

Dr. Fielding's Written Testimony to the Senate HELP Committee - January 22, 2009
"A National Strategy to Reduce Tobacco Use and Obesity"

Dear Chairman Kennedy, Senator Enzi, Senator Harkin, and Honorable Members of the Senate Health, Education, Labor and Pensions Committee,

Thank you for this opportunity to appear before you today.

At a time when our nation faces unprecedented economic challenges, a healthy population is an essential prerequisite for economic growth. Preventable chronic diseases sap our nation's collective economic strength, reduce our international competitiveness, and increase medical care costs. Taking action now to reduce tobacco use and the obesity rate can help put our nation back on the road to economic prosperity and save tens of millions of Americans from preventable illness, disability and premature death. Researchers estimate that a third of all deaths in the United States in 2000 were caused by tobacco use and the two most immediate risk factors for obesity (poor diet and a lack of physical activity), primarily by causing a wide range of chronic diseases (e.g., cancer, heart disease, chronic lung disease, diabetes).⁵ These diseases are the leading killers of Americans, are very costly to treat, and result in disability and death for many during what should be their most productive years. Researchers have also found that obesity and tobacco use are linked to decreased worker productivity.

Our country currently spends more than any other nation on health care, 16.5% of our GDP in 2007, yet we still experience poorer health than most other developed nations and some developing countries. It is evident that the status quo approach is not working. Fortunately, many of the premature deaths and costs associated with obesity and tobacco use are preventable. However, in order to take full advantage of the opportunities for prevention, we must look beyond the borders of our health care system. To effectively reduce the rates of obesity and tobacco use, we also need to enhance the public health infrastructure of state and local public health departments with stronger, sustained support. Furthermore, we need policy changes in the other sectors that have large impacts on our nation's health and on the serious health disparities among population groups. And we must work better with other partner agencies, in both the public and private sectors, that share our concerns about how to reduce the toll of these twin scourges.

Reducing the Toll of Tobacco Use

Despite much success in reducing tobacco use over the past several decades, nearly one in five adults (43 million adults) continues to smoke.¹ Among high school students, 20% report smoking, a rate that has remained unchanged since 2003.² In addition, marked disparities in smoking rates exist, with the highest rates observed in lower income populations, African Americans, American Indians, and those with mental health and substance abuse disorders.³

Smoking is the leading cause of preventable death in the U.S., with an estimated 440,000 people dying prematurely from smoking or exposure to second-hand smoke each year.⁴ Tobacco use causes eight different forms of cancer, chronic lung disease, cardiovascular disease, osteoporosis and a host of other serious diseases. Second-hand smoke causes cardiovascular disease and lung cancer in adults, lower birth weight and SIDS in infants, and chronic ear infections and respiratory problems in children. In total, more deaths are caused by tobacco use than by HIV, alcohol use, motor vehicle injuries, illegal drug use, suicides, and homicide combined.⁵ Additionally, an estimated 8.6 million people in the United States are living with one or more serious illnesses attributable to smoking, primarily heart disease and chronic obstructive lung disease.⁶ Perhaps most disturbing is the toll that smoking takes on our nation's children. Approximately 80% of smokers begin before the age of 18.⁷ Research indicates that people who start smoking in their teens and continue throughout their lifetime will die 12-21

years earlier than people who never smoked. One in three youth smokers will eventually die of a smoking related disease.⁸

In addition to the human toll, tobacco use also places an enormous economic burden on our society. During 2001-2004, average annual health care costs for smoking-related illness were an estimated \$96 billion, with an additional \$97 billion in productivity losses – making the total annual economic toll a staggering \$193 billion.⁴

Reducing tobacco use and exposure to secondhand smoke requires a four-pronged approach. Firstly, we must prevent the initiation of new users by raising the price of tobacco products, effectively restricting minors' access to tobacco products, expanding and sustaining effective mass media campaigns, eliminating tobacco marketing to minors, and reducing the depiction of tobacco use in our popular culture, such as in movies. Secondly, we need to expand proven interventions that help tobacco users quit: increasing the price of tobacco products, sustained mass media campaigns to encourage tobacco users to quit and providing information about resources available to help them to do so, expanding tobacco cessation quitlines that can provide free help to tobacco users interested in quitting, covering effective tobacco-use treatments under all public and private insurance with no deductibles or co-pays, and ensuring that all health IT systems include screening and treatment prompts to ensure that all tobacco users receive treatment every time they are seen in the health care system. Thirdly, we need to increase regulation of tobacco products and their marketing. Finally, we must protect all non-smokers from the deadly effects of second-hand smoke by ensuring that all indoor environments are smoke-free in every community in the country. The good news is that there is a strong evidence base demonstrating the effectiveness of these interventions.

Community Prevention Measures

Based on the research evidence, the Task Force on Community Preventive Services has concluded that increasing the price of tobacco is effective in preventing the initiation of smoking and increasing the percentage of teen and adult smokers who successfully quit or reduce the amount they smoke.⁹ Price elasticity studies indicate that every 10% increase in the price of a pack of cigarettes results in a 4% decline in consumption (studies also show about 50% of this consumption decline is due to fewer smokers and 50% to fewer cigarettes consumed by continuing smokers).¹⁰ A cigarette tax resulting in a 50% increase in the price of cigarettes would decrease smoking prevalence by 10%, a net reduction of 4.3 million adult smokers in the U.S. Congress is currently considering raising federal tobacco taxes, which include increasing the tax on cigarettes from 39 cents to \$1 dollar per pack to help pay for the State Children's Health Insurance Program (SCHIP).¹¹ This important piece of legislation is a good start towards achieving the Centers for Disease Control and Prevention Healthy People's 2010 target of a \$2 dollar per pack tax increase. Increasing the federal excise tax on cigarettes to the Healthy People 2010 goal offers an important opportunity to simultaneously reduce smoking rates and raise revenue that can be used to fund comprehensive tobacco prevention and control campaigns.

Another effective community prevention strategy is the use of mass media in multi-faceted anti-smoking campaigns, similar to those in California, Massachusetts, and Florida, and the national American Legacy Foundation campaign. Media campaigns can be effective in both reducing youth smoking initiation and in increasing cessation rates. For example, the American Legacy's truth® campaign, the only national youth peer-to-peer smoking prevention intervention, was responsible for 22% of the overall decline in youth smoking in its first two years, resulting in 300,000 fewer youth smokers.¹² Increasing support to expand these types of campaigns and assuring that the campaigns have national reach will help to counter the effects of the tobacco industry's substantial marketing efforts.

Exposure to smoking in popular culture is another powerful pro-tobacco influence on children that must be addressed. For example, studies indicate that Hollywood movies deliver billions of tobacco images to young audiences every year, and are responsible for recruiting one-third to one-half of young smokers in the United States.¹³ Additionally, the CDC has repeatedly linked smoking in films to the recent stall in the decline of youth smoking, and the National Cancer Institute has concluded that exposure to onscreen smoking causes adolescents to start smoking.^{2,14} Given these findings, it is crucial for the public health community to work with the entertainment industry to develop meaningful strategies to reduce the depiction of smoking in movies, and for the entertainment industry to implement a ratings policy for smoking that will reduce youth exposures and allow parents to make informed movie choices for their children.

Other efforts to reduce youth initiation include reducing minors' access to tobacco products. These efforts require strong community support at the local level. Smoke-free policies have also been shown to reduce youth initiation and offer protection from the harms of second-hand smoke.

Recommendations:

- Increase the federal excise tax on cigarettes.
- Increase support to expand multi-faceted anti-smoking mass media campaigns.
- Work with the film industry to reduce the depiction of smoking in movies and implement a movie ratings policy for smoking that will reduce youth exposures.
- Reduce minors' access to tobacco products.

Smoking Cessation Interventions

A nationwide survey in 2000 found that 70% of smokers said they wanted to quit¹⁵ and a 2007 survey showed that nearly 40% of current every day smokers had made a quit attempt in the past year.¹ However, these rates are lower than in years past, and survey data show a long-term decline in the percentage of smokers who make quit attempts.¹ In addition, the majority of smokers who attempt to quit do not use recommended cessation methods and most of these untreated smokers relapse within days of making a quit attempt.¹⁵ Moreover, only about 35% of smokers enrolled in commercial and Medicaid health plans received cessation services recommended by the U.S. Preventive Services Task Force.¹⁶

It is clear that as part of health and health care reform we need to increase the number of smokers who try to quit as well as the percentage of smokers who are successful in their quit attempts. To achieve this we must implement community interventions that increase cessation attempts and cessation success, as well as expand access to cessation services that have proven to be effective—doubling, and in some cases, tripling the likelihood of successful quitting.¹⁷ One method for getting more smokers to make quit attempts, to contact quit lines, and avail themselves of smoking cessation aids, is to increase smokers' motivation to quit and knowledge of cessation resources via the mass media. The American Legacy Foundation partnership with states on the "Become an EX" campaign is an excellent example of how this type of community intervention can work.

The Task Force on Community Preventive Services' recommendations include reducing out-of-pocket costs for treatment services and utilizing telephone cessation quitlines to increase both the number of tobacco users who use treatment and the number who successfully quit.⁹ Therefore, providing barrier-free coverage for counseling and FDA-approved medications should be part of the basic benefits package offered under all public and private insurance. In addition, telephone cessation quitlines or helplines are effective ways of providing intensive counseling services in ways that are easy for tobacco-users to access. Every state now has a cessation

quitline, available through a single portal number that works nationwide: 1-800-QUIT NOW. However, these quitlines are under-funded, so the extent of services available varies by state and is largely insufficient to meet the demand for such treatments.

Clinical recommendations for enhancing smoking cessation services include systems-level changes to encourage clinician screening and brief intervention every time a tobacco user is seen within the healthcare system, and increasing referrals to telephone quitlines.¹⁷ By employing evidence-based smoking cessation interventions, we will enable a greater number of Americans to live healthier, longer lives. For example, a study by the National Commission on Prevention Priorities found that increasing the delivery of tobacco-use screening and brief intervention is the single most cost-effective health insurance benefit for adults. In fact, it is more cost-effective than other commonly provided clinical preventive services, including mammography, colon cancer screening, PAP tests, treatment of mild to moderate hypertension, and treatment of high cholesterol.¹⁶

Recommendations:

- Expand access to cessation services that have proven to be effective.
- Implement systems-level changes to encourage clinicians to screen their clients for tobacco use and offer brief interventions.
- Provide barrier-free coverage for counseling and pharmacotherapy as part of a basic health care benefits package.
- Provide funding for mass media efforts to get smokers to quit, and to seek help through telephone quitlines and the medical care system.

Regulation Efforts

The tobacco industry's marketing expenditures have risen at unprecedented rates in the 10 years since the 1998 Master Settlement Agreement. According to the Federal Trade Commission's most recent report, tobacco marketing expenditures nearly doubled from 1998 – 2005, from \$6.9 billion to \$13.4 billion.¹⁸ Furthermore, the tobacco industry is using new marketing avenues, such as the internet, to pitch their products.

To counteract these efforts, we have to consider stronger regulation of tobacco products, including their sales and marketing. Considering the toll of tobacco use on the nation's health, legislators should consider measures that can halt tobacco marketing and sales to our youth, require tobacco companies to disclose the contents of tobacco products and remove harmful ingredients, and require more effective health warnings on tobacco products.

Recommendations:

- Consider stronger regulation of tobacco products, including their sales and marketing.
- Halt tobacco marketing and sales to youth.
- Require tobacco companies to disclose the contents of tobacco products and remove harmful ingredients.
- Require more effective health warnings on tobacco products.

Reducing Secondhand Smoke Exposure

At present, only 18 states have passed stringent indoor smoke-free ordinances that protect non-smokers from the deadly effects of secondhand smoke.¹⁹ Even fewer states have ordinances that restrict outdoor secondhand smoke exposure. This leaves most of the nation without adequate protection against secondhand smoke. Federal legislation to make indoor and outdoor environments smoke-free, including restaurants, bars, workplaces, parks and public building

entrances should be considered as a means to accelerate national progress in reducing non-smokers' exposure to secondhand smoke.

Recommendation:

- Consider federal legislation to make indoor environments smoke-free, including restaurants, bars, workplaces, and public buildings.

Roles of State and Local Health Departments

State and local public health agencies have been on the forefront of the fight against tobacco for decades. They have been facilitators and conveners, advocates and educators. They have taken the lead in implementing many of the evidence-based community recommendations that have greatly contributed to our progress to date in reducing tobacco use. However, many of these agencies have no sustained funding, and almost none have sufficient funding to implement the recommendations of the Centers for Disease Control and Prevention. If we are going to have a consistent nationwide effort that further reduces the overall toll tobacco places on our society, as well as the disproportionate burden it places on minorities and low-income populations, then it is essential that we increase sustained core funding for public health agencies at the state and local levels.

Recommendation:

- Enact legislation that identifies a specific source and a specific annual amount for the sustained funding of core public health activities at the state and local levels.

Reducing the Toll of Obesity

The obesity epidemic constitutes one of the most significant public health threats facing the nation, with health and social consequences that reverberate across all sectors of our society and economy: to individuals, families, communities, employers, schools, and government at all levels.²⁰ The obesity epidemic has resulted from the convergence of many changes in individual lifestyle behaviors, societal norms, community design, and economic trends.²¹ Eating outside of the home more often and the growth of super-sized meal portions^{22, 23}; less time spent cooking at home²⁴; more time spent in front of televisions, computers, and playing video games²¹; pressure to spend more time on academics rather than physical education in schools^{25, 26}; easy access to unhealthy foods in elementary as well as secondary schools²¹; urban design and transportation infrastructures that are automobile-centric²⁷; and work environments that are highly conducive to sedentary lifestyles²¹ are all factors that have contributed to the rapid escalation of this epidemic during the past three decades. Given the many social, environmental, and economic factors contributing to the obesity epidemic, multiple approaches will be required to stabilize and then reverse the obesity epidemic.

Since the late 1970's, the prevalence of obesity among children – the segment of our population that is most vulnerable to this epidemic – has more than doubled among preschool (5.0% to 12.4%) and school aged (6.5% to 17.0%) children and tripled among adolescents (5.0% to 17.6%).²⁸ In addition, the child obesity epidemic is much more severe in low income and minority populations. In Los Angeles County, for example, the prevalence of childhood obesity in 2006 ranged from a low of 4% in the affluent community of Manhattan Beach to a high of 37% in the city of Maywood, one of the lowest income communities in the county.³⁴ Nationally, approximately 9,000,000 children over 6 years of age are considered obese.²⁹ If this trend is not reversed, an estimated one in three babies born today will develop diabetes in their lifetimes, and

the life expectancy of our children may for the first time in modern history actually be shorter than the life expectancy of their parents.³⁰⁻³²

The obesity epidemic has not spared the adult population either. Among adults 20-74 years, the rate of obesity (defined as a body mass index of greater than 30) has more than doubled in the past three decades from 15.0% (1976-1980 NHANES) to 35.1% (2005-2006 NHANES).³³ In addition, another one-third of adults are overweight (defined as a body mass index of 25.0-29.9) and at risk of developing obesity and related medical complications. Significant disparities also exist in obesity rates among adults by age, gender, race-ethnicity, geography, and socio-economic status, with the highest rates seen among non-Hispanic black and Mexican-Americans. Non-Hispanic blacks and Mexican-American women aged 40-59 years, for example, continue to experience a higher rate of obesity than their non-Hispanic white counterparts (53% and 51%, respectively versus 39%).³³

Research studies have established that obesity is a major risk factor for numerous chronic diseases, including coronary heart disease, type 2 diabetes, hypertension, certain types of cancers, fatty liver disease, and arthritis.³⁵ Among obese middle-aged men, for example, moderate to severe obesity is associated with a 2- to 3-fold increase of developing coronary heart disease and having a heart attack.³⁶ Among children, obesity at an early age predicts a greater risk for earlier onset of type 2 diabetes and heart disease in adulthood.³⁰⁻³²

Between 1987 and 2001, the rising obesity rate and related medical conditions accounted for more than one-quarter of the growth in health care spending in the U.S.³⁷ Additionally, non-health care costs such as lost productivity attributable to obesity have been estimated to be even greater than health care spending, placing many of our businesses at a disadvantage in an increasingly competitive global marketplace.²⁷ In 1995, lost productivity from obesity-related morbidity and mortality was approximately \$47.6 billion nationwide.³⁸ States are also hit hard by the productivity losses associated with obesity. In California, for example, lost productivity from obesity-related morbidity and mortality was reported to be approximately \$3.4 billion in 2000.³⁹ Together, these health care and non-health care costs are likely to grow at an escalating rate over the next generation, as the swelling ranks of obese children reach adulthood and begin developing obesity-related diseases at progressively younger ages.

As a nation, we are faced with the daunting task of stabilizing and reversing this costly epidemic. Because there are many contributors to obesity, leaders at all levels of government and in the community must work together and take a multi-pronged approach to combating the obesity epidemic, implementing effective and sustainable interventions where Americans learn, work, and play. Many national leaders, including U.S. Senator Tom Harkin and Dr. Joseph Thompson²⁰, Surgeon General for the State of Arkansas, have echoed similar calls for action.

Roles of State and Local Health Departments

We currently have the capability to successfully implement prevention measures which will yield results in both the short-term and long-term. Progress requires leveraging resources across multiple sectors of our society. We need to thoughtfully coordinate various community efforts designed to prevent obesity, create stronger linkages between our healthcare system and public health infrastructure, establish robust public-private partnerships with our business community, and demonstrate strong leadership from our federal, state, and local government agencies. Local health departments, in particular, working with their state counterparts, can play a crucial role in spearheading efforts to address obesity and other chronic disease threats given their close working relationships with communities, schools, health care providers, and employers. Similar to their roles in tobacco control, local health departments are often the facilitators, advocates, and implementers of evidence-base prevention policies to combat the

obesity epidemic, such as improved nutrition standards, school and worksite wellness policies, and land use policies that promote physical activity. However, as with tobacco control, their ability to do this vital work is compromised in the absence of a sustained source of funding that is not subject to the yearly appropriation process.

Recommendation:

- Enact legislation that identifies a specific source and a specific annual amount for the sustained funding of core public health activities at the state and local levels.

Prevention Opportunities in the Healthcare System

Health care reform can, and must, play an important role in obesity prevention. Today's health care environment presents many missed opportunities for reducing adverse lifestyle behaviors at the individual level. Incentives must be created for health care providers and health plans to incorporate evidence-based prevention techniques, including body mass index monitoring as a vital sign, nutrition counseling, breastfeeding promotion, providing advice to parents regarding reducing their child's screen watching, and physical activity promotion (including wider use of pedometers). When providers incorporate these techniques in their clinical practice or as part of an overall health benefits package, the patient experience is enhanced with a more equitable focus on both prevention and treatment.^{21, 26}

Recommendations:

- Create incentives for health care providers and health plans to incorporate evidence-based prevention techniques in their clinical practice.
- Increase the utilization of proven clinical prevention techniques such as: body mass index monitoring as a vital sign, nutrition counseling, breastfeeding promotion, providing advice to parents regarding reducing their child's screen watching, and physical activity promotion (including wider use of pedometers).

Community Prevention Measures: Changing Our Environment

Health care reform and efforts to appeal to individual responsibility have limited impact without broader community interventions and policy changes that create environments where the healthy choice becomes the easy choice. These types of efforts require investment and buy-in from different sectors of our society: schools, employers, cities, residential communities, local governments, community-based and faith-based organizations, etc.

There are numerous opportunities to improve our food environments by increasing access to more nutritious foods and by providing consumers with nutritional information to help them make informed decisions regarding how they feed their families. One type of promising policy intervention designed to address child obesity is the establishment of more rigorous nutrition standards for school meal programs and other foods sold on school campuses.²¹ For example, California's passage and implementation of Senate Bills 677, 12 and 965⁴⁰⁻⁴², which set and strengthen minimum school nutrition standards, is a step in the right direction. Minimum nutrition standards can also be instituted in other settings, including work and recreational settings.

Federal programs can also play an important role in addressing child obesity by increasing opportunities for nutrition improvement, especially among low-income families - the segment of our population hit the hardest by the obesity epidemic. Updating and improving the nutrition standards and meal requirements for the National School Lunch Program and the School Breakfast Programs, for example, can make a great impact in promoting health and

combating obesity. Together, these two programs provide a significant proportion of a participating student's daily nutrient and caloric intake on school days. The programs also serve as a safety net for children in need by providing meals at no or reduced cost.⁴³ Likewise, removing barriers to participation for families eligible for the underutilized Supplemental Nutrition Assistance Program (SNAP) can provide greater access to healthful foods for these families. Another resource that low-income families can access to improve their nutrition is the recently improved Women, Infants, and Children (WIC) program food package, which now includes more healthful foods such as fruits and vegetables. WIC also promotes and supports breastfeeding, another important strategy for preventing child obesity.²⁰

Providing nutrition information at points of purchase (e.g., menu labeling) and other efforts to better inform consumers may also prove to be effective in combating the obesity epidemic. According to a recent health impact assessment (HIA) conducted by our public health department in Los Angeles County⁴⁴, if 10% of large chain restaurant patrons were to order an average of 100 calories less per meal as a result of menu labeling, then 38.9% of the 6.75 million pound average annual weight gain in the county population aged 5 years and older would be averted. Our county was also instrumental in gaining passage of a California law (SB 1420) that will require menu labeling (including calories on the order board) at all large chain fast food and full service restaurants.

Restricting food marketing to young children, establishing farm subsidies that support affordable healthy food choices, creating other incentives for the food industry to produce lower calorie products and smaller serving sizes, and supporting programs and policies that eliminate "food deserts" are other food policy and environmental approaches that are required to stabilize and reverse the obesity epidemic.^{20, 21} Oversight of food marketing of products high in calories, sugar, sodium and fat to our youth, for example, remains an important challenge. Youth (ages 8 to 18) spend an average of six hours per day using media, often using more than one medium at a time. In 2006, an analysis by the Federal Trade Commission (FTC) indicates that the nation's largest food and beverage companies spent \$1.6 billion to market their products to children, including pre-school aged children, and adolescents. Of the advertisements viewed, nearly 98% of them by our children and 89% by our adolescents were for products that were high in fat, sugar or sodium.⁴⁵

The importance of engineering opportunities for physical activity in our communities, schools, and work places cannot be overstated. Developing environments which are conducive to physical activity represents a key, viable approach to obesity prevention.²⁶ Various evidence-based physical activity interventions (e.g., communitywide campaigns promoting physical activity, point-of-decision prompts to encourage stair usage, school-based physical education, social support strategies such as setting up an exercise buddy system, and individually adapted health behavior change strategies) are available, and are potentially cost-effective for promoting physical activity in different settings, including at schools and in the workplace.^{26, 46} Federal incentives to help states and local school districts improve physical education programs may promote wider adoptions of these effective, and potentially sustainable, physical activity interventions.

Finally, addressing land use and transportation practices and policies offers important opportunities for reversing the obesity epidemic in America. For example, the upcoming reauthorization of the federal transportation bill provides an excellent opportunity for prioritizing and funding projects and infrastructure that promote walking, bicycling, and other forms of physical activity. In addition, street- and community-scale urban design and land use policies, including zoning regulations, mixed-use and compact development, building codes, street lighting, roadway design standards, traffic calming approaches, and improvements to the

continuity and connectivity of sidewalks and streets, are all promising built environment strategies for increasing physical activity.^{25, 27} Increasing the utilization of emerging research tools such as health impact assessment can help us quantify the potential health benefits of these measures.

Recommendations:

- Establish more rigorous nutrition standards for school meal programs and other foods sold on school campuses.
- Remove barriers to participation of families eligible for the Supplemental Nutrition Assistance Program (SNAP) and Women, Infants, and Children (WIC) program.
- Provide nutrition information at points of purchase (e.g., menu labeling).
- Examine food policy and environmental approaches that may prove effective for combating the obesity epidemic such as: restricting food marketing to young children, establishing farm subsidies that support affordable healthy food choices, creating other incentives for the food industry to produce lower calorie products and smaller serving sizes, and supporting programs and policies that eliminate "food deserts."
- Expand the implementation of evidence-based programs that increase physical activity such as: communitywide campaigns promoting physical activity, point-of-decision prompts to encourage stair usage, school-based physical education, social support strategies such as setting up an exercise buddy system, and individually adapted health behavior change strategies. Provide federal funding for a major national education campaign that uses a multi-media approach to encourage physical activity throughout the life course.
- Expand adoption of urban planning, land use, and transportation practices and policies that promote walking, bicycling, and other forms of physical activity.
- Increase the utilization of research tools such as health impact assessment (HIA) to quantify the potential health effects of policies and practices in sectors where health is not the primary interest but decisions have significant health effects.

Knowing and Using the Best Evidence to Improve Health and Prevent Disease

For the vast majority of our serious illnesses and injuries that are preventable, our success depends on knowing what works, both for individual patients and communities, and implementing these policies and practices. Unfortunately, the two national efforts to systematically review the research, make recommendations based on these findings, and assure that these best practices are disseminated to key user groups and then implemented, are severely underfunded. The U.S. (Clinical) Preventive Services Task Force has been more comprehensive because it has a clearly delineated domain (clinical medicine) and has had a sustained, although inadequate, funding base. In contrast, the Task Force on Community Preventive Services, supported by CDC staff, has had erratic and consistently insufficient funding. It has only been able to cover a minority of the possibly effective community policies and programs, and it has had virtually no funding to disseminate its findings. A much needed increase in funding for both of these expert panels should be coupled with increased support to fill the priority research gaps they have identified.

Recommendation:

- Increase and stabilize the funding for the U.S. (Clinical) Preventive Services Task Force and the Task Force on Community Preventive Services.

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In conclusion, we have many opportunities to reduce chronic diseases, which together constitute over 80% of the burden of disease in the United States. Health care reform can play a vital role in these efforts. Changes in financing, health benefit structure, provider incentives, and practices can be very helpful in reducing the toll of these diseases. However, if we are to reach our health potential as a nation, we must devote equal energy to prevention at the community level. There are policy and programmatic changes at the community level that have been clearly shown to be effective in reducing tobacco use and the rate of obesity. Too often they are ignored.

Finally, we must recognize that there are common underlying causes for most of our chronic diseases, and these causes reside in our social environment and our physical environment. Poverty, poor educational attainment, and social isolation are important risk factors for virtually all chronic diseases. To improve our nation's health and competitiveness, it is vital that all Congressional Committees consider how their decisions affect health. Policies in agriculture, transportation, housing, environment, commerce, and education all affect health and disparities in health among groups. We possess the tools, including health impact assessment, to determine likely health effects of policies being considered in each of these, and other, sectors. By routinely using these tools and considering the health implications of all Federal policies, we can jump-start a national effort to be not just a healthy nation, but the healthiest nation.

Thank you again for this opportunity to address this important Committee and discuss how we can bring a full dose of prevention to the diseases caused by these problems.

Sincerely,

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