“The State of Chronic Disease Prevention.”

Testimony by former HHS Deputy Secretary Tevi Troy

Senate Committee on Health, Education, Labor, and Pensions

Mr. Chairman, Mr. Ranking Member, Members of the Committee

My name is Tevi Troy, and I am a senior fellow at Hudson Institute, and a former Deputy Secretary of the U.S. Department of Health and Human Services, as well as a former senior White House Domestic Policy Aide. In both capacities, I was involved in the Bush administration’s efforts to combat obesity and promote preventive behaviors.

I come here before the committee to talk about the important issue of prevention, particularly prevention of chronic diseases, treatment of which costs this country more than $750 billion annually.

I support the use of funds for appropriate preventive healthcare measures. As Benjamin Franklin wisely put it, “An ounce of prevention is worth a pound of cure.”

I also recognize that there is a lot to prevent. The current state of healthcare in America is well past due for its “ounce of prevention.” I recognize that the concept of “prevention” addresses multiple concerns, including smoking, but I will focus here on the rising obesity epidemic as an illustrative example. Currently, two-thirds of Americans are overweight or obese. This number is increasing at an annual rate of 1.1%, or by about 2.4 million new obese adults each year. As you well know, obesity increases the likelihood for several other co-morbidities, including hypertension, type II diabetes, coronary heart disease, and stroke, each with its own range of associated costs and health complications. With respect to diabetes alone, CDC has found over 16 million people have this terrible, and often preventable, condition.

From an economic perspective, estimates of the cost of obesity to America range from $150-$250 billion annually. $3.9 billion alone stemmed from lost productivity due to obesity, reflecting 39.2 million lost days of work. In addition to increased absenteeism, another study, in

the *Journal of Environmental and Occupational Medicine*, found presenteeism -- decreased productivity of employees while at work -- to be a significant cost-driver as well. Specifically, the cost of obesity among full-time employees was estimated to be $73.1 billion -- "roughly equivalent to the cost of hiring an additional 1.8 million workers per year at $42,000 each, which is roughly the average annual wages of U.S. workers." At a time of consistently high unemployment, which was 9.1% in the most recent report, we need to look at the costs of obesity and those costs' potential impact on U.S. employment levels.

Obesity is no longer solely an economic or a health issue, although it is a serious concern in those areas. Obesity has become an issue of national defense as well; the Army found 27% of Americans in prime years for military recruitment – 17 to 24 -- were "too overweight to serve in the military." The Pentagon alone spends nearly $1 billion each year coping with weight-related challenges. Retired Rear Adm. James A. Barnett put the issue starkly, warning that "[o]ur national security in the year 2030 is absolutely dependent on reversing the alarming rates of child obesity

And yet, we must remember that Dr. Franklin's maxim was aimed at promoting cost-effectiveness, which is a value we must keep in mind throughout this conversation. While I am passionate about the need to address obesity and other issues that lead to preventable health conditions, I am not convinced that the government has all of the answers to this problem. In the administration for which I worked, HHS, then led by Secretary Mike Leavitt, worked with the Ad Council and Dreamworks on a public service announcement with characters from the movie Shrek encouraging kids to "Be a Player. Get up and play an hour a day." The Obama administration has followed suit in this regard, making combating obesity one of First Lady Michele Obama's signature initiatives. In February of 2010, she launched "Let's Move," a campaign designed to end obesity in a generation. While the Bush White House did its PR partnership with *Shrek*, Obama opted for New York Yankee star Curtis Granderson, who said kids should play fewer video games and engage in more outdoor activities. Neither admittedly well-intentioned effort is going to stem the obesity tide. So going forward, we need not just good intentions, but also strong principles to guide us, such as the need for the right process, a

recognition of our dire fiscal situation, a need for focused and not vaguely defined programs, and a recognition that many so-called prevention savings never materialize.

From a process standpoint, prevention dollars should be discretionary and go through the normal and rigorous appropriations process. As you all well know, spending on the mandatory side of the budget is harder to adjust than discretionary spending because it does not have to compete against other priorities in the annual appropriations process. This means that cost-savings must come disproportionately from the discretionary side of the budget. At a time when both Social Security and Medicare are facing severe funding challenges, when we have a $1.4 trillion deficit and $14 trillion debt, putting more dollars in mandatory accounts lessens the sacrosanct status of mandatory spending writ large, and also will put more pressure on our discretionary accounts to find needed cost savings. The irony here is that increased mandatory spending could increase the pressure to cut discretionary spending on prevention, even if such spending has been shown to be effective.

Another important principle is focus. Programs or studies eligible for funding should not be too broadly defined. Laxity of definition may lead to spending in areas that are not directly related to prevention. Already there has been criticism around one program authorizing federal funding for the construction of sidewalks and jungle gyms. Programs should be targeted so as not to incur such criticism, which can damage the prevention "brand." Furthermore, since money is fungible, governments facing severe fiscal constraints could potentially use poorly targeted money for ancillary purposes.

In addition, I recognize the importance of rigor in the review process to get the best results. In order to have maximum effectiveness, dollars should be distributed via a competitive process. Policymakers should keep in mind the risk posed by the spending of federal dollars with inadequate supervision or the ability to correct abuses. A single flawed project can be subject to ridicule – as we have seen with the Solyndra project -- and therefore harm the entire endeavor by creating the perception that the program misuses taxpayer dollars. Prevention funding must be targeted so that we are dedicating enough resources to make an impact that actually reduces childhood obesity in the long run. We currently fund over 300 different obesity programs, which

suggests an insufficiently focused approach and increases the risk of duplicative or ineffective spending. We must ensure that prevention dollars are spent wisely, and not used to fund parochial projects that do not advance the prevention goal.

In addition, it is important to remember that the "prevention" label itself does not necessarily lead to cost savings. As Robert Gould, president of Partnership for Prevention, has said, "Some preventive services save money and some don't." Just labeling something a "preventive" service does not mean that it prevents anything, or that it will save money. A recent letter by Congressional Budget Office Director Douglas Elmendorf underscores this point. According to Elmendorf, "the evidence suggests that for most preventive services, expanded utilization leads to higher, not lower, medical spending overall." This is because, as Elmendorf noted, doctors, whatever their skill level, are not prophets: "[I]t is important to recognize that doctors do not know beforehand which patients are going to develop costly illnesses." As a result, insufficiently targeted "preventive services" end up adding to total costs because they are too often used on those who will not develop expensive conditions. We need personalized medicine to play a role here. If we can target those with the greatest risk, we will be more likely to have cost-effective interventions.

Even beyond CBO, a recent study by Rutgers University Professor Louise Russell found "that contrary to common belief, prevention usually increases medical spending." The same study found that "Less than 20 percent of the preventive options (and a similar percentage for treatment) fall in the cost-saving category—80 percent add more to medical costs than they save."

Dr. Russell, does, however, open her study with some positive words on preventive spending: "Careful choices about frequency, groups to target, and component costs can increase the likelihood that interventions will be highly cost-effective or even cost-saving." I fully agree. We must find an alternative approach to this very real problem. With this in mind, I would like to highlight one type of program that has proven to be both effective and cost efficient: employee fitness programs. Both Motorola and PepsiCo received at least a $3:1 return on investment from

their employee fitness programs. These are private sector initiatives that do not cost the government money, but do help reduce obesity and other preventable conditions. We should encourage these initiatives and let them develop without micromanagement, as maintaining autonomy in employer sponsored wellness programs is imperative. Government intervention in the design and administration of these programs will likely discourage employers from engaging in this worthy endeavor. In additions, consumer driven health care, promoted by programs such as Health Savings Accounts, will give individuals additional financial incentives to take the steps necessary to pursue prevention on their own initiative. I would also like to see the Senate continue to work to give the private sector flexibility to promote prevention in the workplace, including the use of differential premium costs to encourage healthy behavior.

I believe a new focus on preventive medicine can prove to be a prudent investment in the future of our country. While doing so, we must not forget the severe fiscal challenges that other important government programs such as Medicare or Social Security already face. We must ensure that the services eligible are not too broadly defined, and that we maintain a strong commitment to rigorous program evaluation. Most importantly, we must proceed in a cost effective manner, targeting those areas that are both the safest and most cost effective. And we should unleash the power of incentives and try to move towards a more consumer driven system, one that will encourage individuals to make healthy choices for themselves and their families. As I have tried to show in my testimony, there is so much at stake in getting this right.

Mr. Chairman, Mr. Ranking Member, Members of the Committee, I thank you for your time here today, and for your efforts on behalf of prevention.