The Burden of Childhood Obesity

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I feel a deep personal connection with the NPHIC (National Public Health Information Coalition) as Don Berreth and I were longtime colleagues and friends at the Centers for Disease Control and Prevention (CDC). My wife was the guidance counselor for his kids, and I was with his family when he died. I remember his work to help establish your organization; I attended one of your early meetings with him. So it was great to see his photo and biography in your program

For those of you who may remember him, Don was a pioneer in public health communications. He headed that department at the CDC for 18 years, and helped the agency and the nation through several tough public health moments—from the first large outbreak of Legionnaire's disease to the start of the AIDS epidemic.

Even though he lived in Atlanta for many years, Don never lost his feel for his roots in the upper midwest and the rural small town where he grew up in South Dakota. When the CDC would write up a press release or prepare for a press conference, Don would always make sure that we'd never forget that we were talking to the person in a small town—we had to make sure that person understood what we were talking about—and he thought about how they would react to what was said.

I'll never forget this: Don told us that he'd always ask, "what would my father think?" He imagined his father's reaction often would be: "It's worse than I thought," then Don would assess whether that is what we wanted to convey or whether we hadn't reassured the public as well as we needed to.

In any federal agency, common sense is the resource that—even more than money—seems at times to be in the shortest supply. Don had common sense and gave it to the CDC. His good judgment made him a sought-after adviser on many things that really weren't communications related issues at all.

Don, unfortunately, was taken from us far too soon. But his legacy lives on in your organization and in the work of its members all across the country. I think he would be proud of how far the field has come.

Now I am going to change the purpose of my talk for you a little. The title was to be about childhood obesity and I will still address it, but also try to put it into a somewhat larger context.

Every day, you try to translate the sometimes complicated science of public health in a common sense way—making sure people are clear about whether what we're discussing is better or worse than they thought, what they should do—and why the public health experts feel that way.

The fact that your role has grown to be so central to the field of public health demonstrates how unique public health is from almost all other scientific fields. In most other areas, scientists only want to—and need to—talk with each other. Their findings become truly relevant to the public at large only years after they are first discovered. The public doesn't really need to know how the silicon chip works or how statins lower cholesterol—just that they do.

But for public health to succeed, what its practitioners and leaders discover or propose must be translated and communicated to the public at large—often immediately. It's essential that the public engage and act based on this information. It's critical to our mission.

This is abundantly clear during times of crisis. We heard from Lieutenant General Russel Honore and David Lackey, M.D., regarding the effects of Hurricanes Katrina and Ike. Over the recent past few weeks, Texas has been dealing with the devastating effects of Ike.

As many of you know, the days after a hurricane are often deadly too, not just the time during the

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storm. In Galveston, for instance, the week after Hurricane Ike, water and sewer systems weren't working. The hospital was closed. The city was choked with debris. Stagnant and contaminated water was creating a breeding ground for mosquitoes and infections. Clean drinking water was in short supply.

In such a situation, communication is a central part of public health efforts—directing people to the resources they need, offering guidance of how to get by, letting them know the dangers in premature attempts to return, and yet also calming their fears with clear, relevant information. This information is critical, and often emergent in its need and, hence in the speed with which you and your bosses must act. Being nimble, creative, accurate and appropriately reactive to the situation on the ground is vital.

Communication is also critical at the other end of the health spectrum—not just when there is an immediate disaster, but when there is a slower on-going, but still pressing need to avoid disaster and recommend behaviors and policies. This work is often more difficult to carry out because the urgent, often, can crowd out other important issues.

Without a doubt, choosing long-term themes and purposes and then sticking to them is a challenge in the best of times—but they are no less important than dealing with the crisis of the day. Framing remarks, identifying the appropriate venues and weaving in the big issues into the news of the day for public health agencies are some of the important tasks you do every day. And it is here that I want to challenge you on behalf of the public's health.

Arguably one of our nation's fundamental failures has been our unwillingness to act on the long-term, difficult issues when they are recognized because the solutions will cause discomfort in the near term. On Wall Street, a few economists and market-watchers were ringing the alarm bells for several years about the huge risks banks were taking with mortgage-backed securities. But as we all have learned over the past few weeks, those warnings were not heeded by the banks nor by the government.

In public health, we have our own long-term issues that often are neglected where our nation has growing long-term need and risk to its economic and physical health: the issues of an aging population, the cost of medical care, the burden of chronic illnesses, and failure to act on interventions on their precursors like obesity and tobacco are just a few.

I believe these issues are so serious that there has never been a time when we have had a greater need of your services and those of your bosses than today. A large part of the responsibility for framing these issues, repeatedly and forcefully in the releases from your agencies, is yours.

No area better illustrates this than the need to reverse the rise in obesity, especially among our nation's children. While obesity has escalated in adults, it has gone up much faster in kids. Over the past four decades, obesity rates have soared among all age groups—jumping over fourfold, 400 percent—among kids ages 6 to 11.

What's happening is not that complicated to understand: There is a large gap between the energy we are taking in and the amount of energy we are burning up. But most important is that it is a daily gap that over time accumulates into pounds, and eventually into tens of pounds. The net is that children have consumed about 110–165 more calories than they have consumed on average during the 1990's, leading to about an 11 pound weight gain. In other words, the average child in the same percentile in 1990 and 2000 weighs 11 pounds more today. Now for the obese child, the excess consumption is much greater at approximately 770–1000 calories a day, weighting about 58 pounds more.

The statistics are startling. And we know that the effects of this extra weight are not just cosmetic. Being overweight or obese has serious health ramifications for individuals and society.

- Not only are obese children now getting adult diseases—like type 2 diabetes and high blood pressure—but these children also are more likely to stay heavy as they age, and when they do, their

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health prospects dim considerably.

- They are more likely to be debilitated or die of cardiovascular disease and diabetes; stroke; colon, kidney or breast cancer—and die much younger than they should.
- On top of that, if you are obese, as you age, you're more likely to be seriously disabled. Researchers at RAND estimate that an obese 70 year-old will have a 40 percent chance that he or she will need help bathing, dressing, using the toilet, getting in and out of a chair, and—ironically—eating.
- According to RAND, as many as 25 percent more Americans will need to enter nursing homes by 2020.
- America's bill for obesity-related medical expenses and lost productivity is currently estimated to be as high as $200 billion a year, and that's before the crop of today's obese and overweight kids come of age.[1]

All this means it is critical that we prevent the onset of obesity as much as possible and that the changes required are not a crash diet but a permanent change in how we live our lives.

What I'm telling you is not new to anyone in this room. But it's worth reviewing the extent of the obesity challenge because it drives home a point that too often is overlooked in discussing our health challenges and that's how important public health is to the health of America. The time has come for honesty on what we have learned so far in our nation's quest for better health, affordably priced.

Technological advancement, where our nation's leadership is unquestioned, has failed to rein in growth in medical care costs. Nor has it even enabled us to have better health relative to other countries of similar wealth and development according to standard macro measures of health outcomes, such as life expectancy and infant mortality. In fact, we have even gone down in ranking over the last few decades. That is, other countries are getting healthier faster than we are despite our rapid increase in dollars spent on medical care.

This is not stated to belittle the important advances made against the leading killers like heart disease and cancer. I merely want to affirm that the advances made have either not been substantial enough, or that they move so rapidly around the developed world that there is little advantage detectable with regard to our health bottom line compared to other countries. Yet the United States is the country that made many of the scientific advances.

So the growing disparity between us and other countries in costs, in coverage, and in life expectancy must be due to factors other than too little investment in biomedical research or too little application of high-technology medical care.

So we look at our medical care delivery system and find that after decades of research—including the emergence of entire fields like quality of care and health services research—there has not been a large-scale, within-the medical-care-system way to arrest the climb in health care costs or lead to faster progress in improving health outcomes.

Our medical care system is really about repair work. The likelihood of initially becoming ill or suffering an injury is practically unrelated to access to good quality medical care. Initially becoming ill is really about whether one smokes, what and how much a person eats, whether one is active, the safety of one's neighborhood, the toxins or microbes people are exposed to—where you live, work, learn and play.

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[1] See Data Presentation, Edward Sondik, Director, National Center for Health Statistics. *Healthy People 2010* Progress Review, January 23, 2004. (Slide #2, Bullet #2.) www.cdc.gov/nchs/ppt/hpdata2010/focusareas/fa19.ppt#2

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This all leads me to conclude that the major disease problems of our time will not be solved by the clinical care system alone. What we need isn't more treatment; what we really need is less disease. To do that as a nation, we must think differently and look elsewhere for potential solutions.

That's why the Robert Wood Johnson Foundation is taking a major interest in the health of our public health system. We are dedicated to improving the health of all Americans and are willing to take on large, systemic change in order to get that done.

Turning the tide against obesity is one of the top things we can do to improve the health and health outcomes of millions of Americans. We are at a critical juncture with this epidemic. If we act now, we can begin to reverse the tide of increasing weight and diminishing health or we can wait until we've lost an entire generation of children.

That's why we at the Foundation have committed $500 million over five years to prevent childhood obesity. This is the largest commitment we have ever made prospectively. We want to achieve permanent, sustainable results by 2015 reversing this epidemic, with the health, health care and fiscal benefits stretching deep into the century. To do that, we are helping to:

- build the evidence base;
- catalyze action in communities throughout the nation;
- energize the advocacy that is needed to bring about change; and
- coordinate and connect efforts around the country.

The Alliance for a Healthier Generation's Healthy Schools Program is working to improve nutrition and fitness in thousands of schools by establishing standards for food and activity policies for schoolchildren and staff. They also have negotiated an agreement with the American Beverage Association to set guidelines for products and portions in school beverage sales. They recently reported an independent evaluation of the impact—a 60 percent reduction in soft drink calories shipped to schools and 79 percent of the pouring contracts meeting the new guidelines ahead of their goal of 75 percent.

We are supporting the National Governors Association (NGA) to have governors convene people from the various sectors of society that are important in this work—education, health, economic development, transport, agriculture. A series of surveys will track policies in elementary through high schools and a variety of factors in their communities, including type and density of food establishments.

One of the developments that enabled us to undertake such an ambitious mission is that people now understand that obesity isn't just the result of the lack of self-control or personal failings, but it's also about our societal policies. While personal responsibility has a central role to play, so does the environment in which we live—meaning our neighborhoods, communities, schools, states and nation.

This includes what kinds of behavior organizations—public and private—support or inhibit; how our communities are designed and built; and what priorities we have and what we do in transportation, agriculture, housing, schools and workplaces.

If kids are offered the choice of deep-fried chicken nuggets and soft drinks at lunch time every day at school, guess what they will choose now and as they grow up? Take families in poor neighborhoods. If the only place they can shop for food is at a small corner store and it doesn't sell fresh food, what will they eat? If parks are nonexistent or too dangerous to play in, what choices can parents make when their children want to go out and play?

To halt obesity, we must make headway in some critical areas of public policy that go far beyond the normal boundaries of public health. This is not really about the programs your agencies have

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responsibility for, it is about the health of the communities, the states you have responsibility for.

That's why your work is so vital. Changing laws, public and private attitudes, the built environment, school curricula and human behavior won't be easy. It will take a clear, concise and persuasive message backed by unimpeachable evidence, delivered strategically, passionately and repeatedly by our health leaders.

And that takes me to the first of three assignments that I have for you today.

You must be proactive about the long term.

Use your position to help shape the agenda for your state and our nation, not just react to the events and issues placed before you. Shape the agenda of your boss, of your agency, of your governor, of your state. We have all been watching our political candidates get their key messages into the answers they make regardless of the question asked. Who taught them this? Their communications team. Why? Because they think those points are so important, so central to the future of the country, they must use every opportunity to help the American people remember what should be the focus of our national discussion.

Unfortunately all the discussions about health are about medical care coverage only. In a future where resources are going to be tremendously tight, you must help public health make its case for its role in the big issues of cost and disease burden.

The truth is that people are starting to understand the importance of public health. As I just mentioned, they are just beginning to learn how their neighborhoods and schools affect the obesity rates of their community.

You may hear about this from Bob Blendon who is on your agenda later. A recent Harvard School of Public Health survey found that over the past decade the percentage of people who said that public health is important jumped from 17 percent to 37 percent. That's the good news.

The bad news is that they have no idea what their local health department is doing or can do for them. Two-thirds of respondents said that they had no interaction with or understanding of the public health department.

These data point to both a challenge and an opportunity. The challenge is to convince the people you serve that what the health department does is vital to their personal well-being as well as the future of their towns or states.

The opportunity then follows: Once you establish a bond of trust, you must then help frame the important issues facing your city, county or state. From obesity to tobacco control, from disaster preparedness to healthy living, you must help your directors set the long-term health agenda and help policy-makers frame the choices for our nation and help improve the lives of those you serve.

Make the case for quality in public health.

From six sigma to total quality management, the measurement of the quality of outcomes has become a priority across the economy, especially in private companies and medical care.

Consumers are beginning to use public reports about how good hospitals, surgeons or health plans are so they can decide everything from which doctor to visit, to the best hospital in which to deliver a baby. The measures may be crude, but the idea that consumers should be able to assess quality is a powerful one. One that is catching on.

This push for quality is happening in more than the private sector. Think of crime or education. When people move to a new town or neighborhood, they want to know: How good is the school system? How are the SAT and ACT scores? What are the teacher-pupil ratios? How does the school rate compared to its peers? Often, the answers to these questions are the determining factors in where people

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move.

Now, why doesn't that family looking to move ask these same questions about health? How healthy is this as a place to live? What's the life expectancy rate or even the percentage of people who feel their health is good compared to others their age? Does the town have a lot of parks and hiking trails to keep kids fit and healthy? How does it compare to other towns? Part of the reason why these questions aren't asked is that when it comes to public health, we are not very clear about what the public should expect– nor how critical they are to their health.

But you may have seen the recent *U.S. News and World Report* cover this weekend. I believe it is seminal; it rates the best places to retire, similar to what ranking the magazine started with colleges. However, the rating is now about "Healthy Places to Retire," and it has precious little to do with having great hospitals nearby. When you read the quotes in the article it is all about health promotion and being active. The public is interested in these questions and they will start to rate communities as they see fit unless public health itself identifies those elements that are most important.

We have to come up with a good way to measure quality. Right now, someone living in a big city or a small town doesn't know what to ask from his or her public health agency, what standards to compare it to and what constitutes adequacy or excellence.

We also have to own up to the fact that we are much less of a system than we talk about. Neighboring health agencies don't have to give priority to the same things or work on them in the same way. So how do you tell if your health agency is doing its job?

We at the Robert Wood Johnson Foundation are working on that with CDC, ASTHO, NACCHO, NALBOH, APHA and others by supporting a national voluntary system of accreditation of health agencies; helping to establish benchmarks and realistic standards of quality in all areas of public health– not just to improve performance, but also to provide a basis to build public support for public health quality efforts.

I don't believe that we need to wait for all the data to come in. If you provide people with information about how their community promotes healthy living and what their health agency is doing to protect the public's health, they will appreciate that information, use it and eventually expect it.

Start making the business case for public health.

Too often, we appeal to policy-makers' and the public's head with data on health effects, number of cases or deaths prevented, and occasionally to their hearts with stories and anecdotes. We now need to start talking to their pocketbooks. Especially as our economy enters what can charitably be called "challenging times," we need to make sure people know that public health has a phenomenal return on investment.

Intuitively, I know we all know this, and we regularly say an ounce of prevention is worth a pound of cure. But there is now a growing body of hard data that establishes a direct cause and effect between what a community spends on a public health and specific health outcomes.

We supported Glen Mays, M.P.H., Ph.D., and Sharla Smith, M.P.H., of the University of Arkansas to conduct what is now the most comprehensive look at state public health spending on population health, doing their best to exclude the same things and include the same things from each state.

Mays and Smith found that for each 10 percent increase in public health spending, mortality rates fell between 1.1 percent and 6.9 percent. And that funding public health seemed to be a faster and cheaper way to lower mortality rates than investing in local medical resources. There is a special point to be made here: With more resources come large health improvements.

We also funded a second report, this time by the Trust for America's Health called *Prevention for a Healthier America*. It is the first report that estimates the cost savings from community interventions; most

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reports of the savings from prevention deal with clinical preventive interventions like screenings and vaccinations. This report looked at state-by-state savings from an investment of $10 per person per year for things like the tobacco control programs in California or the *Shape-up Somerville* program that reduced obesity in that community. Things that were outside the medical care system, did not involve direct medical care services, that affect eight chronic diseases—the investment would return $5.60/$1 invested within five years to Medicaid, your state budgets, Medicare and the private sector.

To some of you this might sound just like past discussions. I think it is fundamentally different. The growing public expectation that they can determine if their schools are good, or their neighborhood is safe or their doctor is the best is beginning to move to health. They want to know they are getting quality and how to be sure. They are learning that public health is important. But how can they know what they are getting is good quality and good value?

Increasingly businesses are asking the same question. The governor of Indiana talks about recruiting companies to his state as that they have a lot to brag about—better educated people, good cost of housing, lower taxes than average, but their health care costs are higher. He doesn't tell that to companies but they learn about it. He has become a big proponent of prevention, raised tobacco taxes, promoted exercise and good nutrition and worksite health promotion. Oh, in case you didn't know this Gov. Mitch Daniels was the former head of Eli Lilly and Company and also former head of the Office of Management and Budget earlier in this Bush administration. Hard-nosed conservative, private-sector oriented, Daniels gets it.

No matter who wins the election this fall, the fiscal and physical health of America will be at the top of the next president's agenda. Those issues are joined at the hip. You may have read the *New York Times* this Sunday. There was a full-page advertisement about our unfunded future costs: Eight trillion for current debt including the $700 billion for the Wall Street bailout. Thirteen trillion for Social Security and $43 trillion for Medicare and other promised health insurance. Few people know how big the issue of health care costs is.

You are the ones whose responsibility it is to frame what the American people must think about related to public health. So regardless of the issue, make sure you build into the discussion of how this affects our big national interests, of the value of public health and prevention, and of the major illnesses of our time:

- People should expect quality and effectiveness.
- If the best programs are done even at relatively little cost, it will help attract business and make their community a healthier place to live and raise a family.

As information and communications leaders, you must shape the nation's understanding, open this discussion and set the agenda. All you need to do is be proactive, embrace this role and show that leadership. Public health needs that leadership from you more than ever.

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