



THE INSTITUTE FOR INTEGRATIVE HEALTH

Conversations on Health

An initiative to understand definitions, perceptions, and novel insights on health

Funded by the Fannie E. Rippel Foundation

In 2009 in the United States, we are in a ferment of healthcare reform debate. Government, media, corporations, non-profits and neighborhood meetings alike engage in broad, constant discussion of health and healthcare. Yet, in the crosscurrents of politics, money and human concern, are we really clear what we mean – as a nation or individually – when we talk about health? Are we working with a shared understanding? What actually is health?

In the context of the national discussion, The Institute for Integrative Health, a non-profit organization, has undertaken to question twelve individuals from diverse perspectives regarding their understanding of health. With generous funding from the Fannie E. Rippel Foundation, we set out to learn what a range of actors in this intense debate think; what have they chosen to do with their beliefs about health, professionally and personally; what barriers they see as interfering with health; and what they think the place of integrative medicine and integrative health may be in this large picture. Further, we asked a “magic wand” question. We wanted to know what they most hope to see come out of the healthcare crisis in which we find ourselves now.

Our initial research for this project gave us an early sign of its importance. We were surprised to find that many preeminent health-focused websites make no effort to define their subject. The National Institutes of Health, the Food and Drug Administration, the American Medical Association, and the website Health.com do not address what they mean by “health.” The National Library of Medicine gave us a starting place with its information service, Medline Plus. There, health is defined as “the condition of an organism or one of its parts in which it performs its vital functions normally or properly: the state of being sound in body or mind: *especially*: freedom from physical disease and pain” (www2.merriam-webster.com/cgi-bin/mwmednlm?book=Medical&va=health, accessed October 10, 2008). At its founding in 1948, the World Health Organization adopted this definition: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (www.who.int/suggestions/faq/en/index.html, accessed October 10, 2008).

Participants in the Conversation

So how do these definitions from the dictionary and the World Health Organization play out in the lives of a dozen real people involved in “health” in a range of important ways at this crucial time?

We hope that conversations with these engaged individuals can help clarify what we mean by “health” and, beyond that, identify gaps and opportunities for promoting health across the lifespan.

The Institute for Integrative Health carried out, documented and synthesized twelve *Conversations on Health*, with invited participants including –

- The president of a leading healthcare policy consulting company
- The vice president of a managed healthcare services company, working extensively with the public sector
- The director of health and wellness services for a major defense firm
- A social worker and clinical director of a nonprofit serving abused and neglected women and children
- A young woman from a poor coal-mining family, now making her career after completing a master’s degree in complementary and alternative medicine
- An attorney, former corporate human resources director, and single mother of four, with significant experiences as a patient in the healthcare system
- A physician and former CEO of an urban tertiary care hospital
- A physician and innovative county health commissioner
- A medical school professor specializing in health policy, preventive medicine and the critical appraisal of research evidence
- A physician advocate for a national health plan
- A physician, writer and founder of a major corporate wellness organization
- A bicultural nurse-midwife with long experience in lay-midwifery, hospital and home births

We are deeply grateful to each of these busy, committed individuals who generously shared time and ideas with us. Following is a synthesis of what they conveyed – their views of health, perceived barriers to health, proposed solutions and, significantly, their hopes for the future.

Participants’ Views of Health

Every participant, most notably, defined health as more than the absence of disease. Words used to describe health, or to convey the meaning of health for participants personally, include: *broad, positive, productive, happy, ability, wellness* and *wellbeing*. Often individuals described health as a state of being that involves emotional, mental, spiritual and social as well as physical aspects. A clinical social worker added, “It’s all about balance ... and feeling like a whole person.” A nurse-midwife said that health is balance; it’s when “your insides and your outsides match.” People described health in dynamic terms as well. A healthcare executive said, “It isn’t an end state. You’re always working toward it.” An attorney and single mother of four, who has had many health problems, said, “Health means I can go about my daily life psychologically and physically, and interact with my world (people, things, jobs, creative ideas, whatever) unencumbered.... It’s about seeking things, but also being open to things that cross your path.” Said a young woman who grew up poor and has seen drug abuse in her family, “Health is about finding something ‘good’ to be ‘addicted to’ that pulls you into contributing to society, instead of being pulled away from it.” A pioneer in corporate health

elaborated: “Health is a life fully realized. It’s not about perfect mind, perfect body, or even the absence of trauma, or even a long life. It’s about realizing one’s life force.”

Barriers to Health: Individuals, Environment and Society

We asked our participants why they think many people do not focus on their health. What is it that gets in the way? Responses uncovered factors ranging from a lack of healthcare access to negative cultural influences to a lack of personal motivation for self-care. The physical or “built” environment itself may act as a barrier to health promotion. A neighborhood or region may lack hospitals or in other ways discourage healthy behaviors, perhaps lacking sidewalks or good quality grocery stores.

On a larger scale, we have a society “that doesn’t take care of itself and in fact encourages bad behaviors,” according to the former hospital CEO. This may be due to a lack of role models for good health practices or a lack of health education in schools. Cultural images matter. Advertisements routinely promote unhealthy body images and push “comfort foods,” often nutritionally depleted products. Mass purchase and consumption of such foods led a corporate wellness expert to suggest that “the obesity epidemic isn’t independent from the economy.”

The nurse-midwife observed, “We’re in an anxious society in an anxious time.” She sees many women with physical and mental symptoms arising, she believes, from underlying anxiety, drawn from our environment. She spoke too about the many women she sees who have histories of abuse or multigenerational histories of trauma. These women first have to be gently helped to identify what self-care is, before they can engage in it.

Our work settings are another significant factor. We value high workplace productivity as a form of life satisfaction, which several participants cited as an overall negative influence. A corporate director of health and wellness noted that in his organization, “stress is rampant.” As expressed in a recent review:

Modern culture negatively influences wellbeing because it is based on values that are detrimental to health and happiness. Modern life perpetrates ‘cultural fraud’, promoting images and ideals of the good life that serve the economy but do not meet psychological needs or reflect social realities. (Carlisle S, Hanlon P, Hannah M. Public Health. 2008 Jun;122(6):631-7)

Rather than valuing a regular routine of exercise, nutrition and stress management, our culture tends to dramatize healthcare. We commonly speak of medicine as waging “war” on disease, noted a health policy and preventive medicine expert. He said that we look to breakthrough drugs and procedures (sometimes referred to as “silver bullets”) as the way to deal with disease. “To take a cynical view,” he added, “there’s an industrial agenda in promoting that strategy. ... Profit [is] made by treating, not preventing disease, and major power interests would lose a lot if [there were] less of a market for their products.” Healthcare providers and patients too may have a bias toward disease treatment. A medical intervention may show immediate, tangible results, while the pay-off for a routine of daily self-care may be unrecognizable – that is, the absence of disease.

The daily self-care routine, however, requires awareness and the exercise of personal will – less common than perhaps they could be. Several conversations described a sort of “teenage mindset,” in which some people seem to feel themselves immortal, immune from illness and accident. They may not concern themselves with the consequences of their actions, seeming to assume that someone else will fix any future problems. From this point of view, self-care is seen as a tacit admission that we are headed towards decay – an uncomfortable awareness, as we resist facing our mortality. One participant noted that our society supports this illusion by promoting living on credit, literally and figuratively. We may go into “health debt” in order to have immediate gratification, repressing the long-term implications for our well-being.

Nor are healthcare professionals themselves always conscious of self-care. As one noted, surgeons can be seen beginning a long day of work, taking eggs, bacon and coffee while digesting the world’s conflicts in the morning paper. “What does this say,” she asked, “about the frame of mind and body that they take with them into the O.R.? Would it be more appropriate or more reverent to begin a day of surgery with meditation or guided imagery?”

Many participants spoke about how difficult it is to change personal behaviors to enhance health. One physician went into pediatrics because she felt she could instill healthy attitudes and practices in young patients, but would be less successful with older people whose behaviors are fixed. On the other hand, we heard from the clinical social worker that, though deep-rooted patterns can be barriers to health, they are not inescapable. She emphasized that a crisis may be exactly what is needed to bring about health: “Something happens that becomes the window of opportunity for change.”

Barriers to Health: The Healthcare System Itself

Despite their varied perspectives, many participants had similar insights into what one called the “brokenness” of the healthcare system. They identified problems including misguided priorities, misaligned financial incentives, rising costs of both healthcare and medical education, lack of access to insurance, lack of preventive care, and time pressures that degrade the quality of primary care.

Misguided Priorities

With regard to priorities, the president of a healthcare policy consulting company named a fundamental issue. Our “healthcare” system, he said, is actually for “sick care, catastrophe care, as opposed to wellness.” Some participants noted that we are too focused on *disease* and not focused enough on the *person* the disease inhabits. There was a general belief that we do not look broadly enough at multiple influences on health – societal and economic – to establish “good and rational healthcare priorities.”

Participants identified many factors that make our healthcare system increasingly expensive and hard to afford. Some factors relate to direct patient care practices and others to health insurance, all interacting to create an unsustainable system.

Affordability: Patient Care Factors

On the patient care side, the neglect of preventive education and monitoring – which are not reimbursed by insurance – drives up costs by ignoring potential health problems until they require medical tests and procedures – which are reimbursed. Further, as healthcare costs go up, pressure mounts on physicians to see more patients in less time. Tired and frustrated, some primary care physicians leave practice, diminishing the ranks of needed frontline providers. Moreover, new physicians increasingly opt for higher paid specialties in order to cover burdensome medical school loans. This is yet another cost pressure that depletes the ranks of primary care providers, undercutting the workforce that can support preventive care. Participants identified another major issue in our increasing use of expensive technology, especially in the last year of life. Given demographic trends, putting a disproportionate share of our health dollar into end-of-life care raises a question of values and economics that we must face at some point. It appears to be an unsustainable practice.

Affordability: Health Insurance Factors

On the health insurance side, as noted above, medical tests and procedures are commonly reimbursed, whereas patient education, support and monitoring are not. When a psychologist in a large HMO asked for more funding for social workers to intervene with at-risk children, he was told, “No, those people won’t be our concern in ten years. They won’t be in [our organization].” Because most U.S. health coverage is employer-based and thus transitory, insurers know their population will shift to some extent every year. This gives them small incentive to put resources into preventive care. Why avoid medical expenses now, that some other insurer will have to pay for later on? In short, providers do what they are paid for doing, and insurers pay for what they have to. The healthcare industry is organized to provide tangible services when needed, but not to support health and well-being over the span of a life.

One of our participants is director of health and wellness services for a defense firm that covers healthcare for over 500,000 employees and dependents. Over time, he watched insurance costs accelerate to a point where he knew a major shift in priorities was required. Four years ago he developed an innovative, multifaceted wellness program that, after years of health cost increases, has “bent the curve” downward for this population. In a rich and detailed conversation about his experience, several barriers to affordable healthcare became evident. Foremost, he stated that “the healthcare industry could care less about an outcome, more about where the money flows.” What we pay for, we get more of – expensive treatments and procedures, not necessarily good health. A second, less obvious barrier was the company’s assumption that market forces – competition between insurers, together with choices made by employees – would over time yield the best, most affordable coverage. Years of watching cost increases convinced him, however, that the normal law of supply and demand does not apply in healthcare. The way the system is organized does not lead to the best, most affordable outcome because “the consumers aren’t the payers and the payers aren’t the consumers.” The impact of rising costs does not affect a consumer directly enough to bring about a decrease in demand. He decided on a new strategy: “We have to take demand out of future healthcare services” – that is, create an effective wellness and prevention program, and find ways to give individuals a financial stake in their own self-care. This revealed a third barrier, which is the readiness of individuals to embrace wellness opportunities, when offered. He noted, “We have over 180,000 employees that can walk down the hall and get health care services for free, yet we don’t take advantage of this access.” More will be said about this corporate wellness strategy, but the

lesson is clear. As major brokers of insurance options, employers have an important perspective and a large stake in addressing barriers to health.

It should be remembered, however, that not everyone has employer-sponsored health insurance. Children, women, the elderly and some ethnic groups disproportionately lack access to health insurance, either because of employment status or – as one of our participants, a county health commissioner, discovered – because they are unaware of public coverage options open to them. For 46 million people in this country, lack of access to insurance remains a significant barrier to health.

Dealing with the Barriers

Participants in these conversations work in a range of venues – corporate, public sector, nonprofit and their own personal lives – and have approached these barriers to health in different, creative and effective ways. They have a great deal of experience and wisdom to share.

As we have seen, corporations have direct access to – and through infrastructure and financial means a certain amount of control over – large employee and dependent populations. Several participants told us how this access can be shaped and leveraged to promote healthy behaviors. One said plainly: “We have the power to do things within our sphere of influence and change culture.” His organization contains within it a large number of medical and occupational clinics and an extensive food service, all of which he is integrating and coordinating toward a goal of population wellness. Clinics in his company are aimed not at treating a condition, but an individual: “If you come in with back pain, you treat the obesity issue, which leads to the fact that they’re depressed.... There are so many co-morbidities, and that’s what we’re going after.” Food is being shifted toward increasingly healthful nutritional and calorie standards. Within a year after smoking was banned on all company property, over 3000 employees had enrolled in tobacco cessation programs. The company is also branding its own health-related classes, such as yoga, to assure high standards for employees. The depth of his commitment comes through in his summary:

We’re working to create a culture and ... orchestrate our health-related aspects [so that] people understand and make comprehensive, holistic and sustainable changes in their approach to health.... And I’ll be damned if it’s not working! We have phenomenal data analytics. It’s been successful because it’s not intrusive, it’s conversational.

Many participants discussed specific aspects of the workplace. In terms of physical plant, some advocated a cafeteria offering healthful foods, so employees are not left to choose from poor-quality outside options. Others emphasized the need for a gym, available to employees during the workday and spacious enough to be ADA-compliant. In addition to wellness facilities and classes, some companies also provide health coaches to work with employees individually.

For the success of any of these corporate wellness efforts, it appears that top-level executive commitment is a crucial factor. One of our participants is a physician who works with companies investing in healthy workforce initiatives. After speaking with medical directors from many Fortune 500 corporations, he has found that the number-one barrier to achieving a healthy workforce is the medical director’s lack of access to, and appreciation from, a company’s president. Top executives may not see medical directors as significant players, or may not see poor health outcomes as a corporate liability. This physician stated that, though chief financial officers tend not to focus on

quality-of-life measures, evidence is growing that some complementary practices are both economical and clinically effective. There is now sufficient evidence, he said, so that a medical director can turn existing data into a credible business case for workplace health initiatives that include complementary modalities. He cited as an example a major obesity management intervention developed by Dow, using computer interactive models, data analytics, mindfulness-based stress reduction and the involvement of a health coach for education and support of employees. As a further case in point, a former hospital CEO told us that General Mills has a wellness program (smoking cessation, nutrition and stress management) that employees can take during work hours and receive cuts in their medical co-pays. He stated that this program has reduced General Mills' overall healthcare cost by 20%.

Because the private sector pays the insurance cost for such a large percentage of the U.S. population, it can exercise significant leverage in the healthcare system. Some of our interviewees made this point in mentioning the Leapfrog Group, an initiative driven by health insurance purchasers who have joined together to spur improvement in healthcare safety, quality and affordability. Leapfrog conducts an annual hospital survey and publishes a list of "top hospitals" that "demonstrate an exceptional level of performance and serve as a model for other hospitals"

(www.leapfroggroup.org/media/file/2008_Top_Hospital_Release.pdf, accessed July 31, 2009).

Among hospitals responding to the 2009 survey, "efficiency standards – defined as highest quality and lowest resource use – are met by only 24 percent of hospitals for heart bypass surgery, 21 percent for heart angioplasty, 14 percent for heart attack care and 14 percent for pneumonia care." Less than a quarter of U.S. hospitals responded to the survey

(<http://www.healthcarefinancenews.com/news/most-hospitals-lack-quality-cost-effectiveness-leapfrog-survey-shows>, accessed July 31, 2009).

With regard to workplace wellness, the nonprofit sector typically has less funding available than do corporations. As the clinical director for a social services agency pointed out, "Feeding and clothing people comes before reducing your stress. That's a constraint." Nevertheless, she was clear that the wellness of her staff and clients is a high priority for her. Until the funding ran out, she offered stress reduction and energy psychology classes for staff. Now, she said:

I make sure people go home at the end of a shift.... I tailor jobs to best use [individual staff] talents.... That way my staff feels supported, but also challenged.... I also run around and tell people they're doing a good job.... Part of my role is to do a lot of education to [diminish] the frustrations of my staff.

This quality of effort does not take extra expense; yet it makes a crucial point that did not come out anywhere else in our sample. Sensitive, respectful human resources management is a fundamental contributor to workplace wellness. A listener is reminded of the role of "health coach," as described by the corporate wellness physician quoted above. Without calling herself a health coach, this caring and observant clinical director clearly fills some of that role for her staff.

Indeed, she extends sensitivity and respect, not only to the staff of her shelter, but also to the women and children who arrive there in personal crisis. In the basic matter of food, she has consulted with a dietitian to develop meals that respect residents' tastes, while at the same time improving nutritional support for this difficult time in their lives. We consistently heard from our participants that food is a major issue. The question of improving food choices has spawned a broad range of approaches, by no means all successful. One participant cited efforts in New York City,

where they have banned trans-fats from all restaurant food and are taking sodas out of the schools. Though innovative things are happening, results can be elusive. A managed healthcare services company installed a food machine offering fresh fruit, but the fruit went bad before anyone ate it. Ironically, hospital food may be among the worst. A former medical center CEO acknowledged, “Yes, the food for the patient was lousy, but it’s because we didn’t spend enough money on it, to be frank.” He learned from patient surveys that food quality was “way down on the list” of patient concerns, so it did not pay to put resources into improving it. When he asked the contractor for the hospital cafeteria to offer more healthful food for visitors and staff, her response was, “We can supply it, but nobody buys it.” On a recent, more hopeful note, however, we were told of a Marylander who is coordinating local farms and restaurants in an online pilot project to support growers and improve the quality and nutritional content of Baltimore-area food.

Connecting farms and restaurants online is a creative, community-based effort that supports healthy practices. On a larger scale, the most comprehensive community-based approach that we encountered is the *Healthy Howard* initiative in Howard County, Maryland. There, the health commissioner and county executive are implementing a model public health community with four components: First, incorporate healthy practices into basic elements of the community such as restaurants, schools, workplaces and housing. Second, enroll all eligible children in the county into the State Children's Health Insurance Program (SCHIP). Third, create and manage a county health plan that covers all adults not currently insured in other ways. Services are offered through an interdisciplinary healthcare provider group, augmented by 200-250 specialty physicians who see patients *pro bono*. Incentives that draw these specialists to the program include altruism, simplicity of organization, the availability of care coordination, and positive feedback. The provider group does the care coordination, and “each person has a health coach (nurse, physical therapist, [etc.]), meeting face to face in the community.” Coaches are trained in ‘motivational interviewing,’ so they can learn what engages clients in their health, rather than lecturing at them. “Tai Sophia [a graduate school for healing arts and sciences (www.tai.edu)] trains all our coaches in integrative medicine, and [they] get life coach training at Howard College.” Every client has a primary care provider, a health coach and a “health action plan.” The fourth component of the *Healthy Howard* initiative is program evaluation, tracking each patient’s Health Risk Appraisal, biomarkers every three to six months, unnecessary hospitalizations, cost burden and health action plan compliance.

A major *Healthy Howard* goal is to enable seniors to stay well and in their homes. We heard about another community-based senior program with a similar purpose. Healthways Silver Sneakers Fitness Program (www.silversneakers.com) is national in scope, yet based in local gyms and YMCAs. It is a benefit offered by some Medicare health plans to encourage physical activity, healthy lifestyle and social interaction among older adults. It provides free fitness center access, exercise programs tailored to the needs of elders, health education and a “specially trained Senior Advisor” – again, another indicator of the importance of the “health coach” concept, a personal link toward developing new, healthier behaviors.

A group that poses particular challenge for behavior change is that of women who have been trafficked or raped, or are former prostitutes. The nurse-midwife described her approach to working with women so traumatized, they have no idea what self-care is. She looks for what she calls “loose strands” of the woman’s being. She then devises one single positive, life-affirming thing for the woman to do next, so that she can “find that strand, put it in her needle, and have a chance to start

to weave herself again.” The nurse-midwife, whose career has spanned decades, estimates that this approach succeeds at the rate of “one woman a week.”

One of our physician participants, whose field is preventive medicine, stated clearly that the real opportunity for health reform “doesn’t happen in the doctor’s office, [but] in getting people to modify their health behaviors and lifestyle.” An expert in the critical appraisal of research evidence, he has concluded that recent work in comparative effectiveness trials (direct comparison of two or more interventions to determine which work best) and personalized medicine (the use of molecular profiling technologies such as genomics) are “rearranging deck chairs on the Titanic, to avoid dealing with more important influences on health” – in his view, social conditions, economic conditions and education.

His statement points directly to the work of another of our physician participants, a pediatrician who has left clinical work to devote herself to activism in public policy. She has become an advocate for change in the healthcare system through Physicians for a National Health Program (www.pnhp.org), and at the state level, she is working to promote the Maryland United Health Care Act. This would create a healthcare system to include every person who lives in the state, would address accountability and transparency, and would include incentives to direct more primary care providers to underserved areas. The Howard County health commissioner likewise sees his efforts as contributing to larger-scale change. He told us in Fall 2008 that he wanted to have outcomes data from *Healthy Howard* ready for President Obama’s healthcare reform effort. He hopes his county model will stand as a strong argument that the cost of a comprehensive community-level healthcare program is far outweighed by its benefits.

Complementary, Alternative, Integrative or Holistic – Medicine, Therapies, Care or Health

The terminology of this field is fluid, its sources diverse, and its prime purpose to meet the needs of the unique individual. This statement summarizes a number of our conversations. When asked about the meaning of *integrative medicine* or *integrative health*, one described it as “taking the best from medicine historically and medicine currently.... It has to do with lifestyle.” An attorney drew this distinction: *Integrative* means “pulling together a number of different approaches to health and healing.... Integrative medicine is the entity, [while] integrative health is the individual. It’s something that I would practice.” A physician who uses “complementary therapies” herself said that integrative health “would mean incorporating all the different types of medicine and whatever type of health practice would best meet the needs of the patient.”

To a nurse-midwife, integrative medicine is about “looking at the totality, not the separate parts.” When she looks at a woman, “if there’s no light around her, nothing glowing out of her face, then something needs to be done with the pieces to make them whole.” Similarly, a social worker described integrative medicine as “that balance piece, the holistic view.... [You] don’t just need a pill or [you don’t just say] your mind caused everything.... Realize we’re not perfect and it’s a lifelong process.”

A professor of health policy and preventive medicine observed that we have been using the term “integrative” in two distinct ways: “One is around the notion of health.... The other is in the approach, almost from a policy level, of which sectors or interventions you’d take to promote that kind of health.” One might, for example, have back pain and make the choice to deal with stress and

emotions to “get closer to wellness. But having made those choices, the policy side is what needs to happen in the worksite to facilitate that, and what the ... home setting should be, and integrated to promote that health plan.” In other words, he turned the focus toward the social settings in which integrative health needs to be implemented, day by day, in order to be effective.

Indeed, our conversations turned up a number of ideas and programs for social structures to support integrative health. In the Howard County, Maryland, initiative described above, community-based health coaches are trained in integrative medicine through the Tai Sophia Institute. These coaches are trained to listen well to their clients, give them appropriate health education, assist them in writing health action plans, and track their progress and outcomes.

In an ambitious workplace initiative, a major defense contractor’s employee clinics are directed not toward “treating a condition, but treating an individual.” Information on practices such as massage and yoga is made available, but unfortunately that is “not covered under our plan because there’s not enough evidence.”

A psychologist, addressing “the impact of psychological factors on [physical] health,” gave strong support to the idea of teaching schoolchildren to meditate, as a way of stemming the development of aggression. From years of community-based experience, he saw integrative practices as having great potential to prevent future public health problems.

While structures of community, workplace and school can indeed be designed to foster integrative health, this in no way lessens the significance of personal responsibility and will. This was made poignantly clear to us by a young woman from a distressed coal-mining community with little access to medical care. Integrative medicine, she said, “has to do with lifestyle.... There are ways you can prevent things from turning acute to chronic. As long as I do prevention, I don’t have to rely on going to the doctor, and if I have to, it’s to help me get back on track.”

The Magic Wand: What Would They Most Like to See?

We asked our participants how they felt leaders might best tackle these problems, and what they themselves would change with a magic wand, if they could. Some recurring themes emerged:

First, ideally, our society would acknowledge that health is not solely an individual matter. Self-care is fundamental, but is pervasively influenced by social and economic forces. Without diminishing personal responsibility, our participants want to focus on reforming the larger conditions that tend to produce ill health. Examples offered include unrealistic body images in the media, poor nutritional quality in foods, unemployment, lack of insurance, lack of access to healthcare, and lack of education. “Change is not conceptual,” said one. It’s important to “get out there and see the resources, or the lack of resources.”

Second, there is a desire for health and wellness efforts to be broad-based and coordinated among many community organizations. This could include government departments such as transportation (for more bike and walking paths) and education (for higher graduation rates and better food in schools), nonprofits collaborating with health departments and with each other to offer seamless services to those in need, religious organizations, senior centers and others. Small businesses such as daycare centers, hair salons and barbershops have proven an effective way to disseminate health

information at a grassroots level. Community-wide public-private partnership is seen as holding a great deal of promise.

Third, those who are engaged in workplace health initiatives hope to see more employers doing what these innovators are already successfully doing. They see great potential in this approach, since employers insure and have influence with a large proportion of the U.S. population.

Fourth, participants put high value on a future expanded base of research evidence. Health outcomes data should be collected and analyzed to show what health service delivery models are best and most cost-effective. In particular, research in complementary and integrative care is desired, as present evidence (e.g., yoga for back pain) is viewed as inadequate.

Fifth, several participants hope to see a single-payer healthcare system emerge from this national debate, including components of health education, evidence-based care, and substantial cost saving.

Sixth, several express a desire to fundamentally change the financial incentives in our current system. In this view, providers would be paid for helping patients to get well and stay well, not for doing multiple tests and procedures, fee for service. Individuals could be rewarded financially for healthy behaviors, as a number of corporations are already doing with employees. Insurers could be incentivized to support more preventive care and health education, perhaps by moving to a continuous “whole life” model of health insurance.

Finally, all are united in wanting some form of universal healthcare. As a physician pointed out, we are not yet in compliance with the 1948 Universal Declaration of Human Rights:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The Lessons

The purpose of engaging in these dozen *Conversations* and the workshops was not only to network among perceptive, innovative people, nor just to learn from them, but also to give the Institute for Integrative Health a fund of grounded knowledge for action going forward. The enabling grant touched so many participants that it is difficult to capture all that occurred as a result of this effort. Nevertheless, there are many concrete outcomes that we are pleased to report:

1. Perspectives on Health

Out of the deceptively simple question, “What is health?,” we gleaned rich content to inform the development of our soon-to-be-live, interactive, multimedia website, called *SpeakHealth* (www.SpeakHealth.org). In our internal discussions, we also reflected on this concept - that health is having meaning and purpose in life, and that health is a “life fully realized.” One of our vanguard projects stems from this recognition. We are working with professionals from the University of Maryland and Johns Hopkins hospitals to develop an initiative to foster meaning and purpose in the lives of teens born HIV-positive. Despite all expectations, they

have survived to adolescence and now feel rudderless. A white paper is now in preparation, toward the launch of a training program led by the teens themselves. To quote one, “We all face challenges in our lives. For some of us that is AIDS, but what matters is having meaning.”

2. Self-Care

Though many of the participants we spoke to were healthcare professionals, the question of health was clearly not just a workday concern for them. Not only did they show genuine care for their patients, clients or employees, but they were careful of their own personal health as well. In a society that values high productivity as a form of life satisfaction, or a society that values youth more than age, the topic of self-care can be fraught. The questions we have asked ourselves include: How do we encourage and sustain a positive approach to health and self care over the full span of a lifetime? What are the important issues to consider and how can the Institute spark fresh thinking and ideas? We have been fortunate to engage Ellen Hughes, MD, PhD (Clinical Professor Emerita, University of California, San Francisco, School of Medicine) as an Institute Scholar and are honored to support her in her timely and important research on the subject of healthy aging.

3. The Environment as an Influence on Health

In discussing barriers to health, our *Conversations* participants identified significant social and environmental factors that interfere with well-being. No one doubted that individual health is affected by many influences much larger than the individual. The interaction and outcome of multiple factors lies in the realm of complexity science. To support exploration of this growing edge of public health, the Institute has again been fortunate to engage a pre-eminent scholar, social epidemiologist, George Kaplan, PhD (Professor, University of Michigan School of Public Health and Institute for Social Research) as an Institute Scholar. He has proposed to focus on the application of complex systems approaches to intervening to advance population health and reduce health disparities, taking into account an integrative approach. He will focus his attention on a particular major health challenge, such as depression or obesity.

4. Human Relationships – The Health Coach Concept

Several of our *Conversations* surfaced the new concept of the "healing coach," a healthcare professional who works one-on-one with individuals seeking to improve their well-being. It is apparent from the many ways in which this concept is already being applied, that it has the potential to be of real use in communities of all kinds. At this time, however, the field is largely undefined and there are no standards for training and no credentialing in place. Together with the University of Minnesota Center for Spirituality and Healing, we are co-sponsoring an October 2010 symposium to explore and define standards for the education and practice of this promising new profession.

5. The Power of Innovative Leadership in Healthcare

Listening to many of our participants talk about their work, we were again and again impressed with the downstream impact of their efforts. A resourceful county health officer can combine existing government programs and fashion new ones so that every individual in the county has health coverage. A visionary human resources executive can shift the culture of a large corporation toward broader well-being, not only for employees, but for their families as well. A young woman without financial resources says that, if she had money for medical school, she would gladly go into primary care in any underserved area anywhere – and her listeners can already sense the resulting good that would be done, if only this woman had the funds. What is it that primes these professionals to be perceptive, responsive and creative? The Institute would like to know – Is it possible to teach this quality of active compassion? We are now initiating research that will study whether mind-body skills training at medical schools across the country can develop emotional intelligence and compassionate leadership among medical students and faculty.

6. Integrative Health and the Evidence Base

During the *Conversations*, public health physicians and healthcare executives often raised questions relating to evidence. What is the quality of existing evidence for the effectiveness of healthcare interventions, whether conventional or integrative? One stated bluntly, “I want to see evidence and proof of commercial benefit.” With regard to integrative medicine, another said, “There’s not enough evidence.” These comments reinforced a similar message from the Institute of Medicine Summit on Integrative Medicine and the Health of the Public (February 2009) and its panel on evidentiary issues. At the same time, the national health care reform debate has also pointed out the need for comparative effectiveness research in medicine as a whole, to enable better health care decisions and inform coverage of diagnostic and therapeutic approaches.

In light of this input, we have initiated an important collaboration with the non-profit Center for Medical Technology Policy (www.cmtpnnet.org). Together, in November 2009, we will hold an invitational **Stakeholder Symposium on the Evidentiary Framework for Complementary and Integrative Medicine (CIM)**. Bringing researchers together with clinicians, patient advocates and payors, including insurance companies and the Center for Medicare and Medicaid Services, we aim to develop Evidence Guidance Documents to help CIM researchers design studies more directly usable by decision-makers, clinicians and third-party payers.

In addition to the above, the lessons learned from the *Conversations* helped to inform the testimony of Dr. Brian Berman and Susan Berman submitted to the Senate Committee on Health, Education, Labor and Pensions Hearing on “Principles of Integrative Health: a Path to Health Care Reform” [February 23, 2009]. We had an increased awareness of the issues that needed to be brought to the attention of policy makers and reformers, which include: a) improving consumer access to health information; b) supporting better reimbursement for primary care and

prevention, covering a broader range of health care practitioners and health care modalities; c) investing in research that has direct impact on translating knowledge into prevention, diagnosis and treatment of disease; and d) transforming health care at the front line by recognizing the five influential areas of health which are the environment, behavior, genetics, social circumstances and health care.

The Institute for Integrative Health (TIIH) is a non-profit 501(c)3 organization that provides an environment for innovative thinking on health and healthcare, fosters collaborations, and facilitates the testing and implementation of novel solutions.

Contributors to this project from TIIH include: Brian Berman, MD, Susan Berman, Robyn Brenza, Margaret Chesney, PhD, Aviad Haramati, PhD, Beverly Pierce, MLS, MA, RN, CHTP, Richard Scott, Rachel Trippett, MS.



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