NECON Regional Conference
December 16, 2008
Summary of Proceedings

"Think regionally, act locally"

How should a compassionate society with an avowed interest in promoting quality of life for its citizenry marshal its resources and order its priorities in the delivery of health care services? For decades NECON—the New England Coalition for Health Promotion and Disease Prevention—has taken a leadership role in this critical, ongoing debate, arguing that primary *prevention* of disease through a variety of school-based, workplace-based, and community-based initiatives is both a sensible and a cost-effective way to allocate a portion of the several trillion dollars the nation spends yearly on health care. "Think regionally, act locally" is NECON's operative phrase and seeking optimal health is its social and moral imperative. It defines a position that is finding increased resonance in the current national conversation on health care reform.

On December 16, 2008, with the promise and hope of a new administration coming to power in Washington in the air, NECON took the next step in building grassroots support for the prevention movement, hosting a regional conference in Marlboro, Massachusetts on ***Prevention: The Ultimate Cost Containment Strategy and a Key to Affordable Universal Healthcare in America.*** Calling the meeting to order, NECON chair Bertram A. Yaffe pointed to the impressive roster of speakers and informed the several hundred attendees:

> The mission of NECON is to create the political will for a prevention paradigm in New England as a model for the nation. We have never been accused of not overreaching. Those of us advocating the prevention paradigm as an essential component of health care reform have an obligation to define precisely what we are seeking. Simply put, a prevention-oriented health policy addresses the determinants of health. Of over $2.5 trillion being spent annually on health care services, only 3 to 5 percent is defined as health promotion and disease prevention. With total medical care costs increasing as they are, without our attention, the prevention portion will decrease just when we need it the most. The mission of NECON is to change that equation.

Yaffe then paid special tribute to the late Dr. Julius Richmond, former U.S. Surgeon General, who believed strongly in the prevention movement and whose advice as mentor to NECON on how to change public policy for the better was founded on a triad of well-established democratic principles—"a sound knowledge base, a social strategy, and a strengthened political will."

The prime energizer of the NECON process, said Yaffe, is "our access to the New England Governors' Conference," the path paved by, among others, current NEGC Executive Director Charles Tretter. In 1984 and 1986, NEGC Resolutions 51 and 68 charged NECON to interact with New England policymakers and submit recommendations periodically for the improvement of the health status of the region. According to Tretter, NECON has accepted that historical charge with the utmost seriousness and bright hopes for the future:

"NECON deserves to be recognized as the model which NIH (the National Institutes of Health) has made it," said Tretter. "Bert's point about 'developing political will', connected to the words 'non-partisan', is very important," since often, though not universally, when the subject of prevention comes up among political people, their response is that large players, like the federal government, will take care of that. "But through rational arguments and example, Bert has honed it down to the point where it is a very sharp, precise, almost unique posture for six small states in a small part of the country to be demonstrating that prevention starts at the local level and that prevention, as amorphous as that sounds, leads to wellness."

"Efforts at prevention have to be long-term and sustained"

As an expert in nutrition for NIH, Van S. Hubbard, MD, PhD, Assistant Surgeon General, Rear Admiral, U.S. Public Health Service, was emphatic in his endorsement of "the new paradigm of focusing on prevention. . . . Targeting chronic disease risks is where our efforts need to go," he said. "Prevention needs to be regarded in the long-term, not piecemeal or short-term. Efforts at prevention have to be long-term and sustained."

“We are approaching a time of more personalized medicine,” when practitioners will look at longitudinal changes in individuals—whether it be in BMI for obesity, blood pressure for hypertension, or cholesterol levels with regard to hyperlipidemia—and based on these observed changes, rather than on standardized cut points, they will make recommendations for changing behavior.

But getting the prevention message across to underserved populations will not be easy, Hubbard said. “We need to recognize that as we convey our messages, we do not always put ourselves in the perspective of the persons we are trying to reach.” Barriers to sustained change in lifestyles and behaviors are hard to overcome, especially among people who typically do not regard nutrition, diet, and increased physical activity as factors important to their lives.

Thus, the need is to help people realize that throughout their day “some choices are more healthful than others.” Walk those extra steps for stress reduction. See this as an opportunity rather than as a penalty. By conscientiously “changing mindsets” in favor of prevention, we can measurably improve lives and ultimately reduce society’s health care costs in the aggregate, he counseled.

“A powerful set of statistics”

The rise in chronic disease prevalence among our populations is a central component of the rise in health care spending and helps frame the policy debate, said conference keynote speaker and noted health policy analyst Kenneth Thorpe, PhD, of the Rollins School of Public Health, Emory University. “As it turns out, about 25 to 30 percent of the growth in spending is linked to the doubling of obesity since 1985.”

The marker condition for this startling trend is diabetes, which has gone up 60 to 70 percent since 1985 in treated prevalence. “Virtually all of the increase in diagnosed and treated diabetes in this country is linked to a rise in overweight and obesity, pure and simple,” said Thorpe. Another way of thinking about it: The standardized prevalence of diabetes among obese

adults in the U.S. is about 14 percent; for normal weight adults, it is about 4 percent. So there is some genetic component to it. Those numbers have not changed in 30 years. Obviously, what has changed, dramatically, is the distribution of the people within those weight categories.

"We know that three-quarters of what we spend in health care is linked to chronically ill patients," said Thorpe. "In the Medicare program, over 90 percent of spending is linked to chronically ill patients. If you think about this in a policy context, that's a powerful number, because much of the attention in terms of solving the issue of health care spending is focused on the demand side, on insurance benefit design and trying to reduce moral hazard."

Yet the demand side view is myopic, Thorpe said, as the bulk of the money "is linked into a patient basically who is hypertensive, with bad cholesterol, bad triglyceride levels, overweight, so they have back problems, pulmonary disease, bouts of asthma, and they're depressed. That's our patient. That's where the money is. So it seems to me that if you focus on reducing levels of spending in treating that patient by leveraging change through insurance benefit design, I don't see the connection. It doesn't make a whole lot of sense.

"This is a powerful set of statistics, because it focuses our attention on the supply side of health care," on how we deliver care and take the necessary steps to prevent disease from occurring in the first place."

Thorpe enthusiastically endorsed the NECON perspective on health promotion and disease prevention: "It goes back to the basics of what we're trying to do, of how we prevent disease in the first place, and where can we do that in schools, communities and the workplace? And for the people who have multiple chronic conditions, how can we work with them to manage those diseases so they can have better health care outcomes, better quality of life, and hopefully as a byproduct we spend less on it."

"Some of my academic colleagues have confused the issue and limited the idea of prevention to one of secondary prevention, [that is] disease detection," he said. "And their basic notion is that prevention doesn't work, it doesn't save money. . . . On the other hand there are a

whole host of other types of preventive interventions that economists for the large part have not looked at, which deal with primary prevention and . . . issues around how do you prevent disease in the first place." You do it, he said, "by either getting people not to start smoking, or potentially quitting smoking, and certainly dealing with issues around diet and exercise and nutrition. And the question there is, do we have examples of school-based interventions, community-based interventions, workplace interventions that deal with primary prevention that work, that save money and provide better outcomes? And the answer is, increasingly, yes. The challenge on this front is to cull through the data and find the programs that have worked and find out why they work. . . . to pull out the key design features, to find ways to scale them and make them more widely used nationally."

"Just you and me and everybody else"

"No man is an island entire of itself . . . . any man's death diminishes me, because I am involved in mankind. And therefore never send to know for whom the bell tolls; it tolls for thee."

Adopting this literary approach to the question of how best to advance the cause of the public's health and disease prevention was conference speaker David Katz, MD, MPH, Director of the Yale-Griffin Prevention Research Center, Yale University School of Medicine. In quoting poet John Donne's familiar lines Katz found two messages of particular importance to health care reformers and advocates for prevention. The first and more obvious "is our interdependence. Everything requires a village. We are nothing without it. We are inextricably connected to one another in all ways imaginable, and all that we might hope to achieve will only ensue if we work collectively. . . . We all need to be part of the solution or be isolated as part of the problem."

The second message, more complicated, "is that we must put a personal, intimate face on public health. We know the destination, but political cul-de-sacs may wall it off from us. Yet that is never the case when responding to the urgent need of an individual. We are a compassionate society. We generally deal with the clear and present danger afflicting a person into whose eyes

we can actually look, and ask questions about cost afterwards. We know what we could achieve in the realm of prevention and public health, were we simply to apply the knowledge we already have." Application of knowledge already at our disposal, he said, could prevent obesity entirely, and thereby reduce diabetes (mainly Type 2) rates by 90 percent, heart disease rates by 80 percent, and cancer rates by 60 percent.

"We can all acknowledge that these are important public health advances," he continued, "and yet do any of us actually *feel* it. Do you feel it the way you feel anguish when a member of your family is afflicted? Do you feel it the way you feel joy as you gather with loved ones? Public health is encumbered by a colossal fiction. That fiction is the public. There is no such thing. It's just you and me and everybody else, looked at from a distance through the veil of statistical anonymity. John Donne effectively conveyed a sense of intimacy, even while talking about everyone. When we understand that 80 percent of heart attacks are avoidable. . . when we consider the pain, and the anguish that need not occur, it becomes real. And when we amplify that by hundreds and thousands and tens of thousands, the potential stunning advances in the public's health that could be achieved through prevention, it suddenly matters far more than it ever can when viewed from a distance as statistics.

"The question, then, for us today is how best to get there from here. That requires movement. Movement from where we are to where we want to go. To create a movement requires leadership, but something beyond that. You can lead, and if no one follows you, you're moving but it's not a movement."

With Katz as moderator, there followed a panel of regional leaders who have inspired movement within their respective communities. One was John Auerbach, Commissioner of the Massachusetts Department of Public Health, who noted that Massachusetts' universal health care reform legislation mandates that Medicaid must have a smoking cessation benefit involving nicotine replacement therapy and counseling, and that in the first year of health care reform, 11

percent of people on Medicaid took advantage of that benefit, resulting in a significant decline in the number of smokers.

In addition to smoking, the key public health issues, Auerbach said, are nutrition and physical activity, with the main focus being on schools and the workplace. The state will partner with employers and local officials such as mayors and school superintendents and even school principals to get the wellness promotion and disease prevention message across, then highlight best practices and make this information available (e.g., electronically, through an interactive website) for others to use and expand upon. In short, it will help to build a prevention movement. "We need to create the conditions that encourage, nurture, and promote wellness. . . . This is really about a system-wide change than involves individuals, families, communities, and the larger environment. . . . It's not just one more public health program. It's a top public health priority," Auerbach said.

Another speaker on Katz's prevention progress panel was Rajiv Kumar, president of Shape Up Rhode Island, who several years ago as a first-year medical student at Brown University became aware of the problem of obesity and its many correlates. But rather than single out patients in clinics and run the risk of appearing to stigmatize them for their weight problems, Kumar said, "I wanted to create an initiative based around teamwork and community building . . . a statewide initiative. We recruited a surprisingly broad coalition of partners," including employers, private health insurers, and government officials. "People wanted to come together to become healthy." Statewide participation grew each year, with over 20,000 active participants from all 39 Rhode Island municipalities currently working together to promote healthy lifestyles. Weight loss results achieved compare favorably to those of commercial firms, at a fraction of the cost. "This is a replicable intervention," Kumar told the conferees. "It is evidence-based, affordable, and able to reach low-income communities."

Were John Donne present on this day he would have wanted to "give Rajiv a hug" for his splendid work, made all the more impressive because it has been done while engaged in the process of being a medical student, Katz said.

"More than holes in teeth and missing teeth"

An oral health panel then convened to examine the often overlooked but nonetheless vital area of oral disease and its impact on overall health throughout one's lifetime. The panel was chaired by Ralph Fuccillo, President, Oral Health Foundation, who has aligned the Foundation's strategies with the 2003 Surgeon General's "Call to Action" on oral health. These mandates include promoting prevention, emphasizing the importance of oral health to overall health, replicating effective and proven programs that close the gaps on access, increasing cultural competency among oral health professionals, and fostering collaboration and partnerships in addressing the nation's oral health issues. "As much as we need prevention in health reform, oral health needs to be a component of that," Fuccillo said.

The members of Fuccillo's oral health panel actively endorsed the prevention message. "Almost all oral diseases can be prevented," said Alex White, DDS, DrPH, director of analytics for the Massachusetts-based DentaQuest (formerly Catalyst) Institute. "Tooth decay is a chronic infection, a communicable disease. Filling the tooth doesn't get rid of that. . . . There are health consequences. It's more than holes in teeth and missing teeth. There is an impact on systemic health. We know that diabetics have more periodontal disease, and it works in both directions. In diabetics periodontal disease is worse, and periodontal disease itself causes added difficulties for uncontrolled diabetics."

Pediatric oral health was discussed by Dr. Joanna Douglass, an oral epidemiologist and associate professor of pediatric dentistry at the University of Connecticut School of Dental Medicine. "Prevention is about children and also about pregnant moms," she said. "It is where we can get the biggest bang for our buck in terms of prevention and lifelong improvements. . . . The

disease starts in the mothers. The bacteria have to come from somewhere, and they come from moms. The bacteria are passed from mothers to children. That's why maternal health is so important. You've got to get bacteria out of the equation early."

Absent preventive measures, tooth decay typically happens very fast in the very young. "It is the most common disease in children," said Douglass. Among low-income children, 5 percent of 1-year-olds, 20 percent of 2-year-olds, and 30 percent of 3-year-olds have cavities. One in three children in Head Start needs active dental care, she reported.

Recognizing New England legislators and policymakers

"Legislation is key to creating a culture of prevention and an overall prevention strategy," said Dr. William Waters, retired deputy director of the Rhode Island Department of Health and member of the NECON Implementation Advisory Group. Waters described the New England Legislators' Prevention Caucuses and introduced the state legislators from across the region who were in attendance on this day. They included: Sen. Richard T. Moore (Mass.); Sen. Karen E. Spilka (Mass.); Rep. Willie Mae Allen (Mass.); Rep. Mary E. Grant (Mass.); Rep. Denise Provost (Mass.); Rep. Patricia A. Walrath (Mass.); Rep. Lisa Miller (Maine); Rep. Eileen Naughton (Rhode Island); and Rep.-Elect Michael Rice (Rhode Island).

"Change the environment"

In addressing the challenge of improving public health on the state level, David Gifford, MD, MPH, director of the Rhode Island Department of Health, pointed to the tremendous strides made in acute care, particularly infectious disease control, and said we need to study these techniques and approaches and apply them to prevention and chronic disease management. "It's clear we can't do this alone," he said. "It's going to require novel partnerships. We have the business community for the first time really embracing wellness and prevention." Driven by rising health care costs, "they are hungry for evidence-based approaches to addressing prevention, and that is an opportunity for us to reach out there."

The big-picture need is to "change the environment" to make it easier for people to do the right thing, harder to do the wrong thing. In public health, one of our greatest successes has been in tobacco, said Gifford, "We have used tax policy to change behavior." His instant lesson for legislators: Set taxes at a level that will positively impact people's behavior, and not as a pretext for raising revenue to cover some budgetary deficit while achieving no discernible public health advantage.

"How we change broad policies is where we are going to need to go," he continued. "We are just beginning to think about that from the obesity standpoint." In Rhode Island, schools are now required to have wellness committees, not just for the students but also for faculty and staff. Sales of sugar sweetened drinks in schools have been eliminated. Going forward, we are looking at posting calories, posting other nutritional issues, and looking at a possible soda tax, Gifford said.

Environmental change provides a vast opportunity for improving public health. For example, said Gifford, it would involve paying closer attention to air quality (a huge driver for asthma), as well as to the architectural design of buildings and of entire communities. From the standpoint of obesity prevention, some older buildings by design actively encourage visitors to use the stairs, while other, mostly newer structures direct all comers to the elevators. Entire communities can either stimulate people to walk to their destinations, or expect they will get in their automobiles and drive, depending on their design. From a public health perspective, Gifford said, "we need to figure out how to build our environments to lead to better and healthier lives."

"Things that are counted count"

Steven Miller, who directs the Healthy Weight Initiative, a project of the Harvard School of Public Health Nutrition Department, the national Nutrition Round Table, and NECON, reported on the status of the "New England Healthy Weight Trends Report," which is submitted to the New England Governors' Conference for review and action.

“Things that are counted count,” said Miller, echoing a favorite Bert Yaffe aphorism. As the factual underpinning for a strategic plan for the 6-state New England region addressing the prevention and control of overweight and obesity, the Trends Report must satisfy a number of criteria, he said. The Report must be research-based, i.e., linked to population overweight/obesity. It must set appropriate targets or goals. It must be measurable across states over time. It must be actionable, since “public policy can make a difference.” And it must add value by providing a fresh perspective on the issue of healthy weight trends.

Indicators used in the Report have been carefully chosen for their appropriateness as measures of the impact of overweight and obesity in individuals and society. They include: population outcomes and behaviors; health care and insurance; schools and youth; worksites and employers; built environments; the food industry; and the social and cultural environment.

The Report, which is publicly available, is intended to provide policy makers with a dynamic scorecard for measuring disease prevalence and keeping people healthy over time, Miller said.

“A very big and important target”

As moderator of a panel on the progress being made in implementing the NECON/Harvard School of Public Health “Strategic Plan for the Prevention and Control of Overweight and Obesity in New England,” Dr. Walter C. Willett, Chair of the Department of Nutrition, Harvard School of Public Health, addressed a seemingly simple query from the audience: Given all the advances in scientific knowledge and the growing body of literature on nutrition and obesity, “where is the low-hanging fruit?”

His response: “The consumption of sugar-sweetened beverages. That’s broader than just soda, because it includes fruit drinks that are mostly sugar water and it also includes fruit juices that really have as many calories as Coca-Cola does. But the biggest single problem is, of course, soda consumption. . . .

"If we look at what has happened to diet in the United States during this period when we've had this explosion of obesity . . . basically we've kept everything the same and added a Coke. . . . That in absolute amounts, fat, carbohydrate, and protein have stayed pretty constant over the last 40 years or so in the United States, and sugar consumption has gone up. … No big surprise, we put on a huge amount [of weight]. . . . And there's now abundant evidence from intervention studies, as well as long-term epidemiologic studies, that removing a Coke or equivalent sugared soda a day on average would have a major impact on weight gain or prevention of obesity. Also, the evidence is now quite clear, even above and beyond the effects on weight, that soda consumption is directly related to risk of Type 2 diabetes as well. So this is really a very big and important target."

What are the public policy implications of these findings? Tax soda consumption, Willett said flatly. "We subsidize consumption of soda in Massachusetts. Food is basically not subject to sales tax because it's considered healthy, and we include soda in there. . . . It just doesn't make any sense."

And: "We need to look at food stamp programs. We are paying for soda with food stamps. It doesn't make sense to be doing that and writing checks with the other hand for payment for treatment of Type 2 diabetes."

And: "Hospitals are selling soda. It doesn't make any sense. They used to sell cigarettes in hospitals too. We got rid of that. I really do think we have to look at this as the next cigarette smoking. . . . We can do the same for soda consumption."

As a member of Willett's panel, Vivien Morris, MS, MPH, director of Community Initiatives, Nutrition and Fitness for Life Program, Boston Medical Center, spoke to the difficulty of implementing programs in very low income neighborhoods where many of the residents are recently arrived immigrants. Yet there have been notable successes, she said, such as her working with local grocers and their corporate vendors with the aim of stocking and selling affordable sizes of nutritious foods to neighborhood children who stop in on their way to and from school.

“A critical component of any strategy and plan”

Michael Samuelson carries the same health and wellness message, but to a predominantly white collar clientele. As president and CEO of The Health & Wellness Institute and vice president of Blue Cross and Blue Shield of Rhode Island, he conducts senior management seminars and delivers wellness briefings for worksite wellness clients. He relishes his role as the guy who removes the cookies and soda from the workplace. “The day is coming very quickly when you can have all the Snickers you want, all the sodas . . . but not in my building!” he said. “That’s the process we have to move toward. . . . I’m not going to ask your permission to remove it. I’m simply going to remove it. I know that about 20 percent of you are going to yell and scream for a while, and then pretty soon come the thank-yous.”

The conference concluded with incisive comments by Randy Schwartz, MSPH, senior vice president of Strategic Health Initiatives for the American Cancer Society, New England Division, who articulated the prevention message from the perspective of ACS and its far-reaching activities involving advocacy, prevention and early detection programs and services. ‘Coverage’, ‘access’, ‘affordability’, and ‘equity’ were key words that popped into the conversation repeatedly.

“Clearly, the American Cancer Society, our constituents and partner organizations, recognize that for health care reform to succeed, prevention and preventive services must be a critical component of any strategy and plan,” Schwartz said. Prevention being a “cornerstone of health care reform,” ACS’s efforts must and will include establishing and funding evidence-based prevention programs and services, ensuring that preventive services are covered in public and private health insurance programs, removing or minimizing barriers to accessing preventive services, and monitoring emerging issues in cancer control and prevention.

“The ACS Cancer Action Network recognizes the necessity of transforming the U.S. health care system from one focused on illness to one that promotes wellness, in order to truly

reduce the cancer burden on this nation," Schwartz said. "This transformation will include the continuation of our successful advocacy efforts, and other opportunities that will emerge through larger, comprehensive health care reform."