Dr. Steven Woolf:
One of the interesting findings of our report was that even when we looked specifically at white populations, rich populations, insured populations, non-smokers, every way we sliced it, even the most advantaged Americans were dying earlier than their counterparts in other countries.

LuAnn Heinen:
That's Steven Woolf, physician, epidemiologist, and Professor of Family Medicine and Population Health at Virginia Commonwealth University. An elected member of the National Academy of Medicine, Dr. Woolf chaired the committee that in 2013 produced the report on shorter lives, poorer health, comparing U.S. health outcomes to 16 peer countries. Despite much higher spending on health care, the U.S. ranked lower than the peer country average on most major health domains. What happened in the 10 years since this seminal report? We'll get an update on life expectancy in the U.S., delve into root causes behind some of the quite sobering statistics, and explore how companies, communities, and policymakers can make an impact.

I'm LuAnn Heinen, and this is the Business Group on Health podcast, conversations with experts on the most relevant health and well-being issues facing employers. Today my guest is Steven Woolf, who reflecting on the sad state of U.S. life expectancy in a 2023 NPR interview said, “a concerning problem is that the death rate is increasing for children 1 to 19. And put simply, that means our young people are less likely to reach age 20 in adulthood. We need to do something to try to save our children if they're going to have a future.”

Dr. Steven Wolf, thank you so much for joining the podcast today.

Dr. Steven Woolf:
That's my pleasure.

LuAnn Heinen:
Let's start with this, a decade ago in 2013, you chaired a committee of scientific experts for the National Academy of Medicine charged with analyzing health outcomes and life expectancy in the U.S. compared to other countries. And that report called out a notable decline in the U.S. concluding “our relative standing in the world has fallen over the past half century.” And that 2013 report title was attention getting: *U.S. Health and International Perspective: Shorter Lives, Poorer Health*. So now, 10 years later, where are we and what happened in the wake of that report and all the publicity that followed?

Dr. Steven Woolf:
Well, there was a brief period of publicity after the report was released, but not enough to satisfy our committee. We were hoping for much more attention to the problem. Unfortunately, what's happened in the decade since that report was released is that the U.S. health disadvantage, which is the term that we use for describing the problem you just mentioned, the U.S. health disadvantage has only worsened. It became more severe than we had detailed in our report. And at that time, when our report was released, we were already painting a pretty grim picture.

LuAnn Heinen:
Let's get a little granular. The U.S. ranked at or near the bottom of many outcome measures. Can you just recap a few of those?

Dr. Steven Woolf:
The famous one is life expectancy, which we can talk about more in a few minutes, but there's other metrics that we use in health. Some of them are also different measures of mortality, like death rates from specific diseases. Also, we look at measures of morbidity, which is the severity of diseases, how frequently they incur,

and how severe the complications become. On all of those metrics for dozens and dozens of conditions, we found the U.S. being outperformed by other high-income countries. It ranged from chronic diseases like diabetes and heart disease to even injuries like car accident fatalities or adolescent pregnancy in other health conditions. All of these, the U.S. seem to do worse than other countries.

LuAnn Heinen:
Can that be explained by some regions of the U.S., subpopulations, certain income discrepancies? How can you break it down a little bit.

Dr. Steven Woolf:
Well, health varies dramatically in the United States based on not only where you live, but also population subgroups. So racial and ethnic identity, for example, is a major determinant of health. Socioeconomic factors like poverty and limited education also affect our health. Of course, in the more disadvantaged groups, our health is far worse than in other countries. But one of the interesting findings of our report was that even when we looked specifically at white populations, rich populations, insured populations, non-smokers, every way we sliced it, even the most advantaged Americans were dying earlier than their counterparts in other countries.

LuAnn Heinen:
That creates cognitive dissonance, I'm going call it. We are a great country with a wonderful health system, with so many advantages, I think it's hard to reconcile. It's hard to get your brain around and let's not forget that we spend a lot on health care, too.

Dr. Steven Woolf:
That's certainly true. We outspend every country in the world on health care, not just in how much we spend, but even the per capita spending rate is much higher than in other countries. But in a way, this pattern is instructive. We actually get some clues out of it. For example, the fact that our health is so bad, despite all that spending on health care, teaches us right away that health care is not the only factor that affects our health and America is a great illustration of that. But it also tells us that we can't blame all of this on simple explanations. We have a problem with an obesity epidemic, for example. We can't blame it all on obesity. We can't blame it all on guns. We can't blame it all on opioids. It's all of that plus more. The fact that it does involve so many different threads, tells us that the underlying problem must be systemic.

LuAnn Heinen:
Let's dive into that a little bit. Describe what you mean by that - systemic.

Dr. Steven Woolf:
Well, that was one of the things that jumped off the page to our committee is that these health inequalities or disparities relative to other countries affected every body system and even factors outside of diseases like injury rates and homicides and suicides. It told us that we have to sort of look upstream to figure out what it is about life in America that is manifesting itself in so many different dimensions of our health and well-being. The way our committee approached it was we divided up the potential factors that have influenced our health into five buckets or categories. One, health care is the one that most Americans think of right away. There's a tendency to think that health is determined by health care. It only accounts for about 10 to 20% of health outcomes, but it's certainly important. So that was one bucket.

Another bucket is personal behaviors, things like smoking, lack of exercise, what we eat, alcohol and drug use. All of these are behaviors that can affect our health. We now know that our behaviors are influenced very much by our environment, so we can only make the choices that are available to us. The third bucket we thought about was the environment. This includes not only the physical environment like air pollution or whether we have sidewalks and parks near our home, but also the social environment. Things like social isolation, loneliness, also systemic racism, segregation are all part of the social environment. The fourth category, which is very important, is social and economic factors, socioeconomic conditions. By this I'm

referring to things like our education, income levels, poverty rates, income inequality. Then finally, perhaps the most important of all, is public policies. I say important because it really influences all four of the other buckets. The policy choices we make as a nation, at the state level, at the local level, influence health care systems. They influence our behaviors. They influence social and economic conditions. They shape our environment. We had an individual chapter for each of those five categories. In each case, we went through the data for that particular category to see whether there's something that makes America stand out from the other countries that might explain our health disadvantage. Unfortunately, what we found is that in every single category, there were a number of factors that jumped out as very distinctive for the United States.

LuAnn Heinen:
It may not be fair to ask how we can tackle some of the problems in the five buckets. I mean, those are multifactorial, complex issues that you're raising, and affect our political system, our society. But I'm going to still ask, do you have any thoughts about how we ought to go after some of those root causes that you've identified, those five buckets?

Dr. Steven Woolf:
Well, in each of those five categories, there's low hanging fruit. In fact, there are very alluring options for how to deal with those. For example, in the health care category, we're the one country that doesn't have universal access to health care. We have a more fragmented health care system. We don't invest enough in primary care. All of these are policy areas that we can work on in terms of health behaviors, people consume too many calories, the food industry could do more to address that kind of food imbalance, and we could do more to promote physical activity. Drug abuse is a particular problem in our country right now, and there's a set of policy options to try to deal with that. I could go on, but the real challenge across all of these five domains is that there's a reason why we are doing worse in so many different dimensions, and that has to do with our approach to policy. One of the clues that that's the case is by looking at the other countries that outperform the United States. In some cases, those countries have outperformed us for decades. In fact, in a recent study that I just completed, we identified 17 countries around the world that have had higher life expectancy than the United States for 50 years. That's 5-0. So for 50 years, they've consistently had higher life expectancy than the United States. What that tells us is that better outcomes are possible. These countries have figured something out about how to promote healthier lives for their population and keep them living longer than we have in the United States.

LuAnn Heinen:
Are there any examples that stand out you could share - particular countries and particular practices or policies?

Dr. Steven Woolf:
Well, the countries are very diverse. The ones that people immediately think of are Scandinavian countries like Norway and Finland. But it turns out that countries all across the world from Japan to Costa Rica are all doing better in terms of health metrics than the United States. What are they having in common? Their economies are somewhat different. Many of them are democracies and capitalist economies like ours, but they have some priorities that they've been adhering to for many years that aren't as big a feature for us here in the United States, such as promoting equity, such as investing in children and young parents and young families, trying to create policies and support systems so that when families are going through hard times and we all go through hard times in whatever country we live, but policies that help buffer the effects of those on our health so that when people lose a job or have some other kind of disruption in their economic well-being, they don't experience health complications as a result. We don't have those kinds of buffers in the United States, so people's health is more immediately affected.

Another difference is that many of these countries have taken a stronger approach in terms of regulations to protect public health and safety. So products that are potentially dangerous or inherently lethal are carefully regulated or banned so that the health and safety of the population can be protected. That's one of the reasons why in those countries there isn't an opioid epidemic, why a number of other industries from tobacco

to firearms have claimed far fewer lives per capita than they have in the United States, investments in infrastructure to protect health and safety, like road safety, environmental regulations to protect the air so that atmospheric pollutants are not emitted into our sky and so forth are more prevalent in those countries than they are in the United States.

LuAnn Heinen:
We do drive more miles in the United States, I think, than many other countries. Are road accidents a big component?

Dr. Steven Woolf:
We do drive more miles. It's a big country. So, in aggregate, there's lots of miles driven by lots of cars, but traffic and safety engineers around the world, including those in the United States, have studied this in a careful way, looking at death rates per mile driven or per kilometer driven. Again, we stand out as having higher death rates per mile driven than motorists in other countries.

LuAnn Heinen:
What happened after the report was released?

Dr. Steven Woolf:
A very disturbing trend occurred after the report was released. At the time our report was written, we were saying that life expectancy in the United States wasn't increasing as fast as in other countries. Life expectancy has been increasing in all industrialized countries for the past century due to advances in public health and medicine, but starting in the 1990s, the rate at which our life expectancy increased was slower than in other countries, and that's what our report was warning about. What happened after our report was released is that basically life expectancy flatlined in the United States, it stopped increasing altogether, whereas it continued to climb in other countries. In fact, people who followed the news during this period may remember a period of three years between 2014 and 2017, where it was front page news that U.S. life expectancy was decreasing. It was a small decrease, but the fact that it was decreasing at all was news because it's supposed to be increasing.

Researchers immediately began looking into this to try to understand what was going on, what was driving this trend. It turned out to be, at least on the first inspection of the problem, an increase in death rates in middle-aged Americans. Death rates appeared to be climbing in that midlife group. Then as we did more research, we realized, no, it's not just middle-aged Americans, it's also young adults. People as young as in their twenties were dying at higher death rates. That trend turned out to have four main causes. One was drug overdose deaths mainly from the opioid epidemic. Another was alcohol related deaths. A third was suicide. That trio, drugs, alcohol and suicides got the moniker deaths of despair. But there was a fourth one, and that's what we call cardiometabolic diseases, which basically is a fancy name for obesity and diabetes and other chronic diseases that result from obesity. Death rates from that were also increasing in this group. The one bit of good news we had during these years was that although this horrific increase in death rates was occurring in young and middle aged adults, and this is an increase that also had not occurred in other high-income countries, the bit of good news that we had was that at least on either age extreme, the elderly and our children, death rates were falling. They were going in the right direction.

Luann Heinen:
So kids and elderly were doing better.

Dr. Steven Woolf:
Yes. Now that good news ended with a Covid-19 pandemic, because obviously the advantage the elderly had slipped away because older adults were far more at risk of dying from Covid-19. We lost that advantage and then more recently what we've discovered is that even in young people, in children and teenagers, we are now seeing death rates climbing.

LuAnn Heinen:
Wait a second, on the older people first, that's true around the world. That should be true for everyone losing older people at a higher rate.

Dr. Steven Woolf:
It was true in every country that the elderly were more vulnerable. It's just that American elderly were even more vulnerable than older adults in other countries. When our report was released a decade ago, we said that Americans over age 75 had an advantage. Sometimes it would be said in a humorous way that if you could make it to age 75, you were good. But that advantage that Americans have historically enjoyed at advanced age also melted away during the Covid-19 pandemic. In fact, it reversed. People over age 75 were more likely to die from Covid-19 if they lived in the United States.

LuAnn Heinen:
Oh my goodness. Okay, then back to kids.

Dr. Steven Woolf:
Yes, throughout my career, it's always been a good news story with kids. We have seen during the decades that I've been in practice, tremendous advances in pediatric medicine. Diseases that used to send children to their graves as toddlers were conquered. Infectious diseases have been controlled through vaccination and antibiotics. Diseases like birth defects, prematurity, childhood leukemia, major discoveries have been made that have slashed death rates from those conditions. What became the leading cause of death in young people was car accidents. But progress was made in that area too. The enforcement of occupant restraints, things like car seats and seat belts and airbags made a huge difference and improved designs of vehicles also slashed death rates from car accidents. Children are less likely to die in fires. They're less likely to die from drowning. Many, many different injuries that were major killers of children have been reduced through these advances.

It's always been the case that all-cause mortality, which is our term for deaths from every cause, has been decreasing in infants, children, and teenagers. But a report came out in December of 2022, just a few months ago, from the CDC that tabulated the final statistics for 2020 and 2021, and it showed that all-cause mortality had increased in every age group in the United States, except infants. Meaning from age one and above every age group was experiencing an increase in death rates. Now, that's not a surprise for young and middle-aged adults because of the problem I've already explained that we had been tracking for a decade, and because Covid-19 had a disproportionate impact on young and middle-aged Americans, and it wasn't a surprise for the elderly who were especially at risk of Covid. But why the increase in deaths in children and teenagers?

We recently dug into that data to try to answer the question. One is tempted to wonder whether Covid-19 had something to do with that increase and we demonstrated pretty quickly that that was not the answer. Covid-19 only had a marginal impact on this increase in all-cause mortality. Instead, what we found was that the major factor that was driving this increase in death rates in children and teenagers was homicides, suicides, and drug overdoses, primarily in the 10 to 19 age group. A fourth cause was car accidents, which increased also during the Covid-19 pandemic, but the major drivers were homicide, suicide, and drug overdoses.

LuAnn Heinen:
Okay, it was a tough conversation and it just got a lot tougher. This is really hard to hear, especially as it relates to our kids, our youth, the next generation.

Dr. Steven Woolf:
It's very difficult and tragic and I'll tell you why. For all the obvious reasons for anyone listening to this, of course, but as a doctor, we've been so excited about the progress that has been made in saving the lives of children through these advances in pediatric medicine. When we say that all-cause mortality is now increasing, it means that all of those gains, all of the lives saved by preventing deaths from leukemia, from prematurity, from birth defects, and so on, are all being offset by these four causes. What that tells us is the death toll in our young people is so massive now from those four conditions, that it's outweighing all the other gains that

are coming from that progress. Some people might be tempted to think, well, this all happened during 2020 and 2021, so this must be some phenomenon isolated to the Covid-19 pandemic. But for three out of those four causes that I mentioned, we showed that the death rates from those causes have been increasing for years. For example, suicide, one of the four causes I mentioned, death rates at ages 10 to 19 from suicide began increasing as long ago as 2007. Homicide rates in that age group began increasing in 2013. These are problems that have been developing and worsening over time and Covid-19 simply poured fuel on the fire.

LuAnn Heinen:
I've been speaking with Dr. Steven Woolf, an expert on life expectancy, including how and why it varies so greatly. We'll be right back.

LuAnn Heinen:
In this country, we have considerably higher household income. That should be one of our bright spots. Isn't that something that we could leverage?

Dr. Steven Woolf:
Well, our median household income is higher than in other countries, but we also have the highest level of income inequality of any high-income country. The OECD, which ranks developed countries based on Gini coefficients and other measures of income inequality, consistently find the United States as the outlier with the greatest degree of income inequality. What that means, in plain terms, is the kinds of disparities we see in everyday life and on our news, CEOs that make massive fortunes, and the small percentage of Americans who are very well off and seeing their net worth climb, and the rest of the country where there has been a fair amount of stagnation in economic growth since really the seventies and eighties. I think part of it is an absolute effect of economic deprivation and precarity on people's health outcomes, but some of it is a psychological issue having to do with hope for a better future. People who lived in families, for example, that worked for auto plants like General Motors or Chrysler, or the steel industry like Bethlehem Steel, where multiple generations received stable incomes and could count on the fact that they could take out a mortgage, own a house, save money for their children's education, and have a stable retirement, had the rug pulled out under them because of changes in our economy. So the hope of a better future, the hope that your children will do better than yourself, has started melting away because of a lot of the changes that have occurred in our economy and because of policy choices that have deepened in equality and blocked economic opportunity for many groups, particularly marginalized groups. So these deaths of despair that we talk about are a potentially understandable coping mechanism or response to the stresses that people have been struggling with.

LuAnn Heinen:
Are there bright spots in U.S. health care data that we could celebrate and lean into something that, what are things that fit our culture and our ethos and our political and economic system, that we could do more of or expand and grow?

Dr. Steven Woolf:
Well, there are a couple of bright spots. Even in our report 10 years ago, the *Shorter Lives, Poorer Health* report, we noted a couple of exceptions to the rule where the U.S. was actually doing better than in other countries. Example number one is cancer. The U.S. cancer mortality rates are lower than in many other high-

income countries. We've done a better job of screening people for early-stage cancer and instituting treatment early. We have lower smoking rates than many other countries, and that's also been a huge factor in preventing cancer deaths. But to get to your question more directly, it's important for us not to characterize these policy solutions as some foreign strategy that we might see in a country like Finland or Japan. Many of these are policies that are actually being instituted in the United States with great success. For example, when we compare the U.S. with other high-income countries, we see that those other countries adopt certain policies that seem to improve their health. If we look domestically at the United States and break down the statistics by states, we find that states that have more policies oriented in that direction also have better health outcomes than other states that have been less proactive in pursuing those kinds of policies.

LuAnn Heinen:
What's an example?

Dr. Steven Woolf:
One example I'll point to is a study done by researchers at Yale University some years ago. Elizabeth Bradley was the professor who led the study where she compared the United States and other high-income countries based on the ratio between medical spending and social spending. The chart that was produced in that paper has been shown many times. It has the United States as this distinct outlier and all the other countries clustered in a different section of the chart and that's because the U.S. spends so much on health care relative to social spending, and the other countries quite the reverse. When that paper was criticized because we were being compared to these other foreign countries, she repeated this study domestically in the United States and found the same thing. States that spent more on social programs than medical spending states, like Minnesota, Massachusetts, New York and so forth, had much better health outcomes than states that made less of a priority of social spending.

LuAnn Heinen:
If you could magically make certain changes or enact particular policies, what would you do to have the greatest impact on our life expectancy and particularly on youth?

Dr. Steven Woolf:
Let's just start with a question of what factors matter the most in shaping our health. Whether we're talking about young people or adults, it's not health care. I've already mentioned that that only accounts for about 10 to 20% of health outcomes. By the way, I'm a doctor, so I would lose my license if I didn't say that health care was important. We all need access to health care at some point in our lives, both for prevention and treatment, but as I said, it only accounts for marginal influence on our health. What really matters most? If I had to pick two factors would be education and income. Education perhaps the most important of all. It's one of the most powerful predictors of our health and life expectancy. But in a knowledge economy, it's also one of the most important predictors of income and our ability to build net worth and accumulate wealth, especially in a country like the United States. So people with a more limited education have poorer prospects of economic mobility and having a better life for themselves and their children.

LuAnn Heinen:
Are you talking about the percentage of our youth who graduate from high school who go to a two or a four-year college or are you talking about a quality measure for education?

Dr. Steven Woolf:
Well, as a general matter, I am talking about things like educational attainment, which is the academic term for things like graduating from high school or graduating with a bachelor's degree from college, but also the quality of the education. So performance on mathematics at age 15, for example, the U.S. ranks I think about 35th among high income countries. We used to be the most educated population in the world, especially after World War II, but over time, many countries from Finland to South Korea, have surpassed the United States. That happened many years ago, actually, so they have a much more educated population than we do.

LuAnn Heinen:
Having devoted a good part of your career to this work, how do you feel personally about the lack of action? What do you see as the barriers? What are your thoughts and frustrations, candidly?

Dr. Steven Woolf:
Even if I cite our report from 10 years ago, we put a lot of focus on the chapter on public policies and social values, because there are certain approaches and attitudes that we have in America that do differentiate us from the other countries, and those offer potential areas for us to reconsider. They also provide reasons for skepticism and pessimism as to how effectively we can change those. This is a country that was founded by people who were seeking independence and individual freedoms that wanted to throw off the constraints of an oppressive British monarchy. As descendants of those people, it's a culture that prizes individualism, freedom, liberty, don't tell me I have to wear my mask, don't tell me I have to wear the seatbelt, I'm going to ride my motorcycle without a helmet, and there are health consequences of that.

Some of that, I don't think we're going to be able to shake off. It's just part of the American psyche. But there is a middle ground, and I think there is a place for responsible policy that respects and cherishes the values that we prize in America, while at the same time making sure we don't kill ourselves, making sure that our children can live a longer life. The most flagrant example of this is in our current headspace is guns, but we can talk about many other examples where we're pursuing policies that are endangering our health and safety and endangering those of our children. I used to feel that we could reach common ground around issues like that. I have grown more concerned recently because of the polarization that has occurred in our society where even dialogue and debate about these policy issues has become virtually impossible because of everybody going directly to their corners and having these ideological polarizations. But if we can learn to find common ground, I think there's a real opportunity to address some of those root causes. Some structural factors are not going to change, and I'm referring to structural factors that do impede our ability to deal with some of these issues. One stems from the Constitution itself and that is that the founders in the 10th Amendment assign public health authority to the states. Those are part of the category called police powers. Police powers rest with the states, which means that the states are responsible for setting health policy. By design, the founders have a situation set up where we have to have 50 response plans to a crisis like the Covid-19 pandemic. It creates fragmentation and inconsistency. It certainly costs lives during the Covid-19 pandemic. It also creates opportunities for the laboratory of democracy to explore creative ideas for improving well-being. So we've seen some states do remarkably well in certain policy areas and change their statistics dramatically in a relatively short time. That's instructive. That's a source of hope because we have evidence that those policies work. Unfortunately, we've seen other states that for ideological or economic reasons, did not embrace those policies and have not done so well.

LuAnn Heinen:
Do you see the most hope for action at the Congressional level, the state level, or could NIH and CDC make a big difference?

Dr. Steven Woolf:
Theoretically, if I was from Mars, I would think that decisions in Washington DC, at the federal level would have the biggest impact, but it's actually the other way around in our country, at least at this stage of my life. I think the most exciting and energizing policy initiatives are being made at the local level. Some really cool stuff is happening in communities across the United States to improve health, to address inequities, to deal with structural racism, to promote economic opportunity to transform marginalized neighborhoods. Then in the middle is state level policy. There are, as I said, a number of states that have really made some transformational changes possible. Then at the federal level, we're pretty much in a log jam. The political tug of war makes it very hard for Congress or the executive branch to make transformative changes. We've seen some encouraging examples in recent years, but in general it's been a standoff at the national level to address these issues. I will say, though, that whether we're talking about the national level or state and local levels, it's not just the government we need to think about. In the private sector, we have lots of opportunities for transforming health and some of those can be much more impactful than anything government can do.

LuAnn Heinen:
That leads me to the question about large employers. What's a takeaway or two you'd like to leave us with for large employers and their partners delivering health care and well-being services to their employees.

Dr. Steven Woolf:
One important data point to keep in mind as an employer, large or small, is that health inequalities vary dramatically at the local level. We see at the national level disparities in life expectancy of two or three years, four years sometimes, based on racial and ethnic populations and different social and economic categories. But in our cities, it's typical to see gaps of 15, 20, 25 years in life expectancy across our neighborhoods. We can talk more about why that is, but as an employer, it's important to know where neighborhoods your workers are going home to, because some of them are going home to neighborhoods that have conditions that dramatically favor their health and reduce their risk of disease and injury, and mean that they will generate lower health care costs and other people at work are leaving the same plant and going home to neighborhoods where their health and safety are very much jeopardized.

LuAnn Heinen:
I was going to say that large employers are increasingly and some very much aware of those differences and are paying attention to social needs, childcare, housing where there's instability, transportation, food security, you know, very much aware of how they can ensure that the policies they're offering are advantaging those who need help the most and certainly not disadvantaging those who need help.

Dr. Steven Woolf:
Yes, I was going to say they're really wise to do that because health care costs are such a huge drain on the profit margins for so many companies. The only way we can really get control of those health care costs is by dealing with these social determinants of health. I think one major step that companies can take to help their employees is to offer a livable wage. Minimum wage laws can be controversial, but the evidence indicates that they have a dramatic effect on health outcomes. It's been demonstrated in dozens of studies, infant mortality, all the way up to chronic diseases that affect the health of older adults. Across the board, minimum wage can have a transformative impact. Paid leave is a policy that is quite common in routine in the other high-income countries that have better health outcomes and is less available in the United States.

So simple measures like that in terms of benefits that employers can offer their workers can really make a huge difference. But as you said, many companies are also getting interested in making investments in the community to address some of the root causes of poor health. Examples include investments in affordable housing and transportation, in food security, improving education. There's also an opportunity for companies to act as advocates as state or local governments contemplate policy decisions, so they can go to the school board, they can go to the city council, they can go to the state legislature and testify and provide evidence about the fact that certain policy choices are going to be better for the business community and better for their employees.

LuAnn Heinen:
Thank you so much for your time and for this conversation today, Steven Woolf. I really appreciate it.

Dr. Steven Woolf:
It's been a pleasure.

LuAnn Heinen:
I've been speaking with Steven Woolf, Director Emeritus of the Center on Society and Health at Virginia Commonwealth University, and a respected scholar with over 200 publications in academic journals. Having documented the decline in U.S. health outcomes compared to other wealthy countries that began in the 1990s and is worse today, he's become an advocate for policies to improve U.S. life expectancy at every age. Follow him @shwoolf on Twitter.

I'm LuAnn Heinen, and this podcast is produced by Business Group on Health, with Connected Social Media. If you liked the conversation, please rate us and leave a review.