Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well, Margaret, we could know by the week's end, if the Health Reform Bill will become the law of the land. Well, last time, any sweeping social change was made of this size to the American landscape was decades ago with a passage of Social Security in the 1930s and with the passage of Medicare and Medicaid in the 1960s.

Margaret Flinter: That's right, Mark, and it's an exciting time. We were joking around this morning that it seems like every week, we have told you that there was a big moment in Health Reform on the horizon and in fact there were a lot of them over these past months. It's hard to say when but it does look like there will be a historic moment soon. House leaders are working and gathering support from Democratic lawmakers and even the President is out on the road talking with House members and talking with communities about the Reform Bill.

Mark Masselli: Well, this is the week that is or wants to be. Democrats must come together on this. Republicans are unified against the legislation. The challenge this week is getting enough House Democrats to support the underlying senate bill and then to make amendments to improve the legislation. For weeks, Democratic House leaders have been fashioning ways to deal with the senate language. This has not been made easy as all eyes are around the House, but the Speaker has committed herself to move this legislation forward this week and she usually gets what she wants.

Margaret Flinter: Well, it's no secret that the House preferred is version to the senate version of the Reform Bill. So Speaker Pelosi is looking at all the alternatives on that vote. The self-executing role which she proposed earlier this week would let the House vote just once on the reconciliation corrections. Under that vote, passage would signify that the lawmakers have deemed the health care bill as passed. In other words, they wouldn't need that formal up or down vote on the actual senate bill. Speaker Pelosi also outlined some of the amendments to the senate-based health care bill last week. They largely followed the proposal issued by President Obama such as doing away with controversial provisions that affect one particular area, like the Cornhusker Kickback, speeding up the closing of a gap in Medicare's prescription drug benefit, and limiting the text on so-called Cadillac health care plans.

Mark Masselli: This new procedure is certainly one way to appeal those House Democrats who have principal concerns about the language in the senate bill and who are withholding their vote unless certain changes are made. These groups include like Michigan Congressman Bart Stupak who wants stricter abortion language. Some members of the Congressional Hispanic Caucus are

concerned with prohibiting illegal immigrants from using their own money to purchase insurance in the exchange. And progresses like Ohio Congressman Dennis Kucinich don't support the bill because it doesn't offer universal coverage. There is also Pennsylvania Congressman Paul Kanjorski who has threatened to vote "no" after Democrats attached a student-lending overhaul to the bill that could cost jobs at the Sallie Mae processing center in his home district from principal to local politics, they are all driving how people will vote.

Margaret Flinter: And we are learning a lot about what matters to individual Congress people. And Mark, remember, there are those freshman Democrats who are hesitant to vote for the bill because they have got upcoming midterm elections in their conservative districts. But House Majority Whip James Clyburn is pretty confident that he can get the bill passed and he is the one in-charge of rounding up those house votes. Congressman Clyburn was on our show back in January and he said in the interview with us that if we get rid or fax that tax on the working people's plans irrespective of whether we call that the Cadillac or the Ford Taurus, I think we can pass a plan that the American people can be proud of. Despite that difficult task of lining up 216 House votes, the Congressman said that he can do it. The maximum number of Democrats who can defect is 37 if they are going to still make that 216 threshold vote.

Mark Masselli: These votes are going to be a nail biter. In the meantime, let's turn our focus to another very important issue in health care, eliminating health disparities, the difference in health treatment and outcomes based on race and ethnicity. It's been part of our mission at the Community Health Center to fix this. It's also been the lifelong effort for our guest Dr. David Satcher. Dr. Satcher serves simultaneously as U.S. Surgeon General and Assistant Secretary for Health from 1998 through 2001. He now directs the Satcher Health Leadership Institute at Morehouse School of Medicine in Atlanta, Georgia, which is committed to fostering and supporting the diverse group of public health leaders and influencing policies and practices, in that reducing and ultimately eliminating health disparities.

Margaret Flinter: No matter what the story, you can hear all of our shows on our website Chcradio.com. You can subscribe to iTunes to get our show regularly downloaded. Or if you would like to hang on to our every word or read a transcript of one of our shows, come visit us at Chcradio.com.

Mark Masselli: And as always, if you have feedback, email us at Chcradio.com, we'd love to hear from you. Before we speak with Dr. Satcher, let's check in with our producer Loren Bonner with headline news.

Loren Bonner: I am Loren Bonner with this week's headline news. Back in campaign mode, President Obama was on the road again this week trying to win support for his health care overhaul that could be voted on by Congress as early as Friday. The President traveled to a senior center in Ohio on Monday, a state

that is home to several swing Democrats, to speak directly and personally to the American people. President Obama said he came to Ohio because of Natoma Canfield, a Medina cleaning woman who wrote him to say that she was dropping her health insurance because of soaring premiums that coincided with her being diagnosed with leukemia.

President Obama: I am here because of Natoma. I am here because of the countless others who have been forced to face the most terrifying challenges in their life with the added burden of medical bills they can't pay.

Loren Bonner: But there were other reasons that President came to Ohio. He wanted to visit a senior center to address in person criticisms that his bill will make cuts to Medicare.

President Obama: Every senior should know there is no cutting of your guaranteed Medicare benefits. No ifs, ands, or buts.

Loren Bonner: The President is also on a mission to round up House Democrats who would vote on the bill, like Ohio Congressman Dennis Kucinich who doesn't support the bill because it doesn't offer universal coverage. And House leaders are trying to propose a rule that would let Democratic House members cast just one vote on the reconciliation corrections leaving out the up or down vote on the controversial senate-passed bill. The reconciliation bill has already advanced for the Budget Committee when they voted for fast track rules for health care legislation that set the rather complex process in motion this week. At the Budget Committee meeting Monday, Republican Congressman Paul Ryan said the committee vote was a sham.

Paul Ryan: We are right here creating a legislative Trojan horse in which a handful of people hidden from public view will reshape how all Americans receive and pay for their health care.

Loren Bonner: The rules committee is expected to meet Thursday to draft new language for the reconciliation bill compiling a package of fixes to the bill that passed in the senate on Christmas Eve.

Loren Bonner: This week, we are exploring eliminating health disparities and one specific approach we are looking at directly involves the community and addressing their own health problems. I visited a food cooperative in the South Bronx that's working to make a difference in their community by working together to provide healthy and affordable food to everyone who wants it. The South Bronx has New York City's highest rate of obesity with residents facing an estimated 85% higher risk of being obese than people in Manhattan. It's one of the country's capitals of obesity and is also synonymous with poverty and a list of health-related disorders.

Julio Pavon: You know, this is the most unhealthiest community or one of the most unhealthiest communities in the country, and all the statistics that we have in terms of health are some of the worst in the country.

That's Julio Pavon. He is purchasing a few items at the South Bronx Food Coop after coming from a yoga class next door, a class that started because of the coop. He has been a member since the coop began in 2007 in the basement of Nos Quedamos Community Center. The coop is now housed in an actual store front with regular store hours and an expanding membership base, about 200 now up from 16 when it started. As a member, Pavon must work a monthly shift since coop members run the store in order to cut out the cost of labor and make nutritious food more affordable. As a result, the community has ownership of the store and they make all the subsequent decisions about how to run it. Pavon says the idea is slowly catching on in the community. People have become more health conscious, but he says, it's still hard to resist buying something cheaper in a neighborhood that's overrun by fast food joints and bodegas.

Julio Pavon: You go across the street, you buy a Coca Cola, a Pepsi Cola, which is terrible for you, but it's cheaper. Or a woman who is on a fixed income, she goes to supermarket and she buys little juice things that are all sugar and water, she gets like maybe a dozen or two dozen for the price of what you might get for maybe one or two items here. But it's a long process and the thing is to try to teach people that in the long run. This is more inexpensive because that will (Inaudible 9:57) spending time in the hospital or getting sick.

Loren Bonner: The coop has tried to address these issues in various ways. Not only are they open to non-members, but they also accept food stamps and offer a discounted membership rate to those who are on public assistance. Isaac Purdue, a founding member who is working in shift today, says there is a good reason behind this.

Isaac Purdue: The idea is not to make like a lot of money, the idea is to get people (Inaudible 10:25) and be healthy.

Loren Bonner: The store and all its offerings is entirely open to the public. This includes the cooking and nutrition classes and workshops on hypertension and diabetes that are held regularly. Purdue says they get a lot of walk-in customers who come in off the street because their doctor told them they need to start eating healthier and they need advice on how to get started. Purdue says the coop is a necessary and growing community in the South Bronx because people have finally decided that they need to take care of their health. Let's listen to the interview with Dr. David Satcher to learn more about how he has paved the way in reducing health disparities.

Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Dr. David Satcher, former U.S. Surgeon General and Director of the Satcher

Health Leadership Institute at the Morehouse School of Medicine. The institute is an extension of your commitment to improving public health policy and eliminating health disparities. Do you think the same kinds of health disparities you faced while working as surgeon general still exist today? And do you think as the Commonwealth Fund research suggests that high performing health systems can substantially reduce or even eliminate health disparities between ethnic and racial groups?

Dr. Satcher: There is just no way you are going to eliminate disparities in health until we as a nation make the commitment to universal access to care. And the more and more we learn about this, it has to be more than just access to care, it has to be access to healthy environment.

Loren Bonner: Dr. Satcher, there are a lot of people out there who have a good idea about ways to improve access in health care. You have a reputation as somebody who gets things done, doesn't just talk about them, and your curriculum at the Satcher Health Leadership Institute seems to be twofold, both research and also a very action-oriented component. Would you describe for our listeners some key initiatives on both of those fronts, action and research?

Dr. David Satcher: Now, action is centered around the fact that we take on community health issues. We engage our scholars and fellows with community health issues. I have just finished talking with one of our scholars who is doing some work with the transgender population. So we take on the problems that many people would not take on. We don't invite an action but that includes research because we are a learning institute. So, the only way we can know what leadership works best, for example how best to influence policy, we have to really look at, we have to ask the question why did they take 45 years from the time that the Surgeon General's report on Smoking and Health came out in 1964 for Congress to give the FDA the authority to regulate tobacco as a drug. So our scholars and fellows learn that it's not just the sign that it takes to get policy change, but it also takes different forms of influence, clear communication, innovative presentations.

Mark Masselli: You have established a national program at the Institute that works with underserved poor communities. If you go back as far as the War on Poverty in the great society days of the 60s, we find the roots of the concept of maximum feasible participation or they stated more simply in showing that academics don't go in and study communities and leave, but rather that the community itself is empowered to both study and address their problems. How does your model address the active participation of communities that you will be working with? And are there any specific models that you implement that address quality health care and health outcomes?

Dr. David Satcher: Dr. Regina Benjamin, the President's Surgeon General, when she was sworn in, talked about the fact that she got involved in community while

a student here that the faculty didn't send her, they went with her, this institution has a mission that embraces community intervention. But you give me an opportunity to announce the newest program coming out of Satcher Leadership Institute, hopefully starting in July, will be the community health leaders development program. In this program, we will invite our partners in the community, churches, schools, sororities, fraternities, community groups, housing groups, we will invite them to send representatives, if you will, who are interested in becoming community health leaders and we will spend time with them. We will learn from them. They will hopefully learn from us.

Loren Bonner: Doctor, while you served as surgeon general, you released the Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity along with your prescription for healthy living, which outlined that need for physical activity and healthy eating that you are just speaking about. Now, fighting obesity has been getting a lot of attention recently, certainly from Michelle Obama and Let's Move campaign, and we know that the obesity epidemic is not going to get solved in the clinical exam room. So, what are the community-based policy interventions that can help prevent and hopefully even reverse obesity? How are you approaching that with your institute?

Dr. David Satcher: Well, let me say we had a little bit of a head start on that. When I left government in 2002, I worked with the group to develop what we call Action for Healthy Kids and that program centers primarily around working with schools to try to get them to a return or an engage in physical education K-12 and to model good nutrition. In other words, our argument is that we are guilty of addicting out children to sedentary lifestyles and poor eating habits, and our argument is that the schools are supposed to be the great equalizers, whether the children come from a poor home and an unsafe community or whether they come from a community in which they are walking trails and biking trails.

Mark Masselli: We are speaking with Dr. David Satcher, former U.S. Surgeon General and Director of the Satcher Health Leadership Institute. Well, fighting obesity is certainly urgent, there are other dramatic examples of health disparity in our country. Birth outcomes with persistent higher rates of infant mortality for African-American babies is one, the rate of HIV infection in minority groups is another. Are you addressing specific areas of health disparity or addressing the issues on a global perspective? And then how do you decide where to focus the institute's attention?

Dr. David Satcher: We do try to deal with the global issues related to taking on any such problem in terms of leadership. One the one hand, we try to have people on our team who have special strengths and interests in various areas. At the same time, overall, we try to make sure that we are preparing people to go out there and deal with global issues.

Loren Bonner: Dr. Satcher, while in medical school yourself at Case Western in the 60s, I have read that you helped convince the administrations recruit minority students and you are doing the same thing today at Morehouse. Tell us about why this has been a life's mission for you to recruit and teach a generation of diverse public health leaders and health care professionals.

Dr. David Satcher: I have been concerned about the lack of diversity in the health profession. I don't believe again that we can eliminate disparities in health without diversity in health profession. And I am not one who believes that you have to have a white doctor for a white patient or a black doctor for a black patient, I don't believe that. I believe that the health system has to present a diverse picture to the communities we save in order for people to feel comfortable.

Mark Masselli: Speaking of the health system, Dr. Satcher, you were involved in rebuilding the health infrastructure in New Orleans after Hurricane Katrina. The disaster highlighted a broken public health care system and a lack of health resources for poor and minorities. How can these lessons be applied elsewhere?

Dr. David Satcher: You know it's interesting because we are talking about New Orleans and we are still involved in that by the way. We talk about the health problems before, during, and after the storm. Louisiana had some of the worst statistics in the country in terms of obesity and diabetes and HIV/AIDS before the storm. And so, what happened was of course the storm exacerbated those areas of disparities. And so, what we are trying to do is to make sure that we rebuild the system in such a way #1 that it uses technology appropriately that the records will be electronic, they can't be washed away by water, but also that we put as much emphasis on health promotion and disease prevention as on treatment. So we have gotten involved with some clinics where we are trying to model the use of electronic health records and this outreach for community education.

Loren Bonner: Dr. Satcher, you are well acquainted with Healthy People 2010 which began in 2000 by United States Department of Health and Human Services as a nationwide health promotion and disease prevention plan that could be achieved by the year 2010 and here we are of course at the year 2010. In your mind, what was achieved and what are the objectives now proposed for the Healthy People 2020 initiative?

Dr. David Satcher: I think we have focus on disparities in a really great way throughout the country. We have all the federal agencies beginning with the CDC and NIH funding programs, specifically target disparities in health. We have community programs. Almost every major foundation that deals with health is now targeting disparities in health and many of the health plans of course have implemented programs to make sure that there are not disparities in the quality of

care that their patients receive. So I think this heightened awareness and engagement with the issue of disparities in health has been the most important outcome. The downside of all that of course is that here have been so many negative factors at play since that goal was released and I mentioned before, you have added people to the uninsured roles, you have made it more difficult for people with insurance to get care. So if you just take that one thing alone, you have more unemployed people, so obviously it becomes sort of social determinants of health. For many people, they have gone worse. You can argue that the goal didn't stand much of a chance in that environment. And now, of course, we have an opportunity hopefully to change that environment. I think that Health People 2020 would focus much more attention on social determinants of health following the lead of the World Health Organization.

Mark Masselli: Dr. Satcher, you have been a strong proponent of universal health care. What are your thoughts about the pending Health Reform Bill in Washington?

Dr. David Satcher: Let me start with the positive things. If the President bill that came out of the senate were passed today, it would do three things. It would certainly include over 30 million more people under the umbrella of the insured. It would immediately make it impossible for people to be excluded because of preexisting conditions. Almost immediately, it would prevent the insurance companies from dropping people from coverage once they will severely yield. So, if we had to settle for the situation as it is today, it would be a tremendous step forward, even though I am disappointed that we haven't talked enough about the opportunities for prevention and wellness.

Loren Bonner: Dr. Satcher, our listeners are a curious group, so when you look around the country and the world, what do you see that excites you in terms of innovation and who should our listeners of Conversations be keeping an eye on?

Dr. David Satcher: I thought about this recently because Chile was one of the first countries that the team from WHO that I was on visited, and the reason we started our journey on how to achieve health equity in Chile was that Chile had made a commitment that for the children of the poor, starting at three months of age, it would invest in day care, good nutrition, and as they got older, physical activity and learning. So, Chile had said in essence, we would rather invest in these children in terms of their education and their physical activity than to wait and invest in them when they get sick or when they get on Medicare, on welfare. And not only is it more cost effective, but it's more humane because we have an opportunity to prevent violence, to prevent ill health. I hope that Chile would be able to pursue this and they are obviously trying to just do it aftermaths of the earthquake.

Mark Masselli: Today, we have been speaking with Dr. David Satcher, former U.S. Surgeon General and Director of the Satcher Health Leadership Institute at Morehouse School of Medicine. Dr. Satcher, thank you for joining us today.

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. This week's bright idea focuses on creating Safer Routes to School. The Safer Routes to School program has been making it safe and enjoyable for children to walk and bike to school in several communities across the country. For the past five years, the program has assisted communities with strategies and creative ideas for implementing Safe Routes to School programs. Travel to school by walking and bicycling has declined dramatically over the past several decades. The adverse impact on this trend on air quality, traffic congestion and childhood health are alarming. These programs can bring a wide range of benefits to students and the community. These include an easy way for children to get regular physical activity they need for good health and even to ease traffic jams and reduce pollution around schools. To highlight just one example, the small town of Wharton Borough, New Jersey, started their Safe Routes pilot program in 2005 with a small grant from the North Jersey Transportation Planning Authority. Wharton Borough is a compact community where students are not bussed to school and safe alternatives to driving were needed. The community kicked off the program with an annual walk-to-school day. The event was a huge success and attracted parents, teachers, community volunteers, and 58% of the student body. The following year's walk-to-school day attracted even more. 70% of the student body and Law Enforcement officers participated to ensure safety. After experiencing success with walking, the community went on to organize an annual bike rodeo. Education components were also added. Teachers included environment impacts and mathematics involved with walking to school in their lesson plans. After two successful years with the program, the North Jersey Transportation Planning Authority gave two of the schools funds to pay infrastructure improvements like a raised crosswalk at the three-way intersection in front of the school and sidewalk extensions and repairs around the school grounds. The two schools have also received money for helmets and new bicycle racks. The National Center for Safe Routes to Schools is now accepting grand applications for creative youth-focused ideas that support safe walking and biking to school. To learn more or see how your community can start a Safe Routes to School program, visit Saferoutesinfo.org, creating safe routes to school to reduce traffic, improve health, and make communities more livable, now that's a bright idea.

Margaret Flinter: This is Conversations on Health Care. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

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