



Chronic Disease Prevention: Saving Lives, Saving Money
Alliance for Health Reform
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ED HOWARD: Good afternoon. My name is Ed Howard. I'm with the Alliance for Health Reform. I want to welcome you on behalf of Senator Rockefeller and our board of directors to this program about preventing chronic disease, its impact on America's health, what's being done about it both nationally and in communities around the country.

Very quickly, there is a national epidemic of chronic disease. It affects 130 million Americans. It causes 70-percent of the deaths and accounts for 75-percent of the spending. Those kinds of numbers attract attention, even in a town like this where billions have lost favor to trillions. Congress was listening to those numbers when it passed the health reform law. Several parts of that law speak directly to the problem of chronic disease. Well before that reform was enacted, communities around the country were beginning to address areas such as tobacco use and obesity and the need for more physical activity as a way to improve the health of their populations.

We call today's sessions *Chronic Disease Prevention: Saving Lives, Saving Money*. We're going to hear from folks who can help us understand what can be done to lessen chronic disease in our population, what is being done, and what the

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impact of those steps is. What's more, we're going to look as closely as any briefing we have ever done at the long-term fiscal implications of an illustrative step toward lowering chronic disease.

Fortunately, our panelists are very well equipped to help us examine these various initiatives and the promise that they may hold.

Our partner in sponsoring this briefing is Robert Wood Johnson Foundation, the nation's largest philanthropy devoted exclusively to—if I remember the tag line correctly—helping Americans enjoy healthier lives and get the care they need. I want to thank Jim Marks at the Foundation, who couldn't join us today, and his colleagues for their help in pulling this program together.

A couple of logistical items, before we get to the speakers. In your packets, you will find important information including speaker bios and the hard copies of the PowerPoint slides that you'll see on the screen. There is also a lot more background information available, and that is all available also on the Alliance website at allhealth.org. There will be a webcast available of this briefing sometime Monday, probably, on the Kaiser Family Foundation website, KFF.org. C-Span is also recording the briefing, not airing it live. You can watch

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for the schedule to see when it will be broadcast, and if you happen to be watching the recording on C-Span right now, you can find more resources on our website, including the slides, so that you can follow along.

At the appropriate time, please fill out that green question card, and we'll give our panelists a chance to answer it, and the blue evaluation form before you leave will help us to improve these programs as we go along.

We have assembled an incredibly knowledgeable group of panelists today with both national and community level experience. They're going to give brief presentations, and then you'll have a chance to join the conversation directly.

We're going to start with Dr. Ursula Bauer. She's the Director of the National Center for Chronic Disease Prevention and Health Promotion within the Centers for Disease Control and Prevention. She's an epidemiologist with a long background in public health at both the state and national levels, and she is in charge of strategizing to pursue her Center's goals of preventing tobacco use, improving nutrition, and promoting physical activity. Dr. Bauer, thank you so much for joining us, and let me turn it over to you.

URSULA BAUER, PH.D., M.P.H.: Thanks very much, Ed, and good afternoon, everyone. As you know and you just heard from

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Ed, chronic diseases continue to be a major problem for the United States, even as we're making real progress in reducing rates of heart disease and cancer, which are the leading killers.

Chronic diseases are responsible for seven of every 10 deaths in the U.S., afflict 130 to 140 million Americans, many of whom are living with two or more chronic conditions, and they're being diagnosed at younger and younger ages. Chronic conditions including heart disease, diabetes, and arthritis cause major limitations for nearly one of 10 Americans and account for 75-percent of our more than \$2.5 trillion that the U.S. spends every year on medical care.

Importantly, chronic diseases are largely preventable. It's hard to find a chronic disease that's not caused by, exacerbated by, or negatively impacted by one or more of three primary risk factors: tobacco use, poor nutrition, and physical inactivity. Improving these behavioral risk factors would go a long way toward preventing or mitigating the suffering, the disability and premature death associated with chronic diseases. Effective prevention can reduce or eliminate these risk factors, can detect diseases early and avert progression or complications, and constitute a best buy for the American people.

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Our evidence-based prevention strategies are cost effective and sometimes even cost saving. When prevention fails—that is, when we fail to do what we know works to prevent disease and promote health—we cause needless suffering and premature death and we incur needless costs, not just for the individuals who are living with chronic diseases but for all of those who share a health plan, for taxpayers, and for health insurers, both public and private. Often these payers are businesses and our employers who are burdened with the dual expense of paying for costly and preventable chronic diseases and productivity declines as employees become ill. Many factors affect our health: where we're born, our education and income, where we live and work, and the access that we have to quality health care.

At CDC, when we look at opportunities to intervene to prevent disease and promote health, we focus on the second level of this pyramid, changing the context; that is, putting health in the people's hands and supporting people in taking charge of their health, whether it's opportunities to breathe air that is free from tobacco smoke, having safe places to be physically active, choosing healthy food options in our restaurants, schools, grocery stores, and workplaces, or protecting ourselves and our children from dental caries and

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oral disease and tooth loss that our grandparents and great-grandparents experienced.

Public health interventions that change the context and make healthy choices easy for Americans reach the greatest number of people and can have the largest impact. These interventions are often the least costly as well, and they're certainly cheaper and more cost effective than clinical interventions and counseling and education. However, I want to emphasize that the steps in this pyramid are not in competition with each other. Work in all of these areas is needed to ensure that all Americans have the opportunity to be and stay healthy across their lifespan.

At the National Center for Chronic Disease Prevention and Health Promotion, our role, or, what we do is listed on the left side of this slide. How we do it is on the right, and that's by working in four key domains. Epidemiology and surveillance is the foundation of CDC's work. We provide data and information to develop and employ effective interventions, identify and address gaps in program delivery, and monitor our progress in achieving program goals.

Data and information come with the responsibility to use it well. We engage in health communication, ensure that decision makers have the information they need to make the best

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decisions, and publicize widely the results of our work to demonstrate the return on investment in prevention.

Environmental approaches transform the community context in which health occurs to make healthy behaviors easier and more convenient for Americans. Healthy communities deliver healthier students to our schools, healthier workers to our business and our employers, and a healthier population to the healthcare system. These kinds of interventions have wide reach and sustained impact and often require only modest resources to accomplish, making them high impact, as I said, a best buy for public health and for the American people.

Health systems work improves the clinical environment to more effectively deliver quality preventive services and help Americans more effectively use and benefit from those services. The result? Some chronic diseases and conditions will be avoided completely, and others will be detected early or managed better to avert complications and improve health outcomes.

Innovations like electronic health records, systems that prompt clinicians and deliver feedback on performance and requirements for reporting outcomes, such as, control of high blood pressure and the proportion of the patient population that's up to date on cancer screenings, can be very motivating

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to providers and health insurers to focus on these preventive services. Effective outreach to consumers to increase effective use for these services is also key, as availability of coverage alone will not maximize the effective use of preventive services and the associated health benefits.

Community-clinical linkages help ensure that people have access to community resources and support to manage chronic conditions once they occur. Clinician referral, community delivery, and third-party payment for effective programs like the National Diabetes Prevention program and a variety of self-management programs for arthritis, for heart disease, and more increase the likelihood that people living with chronic illnesses will be able to follow the doctor's orders and take charge of their health, improving their quality of life and averting or delaying the onset or progression of disease, avoiding complications, and importantly, reducing the need for additional health care.

By working in these four areas, we will reduce obesity and diabetes, further reduce heart disease and stroke, breast and colorectal cancer, poor nutrition, tobacco use, and physical inactivity, but we won't do it alone. Public health problems require multi-level, multi-sectoral solutions.

Increasing opportunities for health requires working at the

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national, state, and local level and engaging public and private sectors beyond health that bring resources, expertise, and solutions to the table, focusing on those cost-cutting risk factors that I mentioned and the evidence-based strategies that address multiple chronic conditions simultaneously.

Working together, I think, in these areas, we will improve health, quality of life, and life expectancy for Americans, and we will reduce the need for health care and better control our health care costs.

Thank you.

ED HOWARD: Thank you very much, Ursula [applause]. We're going to turn now to Dr. Thomas Farley. He is Commissioner of the New York City Department of Health and Mental Hygiene. He is a pediatrician by training. He has also had public health service at both the state and national levels, including at the CDC. He's going to share with us some of the successful results New York has achieved in lowering the incidence of chronic conditions. Thank you for being with us.

THOMAS FARLEY, M.D., M.P.H.: Thank you, and good afternoon. I'm going to take you through some examples of ways in which we in New York City have tried to combat chronic diseases. I emphasize that these are not all the things that we are doing, but I'm going to take you through some of the

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important ones and some highlights of them and finish with some evidence of the effectiveness of our approaches.

These are the things that I'm going to go through: interventions that are done in the environmental level, or what Dr. Bauer would refer to as changing the context, and specially smoking prevention; trans fat restriction and sodium reduction; and then a summary of our clinical intervention, and that's a use of a prevention oriented electronic health record with quality improvement technical assistance.

Let's take smoking first. There are three major elements to our smoking prevention program in New York City. First is ensuring the high price of cigarettes through excise taxes. In 2002, when the Bloomberg administration came in office, the excise tax total on a pack of cigarettes in New York City was \$1.58. At that point, there was a tax increase in New York City of \$1.50 per pack, which brought the tax to \$3.39. With subsequent increases in taxes at the state and federal level in 2010, the total tax on a pack of cigarettes in New York City is \$6.86, meaning that the price of a pack of cigarettes in New York City is about \$11.00, which is the highest price in the nation, something that we are very proud of [laughter].

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The second element of this is having comprehensive smoke-free air laws. The 2002, New York City passed a Smoke-Free Air Act, which is a comprehensive act that prohibited smoking in workplaces especially and, of particular importance, with restaurants and bars. This idea has spread to other jurisdictions, but at that time, it was a pretty radical move. The Smoke-Free Air Act was extended in 2011 to include outdoor parks and beaches, and in 2012, through institutional policy, the City University of New York will have all of its 23 campuses in the city completely tobacco free.

A third major element is use of hard-hitting media messages to warn people about the risks of smoking. These are done in ways which show very graphically the effect of smoking. These are done using the best modern advertising techniques. Our messages are developed in focus groups of smokers and evaluated in surveys. The photos you see on this slide are from our most recent campaign in which we recognized that smokers in general are not afraid of dying, but they don't want to suffer. So, this campaign, just to be not terribly subtle about it, is called *Suffering Every Minute*, and it emphasizes how the suffering can last a long time, and it highlights a person with emphysema and another person with stroke.

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This is the overall effect of our tobacco prevention program over the last 20 years. You see that before 2002, smoking prevalence in New York City was at around 21-percent for a decade. Since then, the percent of adults who smoke has dropped down to 14-percent. That's more than a one-third decrease. That represents 450,000 fewer smokers than we had in 2002.

The decline is actually larger than that, though, because we know that the people who are currently smoking are smoking less than those who were smoking in 2002, so the total cigarette consumption in New York City has fallen by more than 50-percent. We are also optimistic about the future, because the decline in youth smoking, which is not shown on this graph, has been even greater. It was about 25-percent in 2000, and now it's 8-percent in New York City.

Moving on to trans fat reduction or restriction. We took on trans fat back around 2005, and the rationale for this was that trans fat is an artificial chemical which doesn't need to be in our food supply which raises heart disease risk. To give you a feeling for this, a 4 gram amount of trans fat taken every day would increase your heart disease risk by about 23-percent.

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In 2006, the New York City Board of Health passed a rule that prevented restaurants, which we regulate in New York City, from using trans fats in preparing food. That rule is enforced by our restaurant inspections, which we do otherwise for general food sanitation purposes, and now over 95-percent of restaurants are compliant with the rule. The idea of trans fat restriction that was started in New York City has now spread to 15 other jurisdictions around the country.

We are also focusing on high levels of sodium consumption, and the rationale for that is this: It's clear that we all consume far more sodium than is good for us, far more sodium than is needed, probably at least twice as much, and that if we reduced our average sodium consumption in this country by about 1,200 mg per day, we would save probably tens of thousands of lives per year in reduced heart disease and stroke.

In the past, physicians have recommended that people adopt low-sodium diets and put less sodium on their food, but it's clear that people individually have very little opportunity to really make meaningful reductions in their sodium consumption because 80-percent of the sodium we consume is already in the food when we buy it. It's in the packaged food. It's in the restaurant food. It's put in there by a

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food manufacturer. If we want to have meaningful reductions of the population level of sodium, we're going to have to have food manufacturers put less sodium in their food, and that is definitely possible.

We founded and now lead what is now a national coalition that has been called the National Salt Reduction Initiative. It has established a goal of reducing sodium intake by 20-percent over five years by reducing the sodium content of packaged and processed food by 25-percent over that time period. It's a voluntary initiative in which health organizations are working with the food industry to make these reductions. The way that it has worked is as follows.

We met over the period of about a year with representatives of major food companies, and through those meetings, we divided packaged food into 62 categories and restaurant food into 25 categories. Within each category, we established a sales weighted mean target reduction for the years 2012 and 2014 with the average reductions being 25-percent. We then put those targets out there, and we asked food companies to commit to meeting those targets in their sales weighted averages. So far, we have 28 companies who have agreed to meet targets in at least one of those food categories.

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This is not the entire food industry, but there are many major food companies on here. If you look on the list, you'll see Kraft, you see Unilever, some of the true food giants in this country, as well as major restaurant chains. Later this year, we should be having report-backs from those companies that have committed to targets in 2012 to see how well they have met their commitments.

Moving on to clinical preventive services. One thing we know is that there are a relatively small number of services that can be delivered by physicians or other clinicians that are inexpensive, that are simple, that are proven to be effective at preventing disease over the long term, and that are not nearly as well delivered as they ought to be in this country. We have a very expensive healthcare system that could do far better in delivering these simple, proven, preventive clinical services.

We have an interest in improving those services in New York City, and we have tried to do this through this project where we established a prevention-oriented electronic health record. We developed an electronic health record with a vendor, and we have now deployed it to more than 3,000 providers across the city, serving more than 3 million

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patients. This is in a city of 8 million people, so we have a fairly large reach across the city.

The features of this electronic health record are many, but the ones that are most important are that we have what we call clinical decision support system. What this is, is an alert that shows up on the screen when a physician logs in about a patient that will say something like, this patient has high blood pressure, it needs to be treated. Those alerts are what are referred to as actionable, so if there's an alert that says this patient has high blood pressure, the physician can click it, then a window will pop up and make recommendations about what the physician could do to lower that blood pressure, and that, in turn, provides opportunities for them to do additional clicking that could read right on down to a change in medication for that patient.

The record also has the ability to generate condition-specific lists of patients in need of care. For example, a physician can say, show me all the patients out there whose blood pressure is too high, and he can have them be brought back in for treatment. Or show me all the patients with diabetes whose diabetes is out of control. It supports physicians who want to manage their entire panel of patients

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rather than just dealing with the patients who choose to come in that day.

The improvements in quality performance by physicians, we learned, is not so much from an individual physician just thinking more or working harder, but rather changes in workflow in the physician's office. We give technical assistance to physicians about how they can shift some of the tasks that in the past they were doing themselves to the nurses or medical assistants in their office so they can be done more consistently. With that and the electronic health record and the technical assistance, we are seeing consistent improvements in performance of these clinical preventive services across a number of categories.

This is showing in prescription of aspirin for patients that could benefit from aspirin preventive treatment, blood pressure control, and smoking cessation intervention. These sorts of improvements have been seen in HMOs where it's a contained organization and where the physicians are on salary and everybody's in an organized way trying to improve their clinical preventive services, but they haven't been seen in this setting, and this setting is one where the physicians are, for the most part, in solo practices or very small group practices. It's a very independent, fragmented system, so it's

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remarkable that we are able to achieve this change in that sort of system, and that sort of system is far more like what the rest of the healthcare system is in the United States today.

What has the impact been of all these on our chronic diseases in New York City? Well, we have a lot of positive news here. This is showing declines in ischemic heart disease, which is the most important type of heart disease, and declines in stroke over the last 10 years in New York City, a 33-percent decline in heart disease and 16-percent decline in stroke.

This is what's happened to our life expectancy. In New York City, the life expectancy is greater than the U.S. as a whole, and it's been rising at a rate that's faster as the U.S. as a whole and is now more than—it's 2.4 years greater than the U.S. as a whole. This is life expectancy at birth, and life expectancy at birth is influenced a lot by what happens with infant mortality and mortality that happens in younger years.

We can also look at life expectancy at age 40. This would capture more the changes that occur in chronic diseases, the diseases that would tend to kill most of us in this room. As you can see here, similarly, the life expectancy of a 40-year-old is greater in New York City than in the U.S. as a whole. It's rising faster. If anything, it's diverging more in New York City than the life expectancy at birth.

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Let me just finish up with this thought that the diseases that kill us the most are really mass diseases as the results of mass exposures, and these things respond to mass remedies. These are population-wide problems which demand population-wide solutions. Those solutions, I think we have demonstrated, are possible. They're workable. They're not expensive, and we have demonstrated that we can make them work in New York City.

Just to finish on a key thought on that, this is the sort of work that is paid for by the Prevention and Public Health Fund. I frequently read about people questioning the value of the Prevention and Public Health Fund, what's it paying for anyway? These are the sorts of things that it pays for, things that are done at the population level, but they can have an enormous impact on health. I feel that we've demonstrated in New York City that if we do that right, we can make them work. Thanks very much.

ED HOWARD: Thank you very much, Tom [applause]. By the way, I would commend to you an article that we didn't reprint but that is listed on the sheet of resources from *The Lancet* that describes in more detail than Dr. Farley had the time to lay out for us some of the successes in the New York City experience.

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Now, we're going to turn to Matt Myers. He is president of the Campaign for Tobacco-Free Kids and one of its founders back in 1996. That campaign has led the fight for a range of actions designed to control tobacco use, and it's had a lot more success than almost anyone had predicted. He's won major awards from the American Cancer Society, from the Harvard School of Public School, and he has a report to us from the front lines of that campaign. Matt, thank you so much for joining us.

MATTHEW MYERS: Thanks for having us. It's a delight to actually be able to talk about tobacco. There's four points that I'm going to want to make about tobacco. The first is, tobacco is one area where we've demonstrated that we actually know how to prevent disease and that we have real life examples to prove it. Second, that we're able to objectively document the progress that's been made over the last 15 years in a way that is both significant and measurable. Third, that we're able to show that where we have actually taken the recommended actions, we can prove that we've saved lives, reduced health care costs, and done it in a way that is documentally cost effective.

In fourth, I'd like to focus briefly on a couple of specific measures that are the topic of a good deal of

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conversation these days and that are relevant, that we've been able to tease out their impact independent from other actions.

First, let me talk about the fact that we do know how to reduce tobacco use, and it's not just anecdotal evidence. This has been studied by the CDC, by the Surgeon General, by the Institute of Medicine and other credible entities. This is one area where we can say with a degree of scientific certainty that if we take any of the actions noted on this slide, we will see a reduction in tobacco use.

Second, I think it's important to understand that we have seen extraordinary progress, which means that we know how to make the changes that we're talking about. Let me give you two quick snapshots, probably not coincidentally during the exact period of time my organization has been in existence, but it's an important snapshot. When we were created, close to 25-percent of American adults smoked, over 36-percent of American youth smoked, and that number was rising, not falling. The total tax on an average pack of cigarettes was only 57 cents. Not one state provided meaningful protection to smokers against the harms of secondhand smoke. As a federal government, we had no regulation whatsoever of tobacco products.

Fast forward to today, and you see a very different picture. You see smoking rates amongst adults at 19-percent

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and falling, albeit very slowly. Equally important, if you compare the 36.7-percent to smoking rates among kids today, it's 18.1-percent. That's a public health success story that very few people realize. If you want to understand some of how it's happened, however, take a quick look at the following data.

The average price of a pack of cigarettes today in the United States—the average tax on a pack of cigarettes today is over \$1.50. Twenty-nine states plus the District of Columbia provide the kind of comprehensive protection against smoke-free—against secondhand smoke that Tom talked about that New York has done. Today, virtually every state provides some form of funding for tobacco prevention programs that fit the CDC best guidelines. Finally, in 2009, we enacted legislation to give the Food and Drug Administration effective and comprehensive authority over tobacco products.

What has it produced? You can see the lines. Among kids, the drop is dramatic. Among the adults, the drop is measurable but not as dramatic. What these two slides hide, however, is if you'll notice in the last five years, the progress has slowed dramatically as a nation, but we can document that in 20 states that have taken more aggressive action along the lines of what's been recommended by the CDC,

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they have seen in the last five years declines in adult and youth smoking in excess of 20-percent. What it tells you is that the only place the policies aren't working is where we're not doing them, and where we continue to do them, we continue to see meaningful and major progress.

How does that translate into issues that people really care about? Well, I think this is something that is very important to take a look at. We've been able to study and evaluate. As a result of the adoption of these policies around the country, we now have 7.8 fewer kids who have started smoking, over 10 million fewer adults who use tobacco. What does that translate into? That translates into over 5 million fewer Americans who will die prematurely from a tobacco-related disease. What it also means in terms of direct health care costs, it means over \$200,000,000,000 over the lifetime of those individuals in health care savings. It is a story of prevention that works and pays dividends.

If you want to see it in a couple of areas that are meaningful to a lot of people, cancer—probably the most feared cause of death in this country—we have seen over the last decade a significant measurable decline in the incidence of cancer death rates, particularly among men. The primary study that looked at it found that over 40-percent, and perhaps much

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higher, of that decrease in the risk of cancer is directly related to one factor, and that is a reduction in tobacco use.

If you want to see it on a population basis, California has had the longest running tobacco control program. When California initiated its tobacco control program, it's incidence of lung cancer was actually higher than the national average. As a direct result of the tobacco control measures that California has taken, it has seen its lung cancer rates fall by four times the national average in that respect.

There is some cause for concern. This chart shows us that during the periods of maximum decline, we also have the most robust state spending on these tobacco prevention measures, but for each of the last five years, we have seen an erosion in the amount of money the states are spending. What does that translate into? The data shows very directly that there is a proportional relationship between the amount that states spend on their tobacco prevention programs and their success in reducing tobacco use, so there's a real cause for concern that we are no longer doing the things that have had the greatest effect as we move forward.

What I'd like to talk about now is two of the issues that many people are currently talking about, both because of the healthcare reform and the Prevention Fund. First, what are

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the benefits of actually expanding tobacco cessation coverage to a wider population? When Massachusetts passed its health reform measure in 2006, it expanded coverage for Medicaid and provided comprehensive cessation services for people on Medicaid.

What did it see? It saw a decline in smoking among the Medicaid population from 38-percent to 28-percent. It saw a dramatic decline, 46-percent, of hospital admissions by that population for heart attacks, and they have now documented that for every dollar that the State of Massachusetts spent in terms of providing these services, it saved over three dollars.

A second area that has been receiving a lot of attention—and this is one, too, that relates directly to the Prevention Fund—is what is the value of mass media in reducing tobacco use? We have documented evidence. Perhaps the best success story as a result of the state's settlement with the tobacco companies in 1998, the American Legacy Foundation was created, and what it did was run a campaign it called the Truth Campaign designed to reduce youth tobacco use. Legacy's work has been independently evaluated, and it is seen during the periods of maximum spending that it reduced the number of tobacco users among kids by over 300,000 and perhaps accounted

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for as much as 22-percent of the overall decline in tobacco use among kids during those years.

You don't have to look at a single example. You can look at states as geographically diverse as California, Mississippi, Minnesota, Washington, and Florida and find that everyone of those states can document the impact of their mass media campaign on tobacco use.

Much more recently, the CDC this year ran a three-month mass media campaign with funds from the Prevention Fund. What were the results? Twenty-four states documented more than a doubling in the increase in calls to their quit lines, people who wanted to quit. What they've been able to document is that it will probably result in approximately 500,000 Americans making a concrete attempt to quit smoking, and it could produce as many as 50,000 Americans who successfully quit. If that happens, then the health care savings as a result will exceed \$70,000,000.

That's an important point. Tobacco control programs that reduce tobacco use are cost effective. Two states provide a good example: California and Washington. As I said previously, California's program is the longest running program, and a recent study has documented that as a result of the reduction in tobacco use in California, they have saved

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approximately—let me get the number right for you—\$86 billion in direct health care costs because of the duration of the program. That is quite extraordinary. But a program that ran for only a few years, Washington state has documented a saving of \$1.5 billion in direct health care costs and a savings of \$5.00 for every dollar spend.

The last issue that I want to just mention here is it's not only direct tobacco control programs. It is the adoption of the kind of policies that Tom talked about in New York City, protection of people against secondhand smoke. We now have multiple studies that demonstrate that where you reduce the exposure to secondhand smoke, you see an almost immediate reduction in hospital admissions for cardiovascular disease that translates directly into substantial direct health care cost savings.

All in all, what this shows is that with tobacco, we can document the benefits of prevention, we can document the lives saved, and we can document the health care cost dollars saved. Thank you.

ED HOWARD: That's great. Thank you, Matt [applause]. You've heard both Ursula Bauer and Matt Myers talk about cost effectiveness, and those of you who are on congressional staffs or deal with congressional staffs know that that's one of the

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areas that a lot of members of Congress are very much actively concerned about. That is, it's one thing to be able to show savings in a particular program, it's quite another to have a piece of legislation that makes a particular change and have CBO score it as either saving money or not saving money.

We are very pleased to have with us today somebody who can address that question directly. Dr. Linda Bilheimer is the Assistant Director for Health, Retirement, and Long-Term Analysis at CBO. She's a health economist with multiple degrees from Harvard. She has quite a storied career laid out in the biographical sketch in your materials, including service at CBO during the debate over the Clinton health reform plan, service as a senior program officer at the Robert Wood Johnson Foundation a few years ago, our co-sponsor for today.

How CBO scores prevention proposals has been a topic we hear an awful lot about. Today, Dr. Bilheimer is going to try to explain to an extremely lay audience how she and her CBO team examine the effects on the federal budget of policies that might promote health and prevent disease.

Linda, thank you so much for being here and for being here on such a short notice, as well.

LINDA BILHEIMER, PH.D.: Thank you, Ed, and thank you, everybody, for inviting us to be here today. I have a full CBO

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team sitting out front here to help me out on some of these questions that you may ask.

Ed is right. I think one of the most frequently asked questions that we have from the public health community is how do you assess the impact of a preventive intervention on the federal budget? I'm going to try and address that today. As many of you know, CBO recently released a major study on the budgetary effects of a smoking intervention, and I will talk a little bit about that at the end, but I want to start out by giving you some general thoughts about how we think about prevention in the context of the federal budget.

The first issue which is really important is to understand that there are different concepts in thinking about costs. When one thinks about the effects of any type of health care intervention, be it prevention or be it treatment, one needs to think probably about what the effect on the cost of health care will be, and people look at health care spending per capita as a measure of that.

People also want to think about the return on the investment that they are making. Is this a cost-effective intervention, and we think about what is the cost per quality adjusted life year.

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We think also—and the Congress thinks also—about the budgetary impact, and that is a separate issue. Obviously, it interacts with the other two cost concepts, but they are not the same, and sometimes they may go in different directions or not in directions that you might have anticipated. When we look at the effects on the budget, which is CBO's focus, we're looking at how does this affect the federal government's spending and its revenues?

When we start thinking about budgetary impacts of any proposed health policy, not just a preventive intervention, there are certain things we have to focus on. First off, we have to think about what the baselines are going to be. A baseline is not a point-in-time concept; it is what we think is going to happen over the next 10 years, in the case of the budget window or maybe longer, in the absence of any change in federal law. So, what will happen to health care spending, what will happen to health risks, what will happen to outcomes, and what will happen to all the drivers of those factors?

You've heard today about what the Campaign for Tobacco-Free Kids is doing, what New York is doing. We have to think about, well, what will New York and the other states do over the next 10 years that will affect what spending would otherwise be, because the policy we are going to introduce will

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have a marginal effect relative to what is going to take place under current law.

Then, to think about what happens to health as a result, we have to think about the behavioral responses to whatever federal policy is introduced, and that means the behavior of all the relevant actors. We're not just talking about individuals and families and households. We're talking about employers. We're talking about states. We're talking about schools—whatever may be affected by the policy and how they will react and then how in turn the interactions of all those responses to the policy will affect health outcomes.

When we have that, we have to decide how this affects federal spending. We're talking about more than just Medicare and Medicaid, and just is a big word there, but we're talking also about Social Security, we're talking about SSI, we're talking about other federal programs potentially as well.

And then we have to think about revenues. Revenues may result directly in the case of taxes and fees, or they may be indirect effects. If health improves, we may see revenue effects resulting from changes in workforce behavior and productivity that we have to take into account as well.

Finally, what is very important to us—and I will make a big plea—is we are evidence and research nuts. We love good

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data. The strength of the evidence base that enables us to do these analyses is really critical. Believe me, we really welcome anything that you can share with us that you think would throw light on the effects of policies or interventions or responses that we can measure.

When we think about prevention, another issue that is important is we often get the question, how do you score prevention? Prevention is actually a myriad of different types of policies and interventions, as you have heard today. We think about them in broad categories, and they all raise different issues. Clinical preventive services raise very different baseline and response issues than do community-based health promotion initiatives.

We also think and get asked about regulations to limit risky behavior, such as, seatbelt laws, 0.08 blood alcohol—those types of regulation. We see more now and get asked more questions now about personal financial incentives to modify risky behavior, maybe through insurance premiums, maybe through cash contributions that people receive if they participate in certain preventive interventions, and then obviously excise taxes on health risks, tobacco taxes, possibly soda taxes, and so on.

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Three years ago, my colleagues at CBO decided that it was time really to start to look at these issues comprehensibly. I don't think anybody realized quite how much time and how many people it would take really to do this. The three leading authors are here: Noelia Duchovny, Ellen Werble, and Jim Baumgardner. I'm hoping that they will be available to answer your questions as they come up.

The goal of the policy was to look at the budgetary increase—a very simple policy—the budgetary effects of an increase in the federal excise tax on cigarettes, a small increase of 50 cents, which was indexed for inflation and for the growth in income. What we wanted to focus on—obviously, there were tax effects, direct tax effects, and we look at those, but what we really wanted to focus on was the health effects that resulted from this and how outlays and revenues would be effected by those health effects that resulted.

We looked both at the 10-year budget window, which is the normal window that CBO looks at, and also the longer term, which is unusual for a CBO analysis to do, but one of the reasons for so doing was because people rightfully say when you think about prevention, you should be thinking beyond 10 years. You should be thinking about what happens to the population

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over time. We took up the challenge and looked at it from that perspective.

That said, it's really important to grasp that decisions are not driven primarily necessarily by CBO estimates. Policy makers are going to take many other things into account. They're going to look at what the health outcomes will be; are they going to improve the health of the population? They're going to look at whether this is a good investment; is it cost effective? There will be ethical questions, questions about the role of government. All of those things go into making a decision of which the budgetary score is just one component.

It's also important to recognize that other policies to improve health would have probably very different outcomes. This is just one particular intervention. One of the reasons that we did this particular analysis was because of the strength of the evidence base. You've heard from Matt about how much we know about the effect of interventions on tobacco. We had a lot of information that we could use, and for many other types of interventions, we don't have as strong an evidence base; hence, the plea for data and research to enable to do more and better analyses.

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If we look at the approach that we go, we start out with a policy intervention, in this case, the increase in the tobacco tax. We look at the implications for the reduction in smoking. We then have to assess how the reduction in smoking will affect health and then how those changes in health stages affect several factors, how they affect health care spending per capita, how they affect mortality, and what effects they have on labor markets. This is a huge body of research, and only when we've done all of that can we then get to these parts where we look at what happens to federal healthcare programs, what happens to retirement programs, what happens to DI, what happens to revenues.

I'm going to give you just a little bit of an oversight of these outcomes here, but I cannot emphasize how much work went to get us to this point of being able to say something about those outlay and revenue effects.

Starting out, we look at what happens to mortality and to life expectation, and what we find is—this first slide takes you out through 2035. This is the first in 20 years, and we see this increase in the overall adult population. Very critically, notice that the bigger increase is in the 65 and older population, and that is really important to a lot of these estimates, that the full impacts on longevity come in the

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65 and older population, which obviously is the Medicare and the Social Security population.

Then we looked at the effects on health care spending and earnings for adults affected by the policy. Adults affected by the policy are those who either quit smoking as a result of the intervention or never started smoking. You will see that it takes quite a long time for the effects to work out.

We had to introduce what we called a health lag into our modeling. Noelia is the expert on this and can tell you about the health lag. The health lag reflects two factors. One, it reflects quite a long period before people who quit smoking gain back the health that brings them back almost to the health stages of people like them who have never smoked. The biggest effects come from youth who never start smoking and who gradually, as they age into the population, we get more cohorts of people who have never smoked in the population. That is why you see those lagged effects over time.

If we look now at the effects of—I've got the wrong pointer—we look at the effects on outlays that derive both from the effects on longevity and the effects of lower per capita health care spending, what you can see is that lower per capital health care spending, the effects decline over time.

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We see lower per capita health care spending through 2083. We'll see the effects of greater longevity. When we look at the total effect on federal outlays, you'll see that initially federal outlays are lower, and then around 2025 or so, we start seeing the effects of greater longevity—which I'll remind you is a great health outcome—pulling up the effects on federal outlays.

Obviously, I should say right now that all of these estimates are highly uncertain. These are our best estimates given the information that we had, and these look to us to be about the center of the distribution of outcomes we should expect.

Coming back now to a shorter time period, because you can see the graph more easily this way, if we look at the effects on outlays by individual programs, you'll see that over the first 20 years or so, the effects on Medicaid and its subsidies and the Exchange—and I would say that these estimates were done before the Supreme Court decision, so these reflect the Medicaid and Exchange baseline that we had before the Supreme Court decision. You'll see that those decline throughout the period. The big effects that we see in Medicaid come from reductions in low birth weight. We don't have nearly as much a longevity effect in Medicaid, because we're dealing

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with a younger population, so, you see the outlays decline throughout the entire period.

If you look at Medicare, you see that initially outlays decline, and then as the longevity effects kick in, Medicare spending starts to rise. With Social Security, we see again rising throughout the period because of longevity, and so the total effect, you can see that around 2025, outlays start to rise where they had fallen up until that period.

If we look at—and I would emphasize these are the health related effects on revenues. We're not talking about the effects of the excise tax itself. You can see that this first line here represents a switch from untaxed compensation to taxed compensation. If health insurance premiums and employers are spending on health insurance, workers will get more of their compensation in the form of wages which are taxed, so that helps revenues. You will see the effects of greater longevity, because workers are staying in the labor force longer. You see the effects of changes in labor earnings per capita, because workers are more productive.

The total effect on revenues from improvements of health rise throughout the period, but you will notice that we're talking about very small amounts here. All these measures are extremely small. We normalize by looking at the

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percent of gross domestic product. You can see how these amounts relate to the size of the economy, and you can see that they are extremely small. All the amounts we are talking about are extremely small.

If we look at the health related effects, not the excise tax, but the health related effects on revenues and outlays and the deficit, you can see the effects on outlays, the effects on revenues. Out here, sort of in the 2060s, the effects on outlays exceed the effects on revenues, and so the health effects resulting from improvement in health—the effects of improvements in health start raising the deficit at about that point in time.

The overall budgetary effect of the policy, if we put in the tax revenues as well, you can see that the deficit declines throughout the who period, but again, the effects are extremely small.

Overall, these are our conclusions. The changes in federal spending from improved health would be relatively small. It would be lower in the second decade, and then spending would start to rise as the longevity effects outweighed the per capita health care spending effects. Revenues would rise on an ongoing basis as a result of better health, and so the health effects would produce small declines

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in the deficit for about five decades, but the largest budgetary effects would be from the tax. Thank you.

ED HOWARD: Thank you very much, Linda [applause]. Okay. Let me just take a moment. If any of our panelists would like to make an observation or raise a question before we go to the audience, you should feel free to do so at this point. Let me point out that there are microphones where you can come forward and ask a question yourself. You can write your question on one of the green cards and hold it up and it will be brought forward.

Let me just go back and focus on something that both Ursula Bauer and Matt Myers talked about and then Linda defined in her presentation, and that is cost effectiveness. It's a return on investment. What does it mean? How much of a return on an investment do you have to have before you can classify something as cost effective in your respective venues.

URSULA BAUER, PH.D., M.P.H.: Well, cost effective is different from cost saving. Not all investments in prevention are cost saving, but of course, treatment isn't cost saving either, generally. We're spending \$2.5 trillion dollars a year treating the effects of poor health. We could avert in any of those costs by investing in effective interventions that don't cost more than the return we could get.

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There certainly are cost saving interventions in public health. Community water fluoridation is a great example. For every dollar you invest in the mechanics of delivering fluoride to people through their water system, you save \$38 in actual treatment for dental caries that are averted because of the fluoridation. That's cost saving where we're actually recouping more dollars than we're investing.

Much of prevention is about quality of life and improved health, averting suffering. Certainly, as we've heard, there are some costs related to additional Social Security payments as people live longer and so on. Americans need to decide if we're better off alive or dead [laughter], healthy or sick, and what we would like to pay for our quality of life and our health moving forward.

ED HOWARD: Matt?

MATTHEW MYERS: I think that's such an important point, and Linda made it so clearly. We're all looking at numbers, but what's extraordinary about these population-based prevention issues is they combine being cost effective with what is truly a societal goal, which is increase longevity for people living not only longer but healthier and an opportunity of being more productive. What never gets factor into these things is that deaths from chronic disease not only take

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somebody out of the workforce, they often take people out of being a mother and father or a parent caregiver, and there's a host of costs that are both economic and noneconomic and therefore a host of benefits that are noneconomic as well.

As Tom pointed out, the programs and policies we're talking about for fairly modest amounts of dollars produce extraordinary results. If you compared it to an individual patient care or the amount we spend on biological research, the dollar-for-dollar return for longevity is quite extraordinary.

ED HOWARD: I should point out there's a story—I don't know if it's apocryphal or not—about Bruce Vladeck who, when he was running the Medicare program, had the Secretary walk into his office and he was out on the balcony smoking. The Secretary said, "What are you doing, Bruce? You're killing yourself." He said, "No, Madam Secretary, all I'm doing is extending the life of the trust fund." [Laughter] Precisely the same point that has been made by this return on investment.

There's a question here for Tom Farley. Smoking in New York has dropped 14-percent, and the question is, is the goal of public health in the city to reach zero percent, or 14-percent sounds pretty good, or is there somewhere in between that's your target?

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THOMAS FARLEY, M.D., M.P.H.: Given what we know about the risks of smoking, we want smoking rates to go as low as they can. I definitely think that we can get them lower than 14-percent. I am doubtful that we could get it down to zero. We certainly have very strong sanctions against, let's say, heroin use in this country, and there's still plenty of people who use heroin. So, we're not going to get down to zero, but I think we can get far lower than we are right now. I think if we were to do that, we would have enormous improvements in health, so we should continue to try to reduce rates.

ED HOWARD: Very good. We have someone coming to the microphone. If you have a question, I'd ask that you identify yourself and keep it as brief as possible.

BARBARA KORNBLAU: Hi. Barbara Kornblau, Coalition for Disability Health Equity. I had a question about New York. I noticed that your lawsuit—you were not successful in your lawsuit with having pictures of smoking effects by the cash registers. At the same time, an article came out in a peer review journal showing good evidence that that worked. I'm wondering what your response is going to be, if you're going to try and work with the federal government to have them put those same pictures back, or what your response is going to be, since

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it was a successful campaign though ruled—the feds kind of overshadowed what you did?

THOMAS FARLEY, M.D., M.P.H.: Yeah. Thanks so much for the question. Just to explain to other people in the room who may be less familiar, the New York City Board of Health passed a rule about 2 1/2 years ago that would require retailers that sell cigarettes to post a warning sign that was designed by the health department at the point of purchase about the risks of smoking with the rationale being that we have warning signs on cigarettes packs, and those are proven to be effective—the graphic warning signs. Nonetheless, you don't get those until you actually buy the pack of cigarettes, and we would rather provide a warning to people before they buy a pack of cigarettes.

When the rule was passed, warning signs went up. We were sued by the tobacco industry, and ultimately that suit was lost. The rationale was that the federal law gave the federal government the powers to determine that cigarette pack warnings preempted localities from having warning signs even at the retail level, that somehow that was parallel to a warning sign on a pack. I don't understand the legal rationale for it, but nonetheless, that was the decision.

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During the time that the warning signs were up, we evaluated it and we showed that two-thirds of current or former smokers going into retail stores saw the signs and that those that saw the signs were more likely to say that they were considering quitting. So, we had good evidence or promising evidencing that this would be effective.

I can't say what our response will be. I can say, though, that we still see smoking as our number one public health problem. We still believe that potential smokers, including children, need to be warned, and we think that retail locations are a place where warnings like that would be valuable. We're going to continue to look at whatever opportunities there are to reduce smoking rates.

ED HOWARD: There is a question that came forward on a card that had to do with ways to spread the experience of New York to other places. I wonder if maybe Dr. Bauer has a sense of—or Matt—where, if elsewhere, is this likely to be adopted in whole or part as a way of dealing with the public health questions that we're talking about?

URSULA BAUER, PH.D., M.P.H.: Sure. Communities are very networked, and our communities are often sort of laboratories in innovation trying new approaches to prevent

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disease, to reduce risk factors, and then evaluating those and building the evidence base for community prevention.

CDC supports sort of the compilation of that evidence base in the *Guide to Community Preventive Services*. We have a website that lists evidence-based interventions that can be deployed at the community level. We also through our grant programs convene community grantees and state grantees to share their experiences and best practices so that we really can disseminate these promising practices across the country.

ED HOWARD: Matt, do you have a sense—oh, I'm sorry. Linda, I didn't mean to take the microphone out of your hands.

MATTHEW MYERS: Well, I do. To the extent—New York is very helpful, and New York's not alone. We have examples from many states where the adoption of these policies has been proven to not only reduce tobacco use but reduce health care costs, assist with Medicaid populations. The goal is to make sure that every state has this information and that as they're making their health care and prevention decisions, they recognize that these policies and programs are probably the most cost effective way for them to improve the health of their population.

We could have shown—either Ursula, Tom, or I could have shown a chart that showed the cancer rates in this country

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state by state pretty well parallel what a state has done with regard to its efforts to reduce tobacco use. In this country today, your risk of cancer depends very much on where you live, and that depends on the political decisions that your leaders make. The more that gets discussed, our hope is that New York State will become the model for the entire national.

ED HOWARD: Linda?

LINDA BILHEIMER, PH.D.: Just to follow up on that, what you've heard discussed here clearly affected our baselines. One of the most challenging issues we had was to think what the smoking baseline should be, given, as you saw on Matt's slides, the slowdown in the decline of smoking rates among adults, given the declines in the amounts that states were spending on smoking, and also given a growing literature that I think Tom obliquely referred to of what is known as hardening of the target. Do you get down to a core group of people who will always be smokers that you can't change their behavior? We really struggled with these concepts in trying to make a projection of what health spending would be, what smoking rates would be in the absence of a change in federal law.

I'm interested in hearing Matt's and Tom's and Ursula's perspectives on that of what you would project is likely to

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happen to smoking prevalence over the next 20 years. What do you think the floor should be 10 years out or 20 years out if you were making a baseline projection?

THOMAS FARLEY, M.D., M.P.H.: I'm going to just jump in on that real quickly. We're dropping about one percentage point per year right now. Again, the people who are currently smoking are smoking much less than the people who were currently smoking 10 years ago, so if anything, it looks like it's easier to reduce smoking rates further now than it was before, because the social norm is building on itself. I don't think we're anywhere near reaching a hardened target. I'm very optimistic about continued declines over the next at least 10 years.

MATTHEW MYERS: Let me site you some data from California where smoking rates are actually lower than New York. They're about 13-percent for adults. A stunning figure, 60-percent of smokers in California smoke fewer than one cigarette a day. What that argues is that we're nowhere near the hardening of the target, that there is a very substantial population out there still that smokes less than their parents smoked and therefore should have an easier time quitting if we provide them the right incentives to do so.

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LINDA BILHEIMER, PH.D.: Do we know the health effect of reducing smoking as opposed to quitting? That was another challenge that we faced.

URSULA BAUER, PH.D., M.P.H.: Yes, I do think that is a challenge. There are studies that have looked at the number of cigarettes that smokers smoke each day. What we're actually seeing now is that smokers are often not daily smokers; they are weekend smokers or they're smoking occasionally in the evening, not throughout the day. This has sort of challenged our understanding of smoking and of nicotine addiction as well.

ED HOWARD: Linda, if I can ask your forbearance at the microphone, let me just follow up. You indirectly raised the question of how strong that strong evidence base is and that you chose this particular example because of the strength of evidence you had. What was there that, besides the prediction of future smoking rates, posed the challenges for you in trying to decide what to assume and what not to assume?

LINDA BILHEIMER, PH.D.: Oh, there were many challenges, and Noelia and Ellen and Jim can jump in here. Obviously, just producing baselines was a huge challenge, working out what smoking would look like in the absence in the change in the law.

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Secondhand smoke was hugely challenging. We tried to take secondhand smoke into account in the estimates, but we could only take exposure in the home into account, and we tried to develop a way to measure that, and if you read the report, you can see that. Exposure to secondhand smoke in the workplace—or as I was in a public place last night when someone lit up in front of me—we could not measure that. We just didn't have the resources to do that.

Also, the effect of reducing rather than quitting was a huge challenge, and we ended up just not taking account of lower tobacco use as opposed to actual quitting. That was with some of them, just some very basic things.

ED HOWARD: Very good.

LINDA BILHEIMER, PH.D.: I don't know whether these guys have anything else they would like to add to that.

ED HOWARD: We would be happy to lend you a microphone for purposes of supplementation if you'd like. If not, let's go to the microphone.

AL MILLIKEN: Al Milliken, A.M. Media. Is there any further update on what is happening to control sugared soft drink soda consumption in New York City? What has been the reaction of the beverage industry, and how are other areas responding to the New York initiatives?

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THOMAS FARLEY, M.D., M.P.H.: We've had a number of initiatives to try to reduce consumption of sugary drinks. We've had media campaigns, general health education. We have proposed in the past, as you may know, tax on sugary drinks. We've proposed restriction on the use of SNAP benefits for sugary drinks, while not reducing the total SNAP benefits at all. We most recently, as I think you're probably alluding to, proposed a cap on the portion size of sugary drinks that are sold at restaurants. That cap on the portion size has been put out for public comment by the New York City Board of Health—we're in the public comment period now—and ultimately will be seen again by the Board of Health after the public comment period in September.

No surprise, the beverage industry doesn't like it, and they've spoken out again, and I'm sure that they will continue to speak out against it. We are fortunate that the rule would be viewed by the New York City Board of Health, which is a panel of health experts that have the authority to act within the health domain strictly on health issues with health rationales. If that committee feels that there is a health benefit to this, then they are authorized to pass it.

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We're optimistic about it, but certainly there would be an awful lot of strong opinions that you'll hear particularly from the beverage industry during this next few months.

ED HOWARD: There is a—

THOMAS FARLEY, M.D., M.P.H.: Actually, could I—
[interposing]

ED HOWARD: Yes, I'm sorry. Go ahead.

THOMAS FARLEY, M.D., M.P.H.: For those people who—if I could just talk a little bit about the rationale for the portion cap. Sugary drinks are associated with obesity in a variety of studies and prospective studies, cross-sectional studies. There's something about putting sugar in water that makes it easy for people to consume too many calories. Consumption of sugary drinks has nearly tripled as obesity rates have gone up more or less in parallel, and so there's lots of reason for us to focus on that one particular product.

There is also a body of evidence that says that people are remarkably driven by the portion sizes that are put in front of them. You give somebody food that's twice as much in size, and they consume almost twice as much, and they don't notice it whatsoever. That would imply that if you give people a smaller portion size, that they will consume that and be just as satisfied. So, we think that the portion cap will have a

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tendency to have people consume less while still getting people the freedom to consume as much as they want, because if they want to drink 32 or 64 ounces, all they need to do is buy two or buy one and put it in two cups.

While it has sometimes been framed as a limitation on choice, it's not a limitation on choice. What it is, is establishment of a default size, and by changing the default, we give people freedom while still giving them some sense of what's appropriate for a human to consume.

ED HOWARD: Alright. We have a couple of folks at the microphones. I don't know who was first. Bob?

BOB GRISS: Bob Griss, Institute of Social Medicine and Community Health. What is the evidence that prevention interventions can save money in the health care delivery system, which can then be reallocated to other purposes? I don't hear any attention to actually capturing surplus in the health care delivery system that can be redirected. It seems to me that is a more actionable relevant consideration, and I'm wondering what institutional structures may be necessary to achieve that goal.

ED HOWARD: Well, if I may, there's kind of a threshold question, and that is, how many more kinds of things can you do this sort of analysis with? Can you do it for delivery system

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reforms? Can you identify the savings before we try to decide where to put them?

LINDA BILHEIMER, PH.D.: I think we have had that question asked of us before. How do you think about the savings in prevention being plowed back into health care? This is not something that we have addressed, and I'm not quite sure how you would envision this happening. Insofar, for example, as health expenditures are lower, health insurance premiums are lower, and through that mechanism, as I pointed out in one of the slides, it doesn't necessarily end up going back into the healthcare system, though there are probably roots in which it would, but it goes back into workers' pockets in the form of higher compensation through wages, because health insurance premiums are less high, and so they are receiving more of their compensation in the form of wages rather than health insurance premiums.

That is one mechanism in which potential savings from interventions are fed back into, in this case, wages but not necessarily into the healthcare system. I don't know whether Ursula has thoughts about how they get back into the healthcare system.

URSULA BAUER, PH.D., M.P.H.: We certainly see reducing the burden on the healthcare system as one of the goals of

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prevention. We want to deliver, as I said, a healthier population to the healthcare system so that as a society we can actually afford to deliver health care to everyone. People who are healthier will need less health care, less treatment for diseases that they don't get.

It becomes very complicated very quickly when you look at the costs of living longer. I would point out that right now, America is 50th in the world in terms of life expectancy, and yet we spend twice as much on health care than any other country in the world, so we're not getting value for our health care expenditures.

The decisions that we need to make are focused on how do we get more health, better health for a better price, and I think investing in prevention is one of the ways that we do that.

ED HOWARD: Okay. Yes, sir. You want to go ahead with your question?

STEPHEN REDHEAD: Hello. Steve Redhead from CRS. I think it was Dr. Farley, actually, who put up a slide at the end of Geoffrey Rose and a quote from him, presumably from his seminal 1992 essay on the strategy of preventive medicine, and I recall in that that he decided that you're best to stay clear of economic arguments when talking about prevention, because in

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the end, everyone has to die from something and it will cost money, and often you're just postponing. He argued that the humanitarian argument is the best one; it is better that people be alive and well than sick and dying.

I have a question for Linda, if I may. I confess to being a little depressed now, because you took, of course, smoking, which is the number one cause of preventive deaths in this country. About one in five deaths are smoking attributable. About a third of all cancer deaths are smoking attributable. This is the big elephant in the room. Yet, your study shows that in terms of—as you measured it—in terms of the impact on the federal revenues and spending, it's very small. The budgetary impact in terms of—if I understand the study correctly—in terms of the long-term reduction in deficit is small, and it seems to be largely propped up by the fact that you have—because of the intervention you chose, an excise tax increase—you have a steady, reliable revenue source. Other kinds of interventions aimed at reducing smoking, if they weren't tax based, wouldn't have that, so that might further diminish the effect.

My question is, if that's what you get with the big one, what implications does your study have—I'm already getting the question from congressional offices who are assuming now

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CBO will try to apply the lessons you've learned in this study to other future scores of prevention. What implications does this work have on whatever else you might be asked to score in the near future?

LINDA BILHEIMER, PH.D.: Good question. First off, I think it's important to note that this was a very small intervention. We're talking about a 50 cent increase in the excise tax on cigarettes. We're not talking about a comprehensive tobacco cessation policy. We're not talking about a \$5.00 increase in the cigarette tax that might have a much larger effect.

If you look at what the effects on smoking prevalence were, I think—and Noelia can correct me—but I think it ended up that instead of a baseline assumption of 15-percent in 2035, it was about 14-percent in 2035, something like that. We're talking about a small decline in the prevalence of smoking resulting from a small policy intervention. Obviously, a large intervention would have larger effects, but again, it's much more difficult for us to estimate just because the evidence base is not strong.

I was talking to Tom before the start of this meeting about how great it would be to have data from New York to look at what happens when you have a really large tax increase on

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behavior, because we only see—in the research literature, we can only look at small marginal changes and look at their effects at this time.

The other thing is, in terms of scoring of other interventions, this is not a CBO cost estimate, and I think it's really important to understand that. This goes into a much broader range of issues than there would be in a CBO cost estimate. In looking at the out years in having—the effects on a very broad range of programs—in having an effect on GDP—by looking at the effects on productivity and looking at the effects on wages and so on, we are going into much more than we would go into in a small cost estimate over a 10-year budget window.

Certainly, we have learned some things that we probably would apply in these contexts but not do nearly as comprehensive an analysis. I don't think anybody wants to wait two to three years for their cost estimate of their proposal.

ED HOWARD: By the way, a couple of asides. One is that I'm pleased to note that the honorary chairman of the Alliance's board of directors, Jay Rockefeller, is the formal requester of the report that CBO produced and maintains a very strong interest in the outcome of that report. The other is that I misspoke earlier and, in fact, the Lancet study is in

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your packets, and I finally stumbled over it. It's canary yellow in color.

Let me pick up a couple of questions that kind of continue the thread of what Linda Bilheimer was talking about. The broader one simply asks, what's the most promising evidence-based way to tackle obesity? The more specific one notes that the Affordable Care Act puts smoking cessation programs in the allowable category for Medicaid coverage and wonders whether weight loss therapies might, if a proposal were put forward to include them in Medicaid, be able to stand up to the kind of analysis that you did for this. Broad questions, policy questions, methodological questions—you can try it any way you like.

LINDA BILHEIMER: I think somebody else should be addressing the obesity question.

URSULA BAUER, PH.D., M.P.H.: Shall I jump in?

ED HOWARD: Sure.

URSULA BAUER, PH.D., M.P.H.: It's a great question. Our toolbox for obesity prevention is really not very well stocked at the moment. Our toolbox for actual obesity reduction or weight loss—even though as a society we've kind of been at that for a much longer period of time—is even less robust at this point.

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We have a number of promising interventions for obesity prevention and control, and we are in the process at CDC through a number of our grant programs of implementing those and evaluating those so that we can actually build the evidence base for obesity prevention. This is exactly the process that was used to develop our tool chest for tobacco control. The evidence really followed the practice by a decade or even two decades. It's because of the work that we tried in the 60s, 70s, 80s that by the 90s we actually had that short list of evidence-based strategies which have been very effective in bringing our tobacco rates down so impressively.

The kinds of interventions that we're looking at for obesity prevention really look at the kinds of foods we're eating, how much food we're eating, the availability of healthy foods in our communities across the country, in our work sites, in our daycare centers, in our schools. We're also looking, as Tom alluded to, what are the increments in calories that we're consuming, and it's quite impressive over the 30 years or so of the emergence of the obesity epidemic and what contributes to those excess calories, and a lot of it is the sweetened beverages, for example.

So, how do we change social norms? How do we make healthy foods more accessible? What's the physical activity

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component, and how do we make physical activity more available to people? How do we integrate that into daily life? Certainly, the way we design our communities, the way we ensure there are safe places for people to be physically active, is one strategy.

The Institute of Medicine recently came out with recommendations. We've been evaluating promising practices through our community guide process that I recommended. We're assembling the tools, but we have a way to go.

ED HOWARD: Linda?

LINDA BILHEIMER, PH.D.: Yeah. On weight loss therapies, this question relates specifically to coverage under Medicare Part D of weight loss therapies and removing the exclusion of weight loss therapies from Part D coverage. The simple answer—the question says, do you need more data, and the simple answer is yes. If we were to be looking at a policy that proposed expanding Part D to cover weight loss therapies, we would really need some more evidence really to do an effective job on the estimate. We would love if people have research on those types of questions. We would love to have it. We would love to see the data if you have it.

URSULA BAUER, PH.D., M.P.H.: I'd just like to add, if I might, that we can achieve many improvements in health with

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very modest weight loss or no weight loss at all. Certainly, physical activity, no matter where you are on the weight spectrum, is going to improve your health status, even if it doesn't move you from the obese category down to the overweight category down to the normal weight category. Increasing your consumption of fruits and vegetables will improve your health no matter where you are on that weight continuum. Although weight loss is clearly a goal and carrying those extra pounds, especially at the obese level, will compromise your health, certainly healthful nutritional and regular physical activity will strengthen your health regardless of where you are on the weight continuum.

ED HOWARD: Two questions related to each other for Dr. Farley. It builds off your listing of the packaged food companies and restaurant chains that have committed to the salt reduction initiative. Question one, how did you do that, and what incentives did they have to sign up? Second, how do you increase those incentives to get a more lengthy list of endorsers and participants without moving into the many-state criticism that was partially evoked by the proposed on soft drinks?

THOMAS FARLEY, M.D., M.P.H.: The health officials at the federal level as well as elsewhere have been encouraging

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the food industry to reduce the sodium levels in food for about 40 or 50 years and haven't made a lot of progress. This was an initiative that was put together that followed the model of what was done in the U.K. There, it was the equivalent of the federal government's FDA that established targets for companies to achieve in a voluntary way—but because it was the federal government, there was a—or was the government—it had a little bit of potential teeth behind it—encouraged them to meet these sales-weighted reduction targets. We followed that model here, and it was strictly voluntary.

I think the smart and more proactive food companies recognize that if they don't make some meaningful reductions, at some point, some governments may say there ought to be some regulation around this. I think that it is far better for companies to make these changes on their own, because it gives them the freedom to produce their products in ways that still people find tasty, that they can market well without the kind of fine-detail involvement of having a governmental regulatory agency involved.

I think that that's it, that there are—first off all, many of these companies strictly on their own said we don't want to contribute to health problems; we want to do the right thing. Every one of the companies on that list I give a lot of

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credit to for having real community concern. To a certain extent, they may also have been motivated by the idea that sooner or later if there isn't action taken, that there may be some government action taken.

ED HOWARD: Okay. Go ahead.

URSULA BAUER, PH.D., M.P.H.: I would add that in the area of sodium, the nanny argument is a little bit flipped around, because when we talk about the nanny taking control, we're talking about limiting people's choices, and people want more choices. With sodium, people have no choice. The sodium is in the food. We can't take it out.

Breakfast cereal is a good example. We don't really expect salt to be in our breakfast cereal, but there's 200, 300 milligrams of sodium in a serving of breakfast cereal. Most of us probably cap off that serving a little bit—maybe it's a serving and a half or two that we're actually pouring in the bowl, then you pour on the milk. Most of us wouldn't be shaking seven, eight, nine shakes of salt into our breakfast cereal. We could do that if the salt weren't already there. We could decide how much salt we want in our breakfast cereal, but right now, that's not the environment.

As we reduce the amount of sodium in foods—and I think companies see this—we actually put choice back into the

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people's hands so that we can decide how much salt we want to consume.

ED HOWARD: Very good. We're getting very close to the end of our time. Let me just remind you that we would really like you to fill out that blue evaluation form to give us some feedback on the kinds of things you'd like to see us do and how we can do better the things we're already doing.

I've got a question here that's aimed at Linda Bilheimer, and the specific question has to do with whether or not you could do an analysis like this for the mental health sector. It does raise the question at two levels. One is, where is the evidence that you would be able to draw on for mental health or other kinds of analyses like this? Second, how about the resources of CBO itself? If it's going to take you three years with an entire section working on a particular project, how could you possibly do the kinds of analysis like this for a wide range of alternatives that our members of Congress probably have in their heads?

LINDA BILHEIMER, PH.D.: Good question. First, I'm not really quite sure what is meant by an analysis of the mental health sector. That sounds very, very broad, and I'm not quite sure what the policy question that we would be looking at would be.

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ED HOWARD: And what the intervention might—yeah.

LINDA BILHEIMER, PH.D.: What the intervention would be. If there was a federal policy that was looking at Medicare or Medicaid coverage for some mental health intervention that was not currently covered by those programs, that might be something that we might look at. It would really depend on the specifics of the policy, how we would approach it.

That also said, we wouldn't—first off, yes, a lot of people were involved in the tobacco study, but they were all involved in other things at the same time. They weren't working around the clock 24/7 on the tobacco study. We would not be undertaking this broad an analysis of a mental health policy; we would be doing a regular cost estimate of a regular health policy. If there was another type of question that really warranted looking at an issue from multiple perspectives over the short term and over the long term, then we might take the resources to do it.

We've learned some from this. We will make some additions to our regular cost estimates from some of the things that we have learned from this, but this is not going to be the type of study that we will undertake on a routine basis, I assure you. Whoever the person was who asked, I would be

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interested in knowing what specific type of mental health policy you were interested in having looked at.

ED HOWARD: Very good. Well, it's appropriate that we end a program like this with a question rather than asserting that we have all the answers, but we have covered an awful lot of ground.

I want to thank you for your active and very thoughtful participation in this conversation. I want to thank our friends at the Robert Wood Johnson Foundation, not just for co-sponsoring it, but as I said, helping to shape how we put the discussion together, particularly Jim Marks.

Please join me in thanking our panel for a very thoughtful and useful discussion about a very tough project.

[Applause]

[END RECORDING]

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