six million members. About two million of those are in a position of lead as it relates to the ability to get their medications, et cetera this organization is such that it has its own pharmacy. It has its own programs in terms of how they set them up such that these people are very much able to get the products that they need.

Southern Ain't Fried Sundays, this was a program in partnership with the state of Arkansas and it looked at the inequities in health in particular as it related to obesity in

several counties in that state. We partnered with them to get information out to do all kinds of prevention programs, screening programs, et cetera.

The result was this book that was published in terms of a cookbook that showed alternative ways of preparing these meals. The results of this, which we had a whole other slide presentation on that, talked about the weight loss that resulted on the programmatic roll-out of this program in that state.

Another one was Florida, a healthy state, it was a program that was run primarily through what's called Pfizer Health Solutions, which is a little bit of an independent part of the company that focuses on partnerships with states, state governments, et cetera. This was a really exciting program here because, as you can see from this slide, the anticipated enrollment was about 50,000 or so patients but you can see as we went through the final year there where it ended up.

This was such a successful program in terms of getting people enrolled, getting them healthier, and saving the state of Florida money until they put out a competitive grant that the Pfizer Health Solutions competed for and was awarded to continue this type of work.

The Southern HIV/AIDS prevention initiative, this was primarily the partnership through the Pfizer Foundation. It was about nine states in the Southern U.S. where the focus was on

HIV education and awareness in terms of connecting the different smaller HIV programs in different locations, connecting them with each other such that they can broaden their reach in respect to their messages.

That's been a very successful program. We've had some of the key leaders from those different states, in particular the leaders in the program in South Carolina join us at the Congressional Black Caucus to speak on this very program for the past three years.

Promoting physician/patient relationships, looking at improving cultural sensitivity in the doctor/patient relationship. As we talk about that relationship, obviously a lot of it is based on communication whether the patient is having difficulty understanding what that provider is talking about in terms of his illness or just difficulty in interpreting what the results of a test or what have you mean.

Health literacy, as we all know, is a major contributor to the problem that we talked about most of the time that we spend here. So Pfizer, through the work of Dr. Barbara Debuono, did a huge rollout and development of a program around health literacy. It had it's own conference actually in D.C. for about the past five or six years.

Again clear health communications, which incorporates that health literacy program, but also is sort of a link to a number of different people who work with that particular

subject matter and looking at how we connect the people that it will best influence and help.

The other things that you see there are also some other programs that focused primarily on the Hispanic and Latino communities in terms of increasing their awareness of their diseases through publications in their respective languages.

Providing access to medicines, again to low-income or those who are unable to purchase them or to the uninsured and there are a number of different programs that we have. One in particular, Helpful Answers, you see a little bit there on the side, there's the Hospital Partnership Program and Helpful Answers, I wanted to get to this slide in particular because any of the programs that come under that, which you see listed here, the Share, the Care, the Hospital Program, the program that gets medications to the federally qualified health centers.

All of those have been made available through Pfizer Helpful Answers. I look at that program sort of as the Wal-Mart of programs to help people find access because if you call that 1-800 number, if you don't qualify for this program or that program, what they do is they help you find the program that you do qualify for.

So it eliminates a lot of the work that patients have had to do that becomes very frustrating for them and in essence then they just drop out of the system and don't do it.

Going forward, health reform, you all have a copy of Pfizer's health reform principles that the company has worked on over the past year. We know that that's a huge topic that's up and coming, is a reform of our healthcare system or our sick-care system depending on how you look at it.

You'll see those principles. I'm going to have a slide that talks about them but I won't go through each and every one of them, have you read that on our own and feel free to provide comment to us regarding those.

Talk a little bit about sort of that hot-off-the-press news around a concept that we have called a center of excellence for healthcare disparities solutions and sort of investing in disease prevention.

Again those principles that I mentioned, the guiding principle for setting all of that into motion was that all Americans, regardless of health status or income, should have affordable access to health coverage and culturally relevant quality healthcare. The goal must be to eliminate disparities in health and healthcare access and quality. So that was the basis for the reform principles that you have a copy of.

Again as we look at this piece around healthcare reform, you can see the words that I highlighted there on the, referring to sick-care versus healthcare looking at preserving patient choice and physician autonomy, quality and efficiency of care, which are sort of key to that whole reform issue.

These are the principles. Again I told you you have those in your bags. The last thing I wanted to just talk to you a little bit about was this sort of center of excellence.

You all are very familiar with that term in particular because of Dr. Ruffin and his center but we're looking at what that might look like to have one embedded within the company and what would that do, what would it look like.

The goal, we think, would be to directly impact health and healthcare disparities by targeting emerging majority and other diverse populations. Why develop this? Looking to partner and earn the trust of other scientists, regulators, physicians, and patients.

Then looking at opportunities to also address other kinds of public health issues such as restricted access, which we talked a little bit about, affordability issues, lack of appropriate cultural sensitivity and diversity in clinical trials.

What would it look like? It could be somewhat of a strategic catalyst designed to align partnerships within the public and private sector to include primary stakeholders who are on the usual list of culprits, clinicians, patient groups, industry academia, government, et cetera, to sort of effectively and visibly eliminate the problems of healthcare disparities.

Then some of the building blocks of this center, briefly, would be the involvement of community, policy, and science, and economics, research, and business growth. These building blocks, I think, are very sound and we looked for obvious comment around these issues also but if we were to use these as building blocks, again much of this is what's been discussed in this meeting, some of which we'll be taking back and looking at how we integrate it to further build on this concept but again looking at how we can put this in place in a company such as Pfizer to have it be as productive as possible.

These following slides here go through the importance of diversity in clinical trials. I don't necessarily think that I need to speak to each of these. I'll go through this slide and then skip through the rest. Why is this important to Pfizer? Why do we think it's important?

Because of the innovation, the engagement of the community, the leadership that a company such as Pfizer must present and then the competitive advantage obviously that it will give in terms of the medications that are developed and those that it can help.

If we don't have the diversity that's needed in those clinical trials then we will have no idea about what that does in certain populations after the fact.

So I'm going to end with this, which is sort of what I started with in terms of Pfizer's commitment. Most of us have

heard the quote by Martin Luther King that talked about of all the forms of inequality, injustice in health is the most shocking and the most inhumane. I took the portion from Pfizer's commitment to taking action against health and healthcare disparities because those with the tools, the talent, and the resources, and the will to build the bridges, we need to have a most urgent duty to do so.

So if we're looking at this concept of public/private partnerships. We're looking at how we do more than just provide financial resources to this issue. How do we look at our scientists working together, our sales force, all within the company looking at how we contribute to eliminating healthcare disparities throughout the company getting everyone there engaged and partnering with entities such as NIH, our community organizations and what have you.

So I thank you very much for this opportunity to speak with you and we look forward to continuing this partnership and getting the work of eliminating disparities done [applause].

JOYCE: Okay. Before I move on to our next panel, I want to do a few quick little housekeeping items. First thing I want to do is to remind you that we did commission a supplemental issue of the American Journal of Public Health, which will actually bear the title of the summit, which is The Science of Eliminating Health Disparities. So keep your eye out for that.

We also plan to try and have the slides and the presentations posted on our website. Another little item that I must remind you of is that for those of you that pre-registered for the conference, an electronic evaluation form was mailed to you on Monday at noon. For those that registered onsite, it should probably be mailed to you today if not last night.

We're going green so we want you to go in and take a look at that evaluation form and give us some feedback. One other thing I need to remind you of is for those of you who did take the shuttle bus to the Gaylord, there will be a pick-up at 1 PM. So you don't want to miss that. I think it would be a pretty long walk but at any rate, I just want to leave those few housekeeping things to you.

Now I'd like to introduce the moderator to our next panel, which is on media and policy.

Our moderator will be George Strait and George is the Communication Director at the National Center on Minority Health and Health Disparities. George came to NIH after more than 20 years in communications and news reporting. For ten years, he was a healthcare correspondent for ABC News where he paid special attention to stories on health disparities.

So as a joke, I said George what do you want me to say about you tomorrow? He said well you can tell them that I'm the husband of Lisa and the grandfather of Miko. So I give you the husband of Lisa and the grandfather of Miko [applause].

GEORGE STRAIT: Thank you Joyce. If the panel members could make their way up. While they're doing that, I want to thank you all for being here and looking out over this crowd, it's been a long time coming, I think, that was Sam Cooke singing that on the first day. It's truly wonderful to see you all here. I could remember in my former life at ABC News that when I approached one of my editors to do some stories about health disparity research, he said come back when some of that research is done in White institutions. So we have an awful long way.

Now we have this wonderful composition in the Maya Angelou sense, with all of the instruments playing loud and effectively together but before we get to the heart of the panel while the panel is sitting down, I want to illustrate the context for a lot of this discussion by showing an excerpt from a highly acclaimed film "Unnatural causes: Is Inequality Making Us Sick?" As many great films can do, it encapsulates the work reported here over the last week and points to the challenges that are still before us. If you could show the film please.

[Video Played 00:21:06-00:24:35]

That's just a taste of what is really a truly remarkable film that's four hours in length. Perhaps you've seen it on PBS but like everything on PBS, it will be shown again and again and again. Also at the NIH, the National Library of Medicine is beginning a project to not only show the

film there and online but also to have sort of a virtual town hall to discuss some of the issues in the film.

On to our panel today. As you know, the theme of this summit is the integration of science, practice, and policy in the elimination of health disparities. The goal of this panel is to explore some of the important policy questions that are before us, how best to implement those policies, then to begin to clarify the role of media in achieving some of those policy goals.

Like all of the panels, we hope that this one will also begin to develop a research agenda for healthcare disparities. Our panel is really uniquely qualified to take a look at this and to guide us. You know them all. All of their bios are in the program book.

To my far right is Dr. David Satcher, again we know him well. He's one of the most important and effective voices in public health over the last 20 years. Next to him is Dr. Claudia Baquet who has brought the academy to the community and amazingly affected change in both state and federal policy, Dr. Brian Smedley, who is a true composer in the Maya Angelou tradition.

Next to Brian is Dr. Tim Johnson, the nation's calm and expert television voice from Medical Matters and my former partner in crime at ABC News. Mr. Raj Shah who has shown us all how private industry can and must be intimate partners in

eliminating health disparities. Next to Raj is Dr. Elmer Huerta.

Even though Elmer is the first-ever Hispanic President of the American Cancer Society and perhaps the most trusted medical voice in Spanish-speaking television and radio. Elmer also still sees patients every day at his cancer clinic in Washington, D.C. and Dr. Hilton Hudson, a true Renaissance man, a noted scientific researcher, physician, publisher, and expert in developing effective media messages to health disparity populations.

Now we've set a number of records here at the summit including probably the record number of PowerPoint slides shown at any one gathering. This panel will be a bit different. We will discuss and debate instead of show and tell.

David, perhaps you could start by helping us define what are some of the important policy questions that are before us as we try to eliminate health disparities.

DAVID SATCHER, M.D., M.P.H.: Well thank you. Thank you. Before I get to one of the policy questions, I just wanted to make one comment from my own sort of life experience in terms of media and policy. I grew up in the South, in Alabama and I was a teenager when the Civil Rights Movement sort of started. So I sort of witnessed close up what happened in Alabama and throughout the country, later being a part of the student sit-in movement.

Observing that and especially observing Martin Luther King, Jr., and we used to walk from the Morehouse Campus to his church whenever we knew that we was going to be in town. When I think about the role of leadership, I think about the role of educating, motivating, and mobilizing individuals and communities toward a goal, in this case, changing policies.

I think one of the things that Martin Luther King, Jr. demonstrated was that if you are the minority, if you're the underdog and you have a case, the best ally that you can have is the media. When Martin Luther King took the movement to Birmingham, this was just 60 miles from my home and Bull Connor and the dogs [misspelled?], his strategy was only clear later and that was to show America the face of racism in the South, something that we were living with every day.

So I helped come to value the media even before I became Surgeon General and I used to say suppose there were a Surgeon General's Report and no media came. Nothing would happen. So we are dependent upon the media. So I want to make that point. There are some very critical policy issues that impact the elimination of disparities and help that goal.

If you don't believe that, just think about the fact that since 2000 when we released Healthy People 2010, at that time there were 39 million Americans who were uninsured. Today there are about 47 million. So we've added eight million Americans to the uninsured.

So access has really declined since the year 2000 because of the policies and because we failed to implement health reform. So I think the overriding policy challenge that we face, as it relates to the elimination of disparities in health is moving toward reforming our health system so that it becomes a balanced community health system, balanced in the sense that it balances health promotion, disease prevention, early detection, and universal access to care.

I think that's the challenge that we face. If we can get there over the next four to eight years then I think it would be the greatest contribution to eliminating disparities in health. I want to make it very clear that I don't mean to imply that this is just about healthcare and this was balanced community health system because the balanced community health system will invest in the social determinants of health, education, early childhood development being very prominent in terms of social determinants of health.

I think healthcare, however, is itself a social determinant of health. There's no place that illustrates that better than the United States because, over the last ten years especially before the economic downturn, the major cause of bankruptcy in this country was people getting sick who cannot afford their healthcare.

Every day, of course, families suffer because of a critical illness and the impact that it has on the finance is

so, in many ways, the lack of access to healthcare is a major social determinant of health.

So I think that's a major policy issue that we must all work toward. Obviously I've been concerned with childhood obesity and I just want to close by saying that when it comes to childhood obesity, there are policy changes needed on the local level, the state level, the federal level, and the global level.

Sanjay Gupta, last week, had on his program a story of a principal who had decided several years ago that her school was going to be quote sugar-free, that the students were going to have model good nutrition, physical education K through 12. She changed policies in that school. School districts across the country are now being challenged to develop wellness policies.

At the state level, of course, states are making decisions about trans fats and things like physical education, what is going to be required throughout the state. At the federal level, when Congress passed the wellness policy in 2004, it was probably the major thing that's happened since the Surgeon General's Report on overweight and obesity, which we released in 2001 requiring all schools to develop wellness policies in order to qualify for free breakfast, free lunch programs.

So on and on, of course, obviously the best example of global policy and one of the few is the World Tobacco Treaty that the World Health Assembly passed in 2003. So these are all really critical policy issues that affect disparities in health and the whole quest for global health equity.

GEORGE STRAIT: Dr. Baquet, a balanced system, break it down as the kids would say, break it down for us.

CLAUDIA BAQUET, M.D., M.P.H.: A balanced system to piggyback on Dr. Satcher's comments is greater and immediate emphasis on prevention and wellness as well as the recognition that our need for health reform goes well beyond providing insurance to individuals and their families.

That includes something else that Dr. Satcher referred to, the investment in education for our children and our families as one of the major ways to focus on not only reforming health but eliminating disparities.

So I do believe that we have an unprecedented opportunity now. I know that you have expressed an interest in what are the roots for some policy related to elimination of health disparities.

Certainly, at no other time in history, have we had a citizen, a public mandate to make change including to make the quality of life, which includes health, social welfare, as well as education as an integral part of any reform package so well beyond insurance.

GEORGE STRAIT: Dr. Smedley, there's some policy implications involving changing the language. A lot of what we've heard this week talks about changing the language when we talk about health disparities, healthcare, of promotion and even prevention. What does prevention mean anymore? Talk about some of those implications.

BRIAN SMEDLEY, Ph.D.: Sure. Our language is so important around these issues. Many folks at this conference have talked about the need to move from talking about disparities, which is more of a numerical concept. The fact that people of Color have poor health status than the majority population to talking about inequality and I believe that when we make that shift, we're making a very, very important statement to policy makers.

So I believe that there's no more important scientific and policy question than the question of how do we manage inequality in our society. Inequality, we now know, has huge consequences for population health broadly, doesn't just hurt those folks who are at the bottom tiers of the wealth and income ladder.

Inequality has important health consequences for all of us. So I think the challenge is to figure out how do we manage this growing inequality, a problem that has been growing much more rapidly since about 1980. We are now one of the most unequal societies in the world in terms of wealth and income.

It's playing out today obviously in terms of the economic downturn.

Folks who have already been at the margins are going to be at risk for even further declines in health status. So this is obviously something that is a key pressing issue, I believe that part of our challenge moving into this new era is to figure out how do we best conduct research and translate that to policy immediately so that we can address the consequences of gross inequality in this country.

GEORGE STRAIT: This really is a discussion so if you feel the need, you can jump in. that's fine. No one here is shy. Tim, is David right that if it doesn't appear on ABC News, it never happened?

TIMOTHY JOHNSON, M.D.: Well there are some other networks where I might have heard [laughter] but I certainly agree with that and with the major point David was making, which is that we've got to look at the overall issue of health policy and not just focus on bits and pieces of it whether it be minority issues or many other issues.

So I'll speak to that in two ways. I just want to tell you a little bit about what we're doing at ABC and I hope is happening at other places. We have a task force on healthcare reform that is working very hard right now.

More importantly, I have convinced the President of ABC News, David Weston and even more importantly, two of the major

anchors, Diane Sawyer and Charlie Gibson, to get on board with this issue. They're very enthused about it. I've met with the staff in New York. I'm meeting with the staff in Washington today. So we are building some momentum inside of our organization to talk about healthcare reform in all of its ramifications and to do a lot of programming.

Even more important, here's where I'm an eternal optimist, I personally feel and we can all talk about this, the stars are lining up a little bit. I had breakfast this morning with Ron Pollock, Families U.S.A. they are holding an all-day conference bringing together 20 disparate organizations including insurance and pharma. We know tremendous activity in Congress right now. Peter Orszag going to the Office of Budget and Management, I think is a great move because he's passionate about healthcare, and finally Tom Daschle being Secretary of HHS.

Anybody who hasn't, should read his new book because it's really spectacular and it talks a lot about issues of minority and inequality. So I think something's going to happen in 2009.

GEORGE STRAIT: Raj, explain how private industry works in here and as I said before, it really needs to be an intimate partnering developing new policies toward the elimination of health disparities.

RAJ SHAH: Let me just make two comments just to support before I address that. First of all, I'm also very optimistic. I think the change is happening and fundamentally one of our slogans is yes I can. I could take care of my health. I'm picking up on President-elect Obama but it's very, very important to realize that technology plays a varied role in how we have to reach the disparity people.

Dr. Satcher, I agree that the insurance issue is about 47 million but probably our estimate shows about 60 million. There are a lot of people with insurance but it's really not complete and the geography and the location. So it's very, very difficult to reach and even if you have insurance, chronic disease and some of the major, major areas are very difficult to get all the right doctors to take care of you.

Now in terms of reaching and this is where it's very important, you have to go where the health disparity population is. Of course it's not just minority and underserved. It is rural areas. That means we've looked at models that use as community ministry of churches we've used as mobile med. We've used primary care coalition types of organizations.

I'm looking at use of technology, whether it's gas station, whether it's grocery store, whether it's other places where awareness and outreach can take place. Go where they do things Elmer's going to talk about it. It's cultural. It's social. It's age-appropriate. You have to, whether it's music,

whether it is the things that they do in the community, health should be explained in such a way that it is an economic problem.

I mean you're healthy, you're going to do well. You're going to go to school. You're going to get education and I think it makes a fundamental difference. So use of Internet, use of media, I even think that in our local papers, it would be nice to see every once in a while supplements that only talks about health as an addition and have the private sector really get involved in funding that and promoting that rather than just having their advertisement. I was happy to see Pfizer. I've been working with them but there are a number of other. I worked with De Novo [misspelled?] in this area and Medstar, which is where Elmer is.

So there is a commitment but what we need to do is build a network that's independent of network that is a standard network. This is a public/private partnership but it needs to start at a grassroots. Reaching them but not just reaching them to the human interface or the social interfaces but through the use of technology. That is something we want to talk about.

GEORGE STRAIT: You raise two issues today. One, from the communication of this but also the private industry need an incentive, need be a policy that incentivize private industry

to do these kinds of things because I mean let's be frank about this. Are they just going to do it on their own?

RAJ SHAH: I think they ought to do it on their own but we could do incentives. Let's talk about clinical trials. Minority accrual is so significant requirement and it is lacking dramatically and if they want to sell drugs to the minority industry, they're going to have to make sure that they're included. So it's an investment to me. It doesn't have to be that government has to provide incentives.

I think they could participate themselves and we've been building that kind of a network. On the other hand, government can and will participate but the issue really comes down to it is wise it, not a business opportunity because you're selling drugs and you need this population also to take care of you.

You think about HIV/AIDS and all the drugs that are being made, when we took it to Africa, a lot of them didn't work. Then we have to retool it. so the issue comes down to it is let the private industry recognize not just this as a care and compassion issue but really it is an investment and it is something that's going to make them a better economic and give them a return on investment.

GEORGE STRAIT: Elmer?

ELMER HUERTA, M.D., M.P.H.: Well it seems to me that the role of the media needs to be to empower people by

information saturation. What I mean by this is that health prevention needs to be on a daily basis exactly like sports, like weather. I ask often to people when I give my talks if they can see their 11:00 news without the sports guy. It would be impossible to see an 11:00 news without the sports guy or the weather guy but you know what? Health is not every day and it is there. it's just a little note that doesn't give any context, any perspective.

So I think consistency, we need every single day. Number two, having comments on everything not being only a periodical in the delivery of health information. In other words, those campaigns, prostate cancer week, for a week you saturate the community with it and then nothing happens until next year. Breast cancer awareness month, one month you are saturated and then nothing happens. No, I think we need to get rid of that mindset and just provide health information to the public on a daily basis but with all sorts of things.

Number three I would say that it is extremely important for NIH to realize that we need to be multimedia. We need to use all kinds of media. So every day, everything and every media needs to be used to deliver the information in order to translate this complicated science language for people to empower them so they can act upon that kind of information.

GEORGE STRAIT: Dr. Hudson, that's a lot of work that you do.

HILTON HUDSON: Yes. Yes it is. I think that it's important for the media not only to show this consistency. I totally agree with you, to show examples of true empowerment, true successes. I think that, as I go around the country, I still do hard surgery and, for the most part, people are afraid to get treated no matter how educated they are, no matter what their access is, what their economic status is, they are afraid to go to doctors.

I think that if we could somehow empower patients using culturally appropriate and sensitive health messages, be consistent with it, it will empower folks and will allow people to make a difference in their lives.

GEORGE STRAIT: So it's not just men that don't go to the doctor?

HILTON HUDSON: It's not just men. It's unfortunately more men obviously than women don't but educated don't as well.

GEORGE STRAIT: But it seems like what we're talking about here though and the use of media is using the traditional media and I wonder if there's an opportunity to reach folks in different ways and to affect policy change in ways we haven't done before by using media that is not so filtered.

If you pitch a story to Tim, Tim becomes a filter for your message. Are there with the Internet and with texting and all the rest, do we have other ways to do that? What's been the experience? Anyone? Brian?

BRIAN SMEDLEY, Ph.D.: I think that Dr. Huerta is right that we need to use multiple sources of media that the President-elect has been brilliant in communicating directly with his constituency through social networking tools, Face Book, You Tube, that kind of thing. I think we need to do that.

I think we need to think more broadly about the role of the media as well. We've focused on strategies to help people improve their individual awareness of health behavior, health promotion. That's all very important but we also have an opportunity to use various forms of media including new media to help empower communities and to help communities to be more effective in addressing their problems. Helping communities to organize particularly through the Internet, I think, is one of the most promising strategies and government ought to help facilitate that as our President-elect is doing.

GEORGE STRAIT: Claudia?

CLAUDIA BAQUET, M.D., M.P.H.: Yes. I completely agree and one format that we're having some preliminary success with, that's gaining attention across the country is putting health information kiosks in community settings.

So there's information on elimination of disparities, their access or risk assessments and then how you can reduce your risk for chronic illnesses immediately available and of course, the print and broadcasting media but in your community pharmacy.

You can go up and push a button in the waiting area of a federally qualified health center, community health center. You can go up to the kiosk. There are large print for the seniors and folks who wear certain types of glasses. There's touch screen. There's keyboards.

So I think increasingly, different more interactive forms of media and delivery of messages, where you can access quality healthcare, what you should do for your child in terms of care-seeking behavior and training children on appropriate care-seeking behaviors that they can take into adulthood.

I think I'm seeing success with the multimedia kiosks that we're using in community settings of different types.

DAVID SATCHER, M.D., M.P.H.: I was going to piggyback on what Claudia's just said. I believe I first saw it in Philadelphia where the Philadelphia Medical Society decided that when they had patients with diabetes, they would give them a prescription to go to whether it was a church or a library where they have these sort of kiosks that they could learn about their disease.

I haven't seen a follow-up to see how well it worked but the idea of trying to bridge the gap in terms of literacy, health literacy, by giving prescriptions to a place where an individual can find out more about his or her disease, I think, is a great idea and a strategy for making sure it works is a different thing.

Could I add one more quick thing? The gap between science and policy is something we've been talking about throughout this conference. It's a very important gap. Communication is probably the most critical issue in that gap because you can be right on the science.

I can tell you, from personal experience, you can be right on the science but the policy that grows out of it is going to be determined by advocacy and how well people are able to do it and communities need help with that. It's going to be determined by deeply held beliefs. We've seen a lot of examples of that over the last eight years.

The science may say one thing but if the deeper held beliefs conflict with that and you can't communicate within the context of those deeply held beliefs, religious or otherwise, it's not going to work. So the gap between the science and the policy is a critical gap that we need to try to help to feel the political process.

The point you just made about helping individuals, the groups that have the most money, obviously, have the most clout with lobbying. So if a group doesn't have a lot of resources, it's very hard to compete in terms of trying to get policies through Congress.

ELMER HUERTA, M.D., M.P.H.: Maybe one way to bridge that gap between science and policy is by focusing the attention of the media on the person with the condition rather

than the condition itself because if you're going to talk about cancer and then you're going to only report on the oncogenes, the PPP3s, you're going to report on the kinases, all these enzymes, people will get amazed but you know what? You are not making that news relevant to the person who is watching or listening to you.

If you, like we saw in this "Unnatural Causes," which is a wonderful series, you focus on the person, the neighborhood, the community. Everybody's going to say my God, look at this plan that we have here in the neighborhood. Would that be a problem? Then those citizens, through advocacy, through grassroots movements, they can influence policy.

I think that will be one way to do it, focusing on the person rather than on the condition itself.

HILTON HUDSON: Let me add in here, it's also focusing on the success of medicine. Too often it's gloom and doom and it scares folks half to death. I think that if the media's paid more attention to focusing on stories of success that you can have diabetes and live longer. You can have cardiovascular disease and do well. I think that would empower people.

TIMOTHY JOHNSON, M.D.: I'll speak to how traditional media is trying to struggle with new media. As you know, every form of traditional media is really scrambling to figure out the new digital world. We, at ABC, have a separate network for digital. More importantly, we have an Internet port where

people can go for information. We try to customize it in some ways.

We have a section called "On-call" where you can go, people who don't want to go to the doctor and find a subject. They will have an answer to a list of 450 questions if they can click on real doctors or real nurses come up on the screen and answer the question. So that's one little way, which we can try to work our way through this new world.

Having said that, I also have to speak to a concern, which I'm sure we all share, which is the quality of the information on the Internet. It's a new highway with a lot of junk on it and a lot of car crashes on the side. I worry about controlling the content. I know that sounds too socialistic but I really do worry about that.

We've all got to pay attention to that somehow. That brings me up to the high level of healthcare reform, which is I don't think any of this is going to happen unless we revive and renew primary care in this country. That's the portal where people have to go to find out what's available, what information they can use. That's going to take a lot of basic healthcare reform.

GEORGE STRAIT: But let me ask this question. If you went to David Weston, the President of ABC News, and said look I want to do a series on primary care, I want to do five stories on World News Tonight and none of those stories showed

any patients and still was about primary care or prevention, would you be able to sell that?

TIMOTHY JOHNSON, M.D.: No but we already sold it and we're going to do a series on primary care actually as part of our-

DAVID SATCHER, M.D., M.P.H.: But Tim you can't do a primary care without showing patients.

TIMOTHY JOHNSON, M.D.: No, we'll show patients of course. Oh yes.

DAVID SATCHER, M.D., M.P.H.: Patients are like the center. That's the whole point of primary care.

TIMOTHY JOHNSON, M.D.: And projects that are demonstrative.

GEORGE STRAIT: It gets on the point that too often a lot of the health reporters get caught up in the esoteric of it.

DAVID SATCHER, M.D., M.P.H.: Our system does not favor primary care. That's not where the money is. That's not where the respect is. So we can change that. Medical students are not dumb. It doesn't take them a long to realize that people out there in primary care are maybe doing great work but they're not getting the kind of reimbursement or the kind of stature or prestige that others are getting.

So part of our health reform has to reform the system so that primary care is again valued in this country and that

healthcare is not just a commodity to be traded in the market place to the highest bidder. I mean I think those are the struggles that we are dealing with.

CLAUDIA BAQUET, M.D., M.P.H.: I wanted to speak to the need for the intersection between the science and the research and policy piece. I see the media as a way to disseminate the findings of quality research and also to disseminate changes and clinical practice and to the general public and who then often would take that to their primary care physician or other healthcare provider.

The policy research and the recognition particularly by the center of the need for policy research to inform future research but also clinical practice is fantastic that this has finally come. All too often being a former NIH'er, all too often the issue of policy was dismissed but it's here and it's being respected in credibility in terms of NIH funding is being put there. So I think that that's fantastic.

I think we have a couple of models that show the beauty of the intersection between research or science and policy and the potential for elimination of health disparities.

The first is, for example, in the Maryland General Assembly or state legislature where this is happening actually at state legislatures across the nation, the data are often used and the results of research findings are used to inform decisions on a piece of legislation.

For example, in our state, our mandated health insurance benefits that would have to cover individuals for certain basic procedures or beneficial interventions for example, cancer screening. Then that has taken by enlightened legislators and it's passed as legislation. Because of restrictions with ARISA, we found out very soon that that covered only 25-percent of the insured population and it certainly didn't cover Medicaid.

We're learning that the state adapted Medicaid benefits and state employee benefits by a regulatory change. So you had science informing legislation, legislation informing regulation but then we took it a step further with funding from Dr. Ruffin. We asked the general public in the state, did you know that this benefit is covered? The majority didn't know it.

So policies and regulation in the absence of widespread education to the general public, they just don't work. So you have to take the complete process forward that involves the general public in learning what they are potentially able to access in terms of their benefits plan.

Now the last piece that's a beautiful national model is Women in Government's initiative to eliminate cervical cancer. you have the technology with the development of the human papilloma virus vaccine. You have cervical cancer rates very high in minority and underserved and low-income communities.

You have women in state legislatures trying to develop policies that could be enacted through both legislation and regulation as well as task forces and then you have a tight grassroots level educational component to talk about the science behind cervical cancer disparities as well as HPV vaccine.

Again I agree with David, in the absence of taking into consideration cultural norms and religious beliefs, you can't be successful. We found that in Maryland. We found it in other states in terms of the need to partner with the faith community in an ongoing way not just around one topic about the importance of prevention, of vaccine for a disease that causes significant morbidity and mortality because it was the faith community that raised questions about wait a minute, nine-years old, 11-year old, you're not going to tell the young girls in my church they need to have something that's going to prevent this sexually transmitted disease.

So I think that with the programs that foster policy research, there has to be a component that fosters, for the general public, not only health literacy but research literacy in order to appreciate the influence of research on community health.

GEORGE STRAIT: Is it common in NIH grants to have a component that fosters this narrowing of the gap between science and policy, mainly a communications component? I think

that they do that at the National Science Foundation but I don't know about the NIH.

CLAUDIA BAQUET, M.D., M.P.H.: Let's just say that I was at the NIH in the 80s and early 90s. There's more than there was then but there's still too little given the fact that we have this crisis in access and outcomes, it's far too little.

So I think it's a struggle. I think the credibility of the center and some other parts of NIH on the need for policy research that that is a legitimate component of the science translation is imperative but certainly not enough funding is put in that.

DAVID SATCHER, M.D., M.P.H.: My first experience with NIH supporting the communication piece was the Sickle Cell. In 1972, I believe, I became Director of the King Drew Sickle Cell Research Center. That's where I met Claudia but I met her then. I hope we don't forget that because the Sickle Cell movement has done a lot to help us get to where we are now because many of us came into research, Lou Sullivan, Marilyn Gaston, many of us, our first major research program was Sickle Cell disease because there was such an urgency to get information to communities than to bridge the gap between science and community.

So we learned from that. I think the National Center for Minority Health and Health Disparities, of course, is really pushing that, bridging that gap like never before.

RAJ SHAH: That's okay. I'm between all the M.D.s so I don't think it's very hard. Just three or four quick points. One of the bridging issue is, which I think everybody's talked about it but I think the communication there will make a very big difference as practitioners.

You're saying primary care but I'm talking about really there's so many clinics. If the doctors really get involved between the science, the institutes, and of course the policy makers, I think that is something that needs to happen and it is happening but not at a level where it should because if you think about it, you go to the doctor's office and if they were really promoting prevention on one side, you talking about the kiosks and all of that.

One of the interesting things I saw second was in a modesor [misspelled?] school a kiosk, a kiosk that was teaching young children about the value of apple and fruits and all the various things. so clearly there are a number of these programs.

The third point I want to make to you is that there is so much, as Tim said, information technology and that is where I come from. Yes, there is a lot of garbage but there is really also controlled, filtered information and to be able to set up and allow blogs to set up that are local blogs by local people, young children to teens and others, we really need to get to healthcare at a lower level in our society rather than us just

talking about Elmer calls it Towers of Babel, remember the conversation we had about that.

So the issue is, I think, all of you are really very learned and educated but I think you need to soon get back to grassroots and I'll end with one thing. We have in Rockville, community ministry of Rockville, that's 26 groups of churches. Six, seven years ago health was not even a discussion issue. It was a social, it was health services. I mean other services. Today there's 24 locations we're providing healthcare services using mobile med. Now this is something that never happened.

So I think that our models, as you all are talking about it but the key of all of that still is networking, the public/private partnership and creating an umbrella that shows that health disparity, the health inequality is not just a care or a compassion issue but an economic issue and it's fundamentally going to make a difference.

I mean when you talk about internationally, terrorism and all the other things are issues of people's poverty but it also relates to health.

GEORGE STRAIT: Okay Elmer?

ELMER HUERTA, M.D., M.P.H.: Yes, I'm a very practical person. Twenty years ago I started to do radio because I realized that when I was doing medical oncology that most of the patients that were sent to me for chemotherapy have very advanced conditions but that was not the point.

The point was that most of those incurable conditions were preventable and early detectable. So I have found no point of giving chemotherapy to these kinds of patients. So when I was talking to this woman with advanced cervical cancer, she didn't know what a pap smear was but she knew by heart the soap operas on television. That's when I quit medical oncology.

I started to do radio and TV. So I made there to giving advice to [inaudible] every night when I drive home at 8:03 p.m. and the local WAMU radio station, there's a wonderful show about the stars, Star Date, what a wonderful show produced by the observatory in Galveston, Texas. I don't remember the name but they tell you every night about how the stars are moving, the planets are aligning, et cetera.

I wonder where is NIH providing daily information to the American people on health. Twenty-seven institutes, all this wealth of information stored there, why don't they have the imagination to put it out on a daily basis for people? Why is it that these people from the observatory are doing it and educating Americans about the stars?

So I think what we need to do [applause] is make sure that NIH really communicates with the public on a daily basis, on everything and using all media, traditional and new media. I bet in five years, the American public are going to be much more aware of many, many, many things that are going to empower them.

HILTON HUDSON: I think another thing that that would do is to increase trust, is the main goal. Unless you address trust, none of this is going to happen despite policies, despite education. Patients and people really need to feel that the information they're getting from their doctors and loved ones is one of trust.

ELMER HUERTA, M.D., M.P.H.: XM Radio now, for example, they merged with Sirius. They have a channel that's called Doctor Radio, wonderful opportunity for NIH to be there on a daily basis promoting health like on my radio show, I have two hours every day now nationwide. They ask me, for example, Dr. Huerta, my father's going to start dialysis, kidney dialysis. I say how old is your father? Well he's 62. He's young for that. What condition brought him to this dialysis? Well high blood pressure. Okay, tell me did your father take care of the blood pressure? No doctor. You know how men are. Okay.

That's a wonderful window for opportunity to talk about the preventative nature of kidney conditions. So I think NIH, they should use all these media and put money behind it. now, the National Cancer Institute, for example and this is a shame, they are cutting their funds for outreach programs for people. this is something that needs to be discussed and needs to be changed and the community wouldn't permit these kind of things [applause].

BRIAN SMEDLEY, Ph.D.: I think that's exactly right.

What we talked about though is the use of media to talk to specific target audiences. I think that's very important. So I think implicitly we're talking about disparity populations but I also think we need to communicate to the general public about health inequality generally because there's such low levels of awareness even when folks are aware of health inequality, there are a whole bunch of myths that surround health inequality around bad genes, bad behavior.

I think there's a real responsibility for the media to highlight in the context of general reporting the fact that we have gross inequality in health, access to healthcare, and healthcare quality. In the example of the reporting on primary care, which I'm very excited to hear about, because primary care is an issue that must be squarely on the agenda and in the general discourse around health reform.

We ought to be talking about not only the fact that our primary care system is very threatened but primary care is also maldistributed so that the very communities that have the highest healthcare needs have the least access to a primary care infrastructure and that infrastructure that exists is often of lower quality.

More importantly, we need to say that this affects all of us. It's not just a problem for those disparity populations over there. We need to be talking to general audiences about

the crisis of our health infrastructure and how inequality in that infrastructure affects all of us.

TIMOTHY JOHNSON, M.D.: I'll just piggyback by saying that is one of the items we have on our working list for primary care. So let me introduce just another little element here. As everybody knows here, we're on our way to bankrupting this country with healthcare because we're spending nine to ten-percent inflation rate versus the general inflation rate, \$2.6 trillion this year.

One of the reasons we're spending so much money is that we are communicating with the public very effectively about all the new drugs and technology. So we have a population. Pardon me?

ELMER HUERTA, M.D., M.P.H.: We're selling.

TIMOTHY JOHNSON, M.D.: Oh yes, we're selling. The consumer advertising you all know about. So Americans have come to the point where we think the latest is automatically the best. We want to get that new drug or that new test or that new technology we heard about on the radio, on television. We're all part of this. So I'm all for more communication obviously but I want to make sure we're communicating at the level of honesty and what works and what doesn't work and that's why I keep coming back to primary care in all of its faces. Obviously nurse practitioners, physician assistants, medical homes, et

cetera, that's where I think people need to get most of their information [applause].

GEORGE STRAIT: Tim, you're right, folks need to get most of the information from those sources but still folks turn to you and turn to Elmer and turn to the major media for a lot of their, if not most of their, healthcare information. I mean again to keep it real, as the young folks would say, isn't it difficult to sell a story in the major media that is not about what is new.

Isn't it more difficult to sell sort of the social determinants of health than the new breakthrough.

TIMOTHY JOHNSON, M.D.: Absolutely. That's one of the challenges I've taken on personally at the one place I have some control, at ABC. That's part of what I'm speaking to the staff about both in New York and Washington. It's a tough uphill battle. I personally refuse to do so-called cutting-edge stories anymore but I'm in a position where I can pick and choose what I want to do.

It is a constant uphill battle but slowly the message is getting across. All I think we can hope for, George, is in addition to that stuff, we're going to do that other stuff.

GEORGE STRAIT: But is there a role for folks around this table, folks in this audience, at the national level, at a local level? Is there a role for them to recognize that there are some gaps here around communication and bring together some

of these communication people, some of the issues and talk about it? is there a role here David? There may be a role but is it possible?

DAVID SATCHER, M.D., M.P.H.: Well I think it is. let me say first though that I really think that when it comes to our schools, our schools should be in a position to educate our children about health and about what it takes to become healthy. Now obviously, we've put a lot of focus on the obesity problem. That's created a situation where we're seeing more.

I think it was Dave Rogers who first had the idea about, it's 36 years, 35 years ago, about school health clinics but I think within the curricula of schools, students ought to learn about health and health and lifestyles.

They ought to also experience it at school because just as children can be addicted and they are every day, become addicted to salts, sweets, and fats, I'm convinced that they can be addicted to regular physical activity and good nutrition.

Parents have shown it. Parents in this country who have shown that when they insist in their home that their children have healthy diets that they grow up. My children are more rigid than I am about eating. I go to their house sometimes and I wonder why are we eating all these fruits and vegetables [laughter] but I mean I believe that children can be addicted. I hate to use that word but habituated to healthy lifestyles.

I believe the schools have a major role to play in that. I believe communities have a major role to play in that but we're not funding that. we don't even fund physical education let alone good nutrition in the schools. So we are addicting our children to unhealthy behaviors an unhealthy lifestyles [applause].

HILTON HUDSON: It actually gets worst, Dr. Satcher, after a child grows up, it's so hard to change their behavior. If you start when they're seven, eight years of age and talk about what's healthy, it's going to be so much easier for them to be more compliant and adherent to a healthy lifestyle down the road. It's a major problem, I agree with you fully.

CLAUDIA BAQUET, M.D., M.P.H.: A part of the healthy lifestyle that should start in the school systems in terms of education of our children should include proper health-seeking behaviors. That is you're a child and when you become a grownup, you should have that annual health maintenance visit. You should focus throughout the lifespan on prevention and wellness. I think that that's essential.

HILTON HUDSON: Sure. Sure, let me interject one other thing. We actually went to a school in Indiana, Imagine School, had about 1,200 kids and we were there to bring them good quality school books. We found out that most of the kids had no idea what a vegetable was, didn't know what broccoli looked like. This is in Indiana. So yes, we decided that perhaps

versus school books that we needed to do wellness material instead.

RAJ SHAH: I think we can also do things like video games and others that really promote the same thing.

DAVID SATCHER, M.D., M.P.H.: That's what I meant to say earlier. The media can partner with the schools. There's a lot that the media can do to help schools put forth that type of [inaudible].

ELMER HUERTA, M.D., M.P.H.: I think we have a lot to learn from the business community. Twenty-four hours after this episode of the shoe throwing to the President, there were video games all over the Internet [laughter], 24 hours selling these things. So that's the kind of thing we need to be very agile in our outreach and changing all the time but maybe practical advice for our audience this morning is that I'm pretty sure many of our members in the audience, they are often consulted by the media on interviews, on things like that.

There is always a moment to talk about prevention even if they are talking about some very specific biological condition or issue, there is always a little window for prevention. I work with CNN in Espanol. I do the medical editing for them. So they call me when something happens. So Fidel Castro is getting, for example, a problem in the colon. Dr. Huerta, what would we be going here? I say okay, but listen, colorectal cancer is preventable whatever. I have

always my little window of pushing prevention, healthy lifestyle, et cetera. So I think they probably can do every time there's a window of opportunity to do that.

GEORGE STRAIT: So if there's a window of opportunity to always talk about prevention, maybe there's a window of opportunity in giving grants for more emphasis on communication and narrowing that gap between science and policy. Go ahead.

RAJ SHAH: There are two issues we haven't talked about. I'd like to think about the future of media and policy in terms of the Baby Boomers are moving to elderly care. That's going to be a very substantial health disparity issue. I'd like to hear from Dr. Satcher about that and Claudia and others. The second is the returning soldiers. I think we have a very serious issue coming out in terms of how are we going to take care of disparity issues that deals with that because this has been a different war.

DAVID SATCHER, M.D., M.P.H.: Let me just comment on the last point because, as you know, one of the things I had an opportunity to do was to release the first-ever Surgeon General's Report on mental health, which still gets far too little attention because when you look at FHL data, mental disorders are second only to cardiovascular disease and cancer is right up there with it in terms of causes of disability adjusted life years.

Mental disorders, depression, it is very hard to control diabetes in a patient who is depressed if you don't diagnosis and treat the depression. That happens every day but we have been involved with both with post-Katrina population and the soldiers returning from Iraq and Afghanistan and we are seeing more post-traumatic stress disorder than we have seen from any form of engagement because of the nature of that war because there's no clear front line, if you will.

Also we're seeing more people returning with mild or post-traumatic brain disorder. The impact that that has on an individual and all of the families that have been destroyed because of people coming back who can't relate to their spouses and their families anymore.

We had a conference here on May 21st, here in Washington, and the title was "Wounded Troops and Partners: The Unmet Needs of Soldiers Returning." So this is an area that needs a lot of attention. We need to look at how we can, number one, better prepare people if we're gong to fight these crazy wars. People ought to be prepared to be more resilient and hopefully we're not going to continue to do that but people coming back with problems that we have not been prepared for.

More people are surviving injuries than ever before but what does it mean to survive and come back here and be unable to function normally? Nobody seems to be that concerned about it. So it's a major problem. We can talk about that all

morning. As I said, we had an all-day conference on it. we had to turn people away because there was so much interest in talking about post-traumatic stress disorder as reflected in post-Iraq soldiers and their families.

RAJ SHAH: But I think it gets into the clinical research. It gets into all of the areas of what we're going to do because that population is really going to need a lot of help and it's going to grow. It is going to create a longer and bigger disparity issue.

CLAUDIA BAQUET, M.D., M.P.H.: Yes. I think you hit it on the head. The returning soldiers are becoming a new disparity population. There's some work in progress, a signed agreement between VA Secretary, HERSA, and HHS. Some of you all are involved in the AHEC program or the Area Health Education Centers Program that is providing existing web-based and other training programs available through the VA to community mental health caregivers.

Originally the focus was largely on health professionals, mental health professionals but in community settings that see these returning soldiers with traumatic brain injury and PTSD. We've added caregivers also that social support and skill building that the caregivers, the loved ones, will have to have. So that's an existing initiative. Please contact the AHEC program at HERSA or the VA for that TBI PTSD program.

I wanted to respond to your health communication grants and if something like that should evolve, that it would include nontraditional ways of communication but also with an emphasis on building public trust in the importance of science and research in the community. The term we use is research literacy.

I think it is a myth that communities most hit hard by disparities, one, are not interested in their health. It's absolutely not true and are not interested in research. The problem is that communication of the researcher, of these complex concepts to the general public is what has to be improved.

When a group of individuals, for example, we have a successful mini-medical school program in Baltimore City and then rural parts of the state. When information is communicated in a way that the general public can understand complex results from research studies, it's like a light bulb goes off.

Then you have the general public asking for human subjects' protection training and HIPAA training and then people started wanting to adopt and hold research. They also want to make it accountable. That is no more helicopter research. No in and out taking samples and not giving something back to the community are the results but going beyond simply CBPR, which is I adhere to those principles in many of my

studies but going beyond and having the community participate in the funding of these projects.

That is the grant money goes to the community. That's both something to build trust. It's a respectful gesture that I value your contributions as a leader at a grassroots level. It's also an economic investment in small community-based organizations who need funding just to pay their lease and pay for their employees.

BRIAN SMEDLEY, Ph.D.: To build on what Dr. Baquet said, I think you're absolutely right. The community-based participatory research has the promise of addressing all of these issues, trust, having communities be a part of the research effort and to have research be accountable to the communities that they're serving. I think it goes further.

When we talk to communities about what they're concerned about, whether we understand what their issues are, they include things that are at the community level, the fact that folks disproportionately have toxic waste dumps, have problems with air pollution, traffic, inadequate housing, being physically separated from areas of job growth.

I think communities understand that these are all issues that relate back to health and they want to put these on our research agenda. I think there are some important CBPR models that do that and help us to importantly focus upstream where we're going to make the biggest difference in prevention.

CLAUDIA BAQUET, M.D., M.P.H.: But in CBPR, funding needs to be shared with the community that is participating not just having the community on an advisory committee. They should be getting funding to do parts of the implementation of the - [applause].

ELMER HUERTA, M.D., M.P.H.: In that regard, maybe another practical advice for our audience here in terms of engaging the media, the local media where they live is don't be afraid of contacting the local radio station, the local newspaper, the local television station.

You will be surprised that these editors, they will really be very receptive to your ideas and practical advice. That happened to me. If they open the door to you, don't let that door shut but be there every time they ask you to collaborate with them.

Little by little, you will create that wonderful relationship between the scientists or the community people and the media and they will always use you and you will have a window of opportunity to put your message out.

DAVID SATCHER, M.D., M.P.H.: Thank you. I just wanted to comment on the community-based research. When, I guess 2000, when Healthy People 2010 was released, the program in government that was best geared toward that was REACH, Racial and Ethnic Approaches to Community Health. In many ways, some of our greatest successes have come from that program.

The major criteria was the grantee had to be the community. Then the community could contract with academia or with the health department but the grantee had to be the community. That was a CDC-based program, Wayne Giles, the PI, but NCMHD has recently funded because CDC lost a lot of funding so Dr. Ruffin looked at that program and has been supporting the REACH program because of the fact that communities are so involved.

I'm sure there are some REACH people here but from our perspective, it's been a great example of just what you're talking about.

GEORGE STRAIT: As we come to a close and begin to close for this panel and begin to focus more on the frankly advising the new administration on healthcare reform, I want to talk a bit about something that I think David brought up earlier.

That's deeply held beliefs and there's a lot of optimism in this panel and in this room and maybe even in the country that we're going to have healthcare reform, that we're going to focus on prevention. We're going to focus on primary care and all the rest.

Well I'm old enough to remember that we went through this before, Clinton one and we all said then well the stars are aligning and all the rest and we're going to get there but there was some deeply held beliefs by a number of folks and a

number of groups that stopped. I mean there's some other reasons as well.

David also raised if you were a young researcher eight years ago and you wanted to go into health disparities, you're 35-years old so I'd like to have a nice life. I'd like to live in Rockville. I'd like to do this but I don't know that health disparities research and this kind of focus is a way to tenure, whether it's the NIH or if it's an academia.

So there are a number of these challenges that I'd like to discuss as our time comes to a close so that we can better strategize how we go forward if indeed the stars are aligned.

RAJ SHAH: George?

GEORGE STRAIT: Go ahead.

RAJ SHAH: The role for private sector comes in very important here. Tim talked about \$26 trillion right now. If you look at 2020, we're talking about four trillion. The health disparity is really one of the largest problems. I think if you think about it, that is pharmaceutical companies or others, and the private sector needs to recognize that there is going to be huge economic impact.

So more than just the government, I think if we get the private sector very activated, you will realize that health disparity is becoming an economic issue to them rather than just a social and healthcare issue. I think that is something

that media has to play a role and the policy maker have to play a role.

HILTON HUDSON: Yes, I agree with that fully. I was just thinking on the day I looked at TV and there was the first face transplant in the Cleveland Clinic. Yet this is not shown what we're doing here. The media has chosen not to do this but to look at that and to sensationalize that part of medicine, I think, is the problem.

I agree. I wanted to follow up on George's point about, I guess what would be the reward? Do people get rewarded for doing research still with the health disparities? I think one of the most important things that the National Center for Minority Health and Health Disparities has done is to draw young people into this field even for giving, as a way of repaying loans, it's a great strategy.

The question for the future's the one that we face in academia. That is are we going to reward this research? We've gone through that. If we encourage people to go into an area, is academia going to reward that with promotions and tenure? Is NIH going to reward that with intramural research dealing with health disparities? Is it going to get the same kind of credibility and rewards as other research?

It's going to be a critical issue in the future. People, especially students and young faculty members, it doesn't take them long to figure out what's important and

what's being rewarded. If it's not being rewarded in terms of grants and tenure and promotion, it's not going to last long [applause].

If I could piggyback on that, I'll say what I said at the outset. I believe there's no more important, no more pressing scientific question than how do we address inequality in health. So I think to the extent that NIH can communicate that and there's still some work to be done in terms of getting all of the ICs on board, having disparities as a core part of that research agenda then I think that we have a lever to help shape the rewards and incentives in academia.

I think of how powerfully NIH sets the agenda for and sets the context for how academic research is conducted. I think to the extent that we communicate the importance of addressing this issue, I think, hopefully, we'll begin to see some change.

TIMOTHY JOHNSON, M.D.: I just have to comment on the facial story. I couldn't agree more. I was called early in the morning to be on Good Morning America to talk about it. I said no. I'm not going to do that. I'm going to write a memo about healthcare policy, I said, and I did literally at that moment, send it out to our people [applause]. I'm not pretending I'm a saint. I've participated in those kinds of things in the past but I am really feeling that we are entering a time when some of these issues are going to get traction with the public

because there is such a generalized anxiety now about the economy, which quickly translates into job insecurity and loss of healthcare and the other things I mentioned I think are happening.

Even as you talk about the battle of the 90s, which we both shared, there were a lot of organizations then, pharma, insurance to name two obvious ones, who continued for a long time to suffer from a disease I call mural dyslexia, the inability to read the handwriting on the wall and [laughter] I think they're seeing the handwriting on the wall because they are, as far as we can tell, actively participating now in the discussions.

They're not trying to fight them. They will at some point, try to stake out their turf but things are happening that weren't happening in the early 90s, I just have to say that.

GEORGE STRAIT: Maybe it's that we're getting to a point where a lot of these discussions, whether it's healthcare reform or discussions about health disparities, it's been us versus them and maybe because of the way the economy is going, there's more of us and fewer of them. Maybe that is a star that has come into alignment. Yes Elmer?

ELMER HUERTA, M.D., M.P.H.: Maybe just they say that all politics is local, same way I think we can say that all health education is local too. So in addition to wonderful

things like Tim is doing nationwide, I think we all have an opportunity to do some local activities and that's going to really change the conditions at the local level. That's very important. That's what I said before. I think all of us, all of us sitting in this room, we have the obligation to reach out to our local media people and do some local contributions.

CLAUDIA BAQUET, M.D., M.P.H.: I'm very optimistic about the opportunities for young people that want to pursue a career in health disparities research. I also want to give my shout out for the loan repayment program. Man it would have been great when I went through medical school [laughter]. It's a phenomenal program [applause]. It's one of the incentives that would allow young people, PhD or clinical, to pay back some of that debt so they could focus intensely on their career development as a researcher.

The other piece for the physician incentives and we've been talking about primary care too is the need to restructure the incentives or the rewards in terms of physician reimbursement, specialty versus primary care because as you said, I'm at a medical school. The medical students who have a lot of debt see the handwriting on the wall.

Okay, if I've got to pay all this debt off, I'm not going to pick primary care. So we really have to look at restructuring how we reimburse and how we reward primary care and prevention and wellness.

GEORGE STRAIT: Also as you all have alluded to and also thinking about what is a study of health, what is a study of healthcare? Is it just PhD and the sciences? Is it just an M.D.? Is it just a masters' degree in public health? I mean could it be a PhD in sociology? I mean those kinds of things and being able to reward all of that and fund all of that [applause].

CLAUDIA BAQUET, M.D., M.P.H.: Yes, yes and in nursing and in social work and in pharmacy, yes [applause].

ELMER HUERTA, M.D., M.P.H.: Health educators.

DAVID SATCHER, M.D., M.P.H.: I think that's one of the major messages of this conference is saying a major message of social determinants of health report is that we have to integrate these disciplines. We have to have transdisciplinary research going if we're going to solve these problems.

I think one of the traps we fall into sometimes though is the dichotomy of being. So you hear people saying it's not about healthcare. It's about social determinants or it's not about personal responsibility.

It's about all of them. If this hotel reports that during this conference, there's been no increase of the use of its pool, it's walking trail along the river. There's something going wrong here. If we're not anymore physically active, that people are not in health, if our diets are no different then we're sending the wrong message. So I just want to make that

point [applause]. So not just social determinants, it's what we do when we have these opportunities.

ELMER HUERTA, M.D., M.P.H.: I think the mode of NIH is health for the people. I would say health education for the people should be the one.

GEORGE STRAIT: We have a remarkable opportunity now to educate some folks who are about to come into office. We've had a lot of discussion from the podium, whether it's the podium here or the podium in some of the breakout sessions, but what we always wanted to do and what Dr. Ruffin, his vision for this conference is to really engage everyone who is here, not just the folks who deliver messages and the folks who receive them but also to hear from everyone.

We're going to take that opportunity now to affect a very specific policy agenda. That policy agenda is healthcare reform but just before I engage everyone here and get your ideas on healthcare reform, I would like thank this panel for being here and for being so wonderful and expert [applause].

[END RECORDING]