

CHRONIC DISEASE  
PREVENTION IN  
LOCAL HEALTH  
DEPARTMENTS:

THE CHALLENGE  
OF THE 21ST  
CENTURY

PROCEEDINGS OF A CONFERENCE

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Chronic Disease Prevention in  
Local Health Departments:  
The Challenge of the 21st Century

# CONTENTS

3

Preface

4

Agenda

7

Keynote

**CHRONIC DISEASE, THE DETERMINANTS OF HEALTH AND THE CHALLENGE FOR LOCAL HEALTH DEPARTMENTS**

Jonathan Fielding, MD, MPH, Health Officer, Los Angeles County, Professor, School of Public Health, UCLA Chair, US Community Prevention Services Task Force

45

Morning Panel

**BUILDING LOCAL HEALTH DEPARTMENT CAPACITY FOR CHRONIC DISEASE PREVENTION (PART 1)**

Jeff Brown, MPH, Director, Nevada County Health & Human Services Agency  
Frima Stewart, MSW, Public Health Director, Marin County Health & Human Services Agency  
Wendel Brunner, MD, PhD, MPH, Public Health Director, Contra Costa County Health Services Agency  
Terri Fields-Hosler, MPH, RD, Deputy Director, Shasta County Department of Public Health

51

Keynote

**THE CRITICAL ROLE OF PUBLIC POLICY IN CHRONIC DISEASE PREVENTION**

Harold Goldstein, DrPH, Executive Director, California Center for Public Health Advocacy

101

Afternoon Panel

**BUILDING LOCAL HEALTH DEPARTMENT CAPACITY FOR CHRONIC DISEASE PREVENTION (PART 2)**

Tony Iton, MD, JD, MPH, Director and Health Officer, Alameda County Public Health Department  
Wilma Wooten, MD, MPH, Public Health Officer, Deputy Agency Director, San Diego Health & Human Services Agency  
Cleopathia Moore, PHN, MPA, Associate Director of Community Health Services, Stanislaus County Health Services Agency  
Ed Moreno, MD, MPH, Director and Health Officer, Fresno County of Community Health

107

Final Panel

**STATE/LOCAL/FEDERAL COLLABORATION**

Bonnie Sorenson, MD, MPH, Chief Deputy Director, California Department of Public Health  
Mark Horton, MD, MSPH, Director and Health Officer, California Department of Public Health  
Ann Lindsay, MD, MPH, President, California Conference of Local Health Officers  
David Souleles, MPH, President, County Health Executives Association of California  
Michael Sage, MPH, Office of the Director, Centers for Disease Control and Prevention



## PREFACE

The publication of *Proceedings from a Conference on Local Health Departments and Chronic Disease Prevention: The Challenge of the 21st Century* is not only an effort to capture the content of a significant event in the recent history of public health in California, but also to serve as a framing document for a series of follow-up regional meetings and web-based conferences intended to help build the capacity of local health departments in California to engage in chronic disease prevention, particularly focused on the social determinants of health. The conference itself involved the participation of senior officials from 45 local health departments in California, as well as representatives from the California Department of Public Health and the Centers for Disease Control and Prevention. The follow-up meetings will be held in four regions throughout the state during the fall and winter of 2008, with web conferences on selected topics to be conducted during the winter and spring of 2009.

Both the conference and the subsequent activities have been co-sponsored by the California Conference of Local Health Officers and the County Health Executives Association of California, and jointly funded by the California Department of Public Health and The California Endowment. Administrative and staff support have been provided by the Public Health Institute.

# AGENDA

9:00 AM

## WELCOME AND INTRODUCTIONS

Anne Lindsay, President, MD, MPH, CCLHO  
David Souleles, MPH, President, CHEAC

9:15 AM

## KEYNOTE

### Chronic Disease, the Determinants of Health and the Challenge for Local Health Departments

Jonathan Fielding, MD, MPH  
Director and Health Officer, Los Angeles County Department of Public Health  
Professor, School of Public Health, UCLA  
Chair, US Community Prevention Services Task Force

10:00 AM

## MORNING PANEL

### Building Local Health Department Capacity for Chronic Disease Prevention (Part 1)

Jeff Brown, MPH, Director, Nevada County Health & Human Services Agency  
Frima Stewart, MSW, Public Health Director, Marin County Health & Human Services Agency  
Wendel Brunner, MD, PhD, MPH, Public Health Director, Contra Costa County Health Services Agency  
Terri Fields-Hosler, MPH, RD, Deputy Director, Shasta County Department of Public Health

10:55 AM

## BREAK

11:15 AM

## SMALL GROUP DISCUSSIONS

12:15 PM

## KEYNOTE

### The Critical Role of Public Policy in Chronic Disease Prevention

Harold Goldstein, DrPH, Executive Director  
California Center for Public Health Advocacy

1:35 PM

**AFTERNOON PANEL**

**Building Local Health Department Capacity for Chronic Disease Prevention (Part 2)**

**Tony Iton**, MD, JD, MPH, Director and Health Officer, Alameda County Public Health Department

**Wilma Wooten**, MD, MPH, Public Health Officer and Deputy Agency Director, San Diego County Health & Human Services Agency

**Cleopathia Moore**, PHN, MPA, Associate Director of Community Health Services, Stanislaus County Health Services Agency

**Ed Moreno**, MD, MPH, Director and Health Officer, Fresno County Department of Community Health

2:30 PM

**SMALL GROUP DISCUSSIONS**

3:30 PM

**BREAK**

3:45 PM

**FINAL PANEL**

**State/Local/Federal Collaboration**

**Bonnie Sorensen**, MD, MPH, Chief Deputy Director, CA Department of Public Health

**Mark Horton**, MD, MSPH, Director and Health Officer

**Ann Lindsay**, MD, MPH, President, CCLHO

**David Souleles**, MPH, President, CHEAC

**Mike Sage**, MPH, Office of the Director, Centers for Disease Control and Prevention

4:30 PM

**WRAP-UP AND NEXT STEPS**

**Linda Rudolph**, MD, MPH, Health Officer, City of Berkeley

**Wendel Brunner**, MD, PhD, MPH, Public Health Director, Contra Costa County

4:45 PM

**ADJOURN**

5:30 PM

**RECEPTION**

**Network for a Healthy California**

Sheraton Grand Ballroom

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THE CALIFORNIA ENDOWMENT AND THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH.



# KEYNOTE PRESENTATION

## CHRONIC DISEASE, THE DETERMINANTS OF HEALTH AND THE CHALLENGE OF CHRONIC DISEASE

JONATHON FIELDING, MD, MPH, MBA  
DIRECTOR AND HEALTH OFFICER  
LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH

**JONATHAN FIELDING:** Any one of you in this room could put together this talk about your own jurisdiction, but I hope that it at least will provide one snapshot of how we think about this, and that it will be a springboard for further discussion.

If you look at Disability Adjusted Life Years (DALYs) in Los Angeles, you get an interesting picture (slide 2). When you combine years of life lost with disability adjusted life years, it's better than simply Years of Life Lost. Look at coronary heart disease. That surprises nobody in this room. For decades we have talked about heart disease as the number one killer. But look at numbers two, three, four, five and six. Alcohol dependence comes in number two because of the big impact it has on disability. Diabetes, number three, followed very closely by Alzheimer's and other dementia, and then by depression, followed by homicide, and osteoarthritis. So looking at DALYs gives us, I think, a more accurate picture of the kind of problems we face as we try and reduce the overall burden of disease and injury in our state, in our counties, and in our cities. We have to focus not just on things that cause death, but on the things that substantially affect disability as well.

Now, look at our funding on the right-hand side (slide 3)—if you can't read that, it's not entirely your fault. It's because that little sliver of green is only 3.4% of our funding. That's for chronic disease. And, that isn't even funding that we got—that's funding we kind of jiggered or engineered, reallocated some things that we won't talk about here.

On the other hand, if you look at disease burden (slide 3), you can see that chronic disease, which is the huge slice on the left-hand side, accounts for at least 80% of the disease burden, injuries are another 11%. So 91% of our total burden of disease is accounted for by chronic disease and injury. Communicable disease is 9%. Now I'm not dismissing the importance of that 9%, it's very important. We don't want to say chronic disease is the only area that's important, and that communicable disease is "so 20th century." We don't want to say that. But we are obviously not spending enough time and attention on the chronic disease issue.

Now, here are the actual causes of death in

the U.S. (slide 4). All of you have seen this. It's an update of the earlier work by McGinnis and Foege. Whether or not the numbers are exactly right isn't important. What's important is that together a very small group of leading causes of death, starting with tobacco and poor diet and physical activity and then alcohol consumption and a few other risk factors, account for 48% of the percentage of total deaths in the U.S. And, let's not forget that firearms are on there at 29,000 annual deaths, as well as the risk of drug use.

Now, here's life expectancy by sex and race/ethnicity in Los Angeles County (slide 5). If anybody doubts that we've made real progress in the disparities, we only have to look at this slide. I'm sure it's similar to many other places. Notice that among Whites, who are in the middle, the range is 75 to 80 years. Now look at Latinos, two years longer average longevity in women and three years in men. And look at Asian Pacific Islanders, 81 years and 85 years—very, very robust. But compare that to African Americans and you can see a great difference. Between Asian Pacific Islanders and African Americans, there is a 13-year difference—a 13-year difference in this day and age—among men, and you see a 10-year difference among women. So that tells us there's huge opportunity that we really should be shouting about, not just talking about.

So, life expectancy in our county has increased by approximately two-and-a-half years over a period of 10 years. So think about it, every four months you live you gained a month. That's not necessarily exactly correct, but that's a way to talk about it. For the population as a whole, we've made unprecedented gains in terms of longevity. And this is the best story you've never heard. I have tried for at least eight years to get a story from the *Los Angeles Times* about the incredible reductions in many of the leading causes of death. I've been remarkably unsuccessful.

More good news. Look at coronary heart disease as a cause of death (slide 6). This is over a period of 10 years. Down 36%. That's wonderful. That's amazing. Do you ever read about it in the papers? Do you ever see it on the news? Absolutely not. Stroke, down 24%. Lung cancer, down 27%.

Emphysema, down 11%. Pneumonia and influenza deaths, down 40%. Colorectal cancer, down 20%. Breast cancer, down 23%. Homicide, down 41%, and AIDS, down 81%.

If you look at that and say, “We’ve accomplished that over 10 years,” and you gave it to a bunch of doctors, they probably wouldn’t believe it. I mean this, from an epidemiological standpoint, is just incredible, but nobody is talking about it. Nobody except you.

On the other hand, we have two in red there that present what I think is a very serious trend. We have a 25% increase in diabetes-related death, in part because we don’t usually put diabetes as a cause of death, but also in Alzheimer’s, with a 220% increase. Alzheimer’s is the silent epidemic. We talk about obesity as a silent epidemic, but another one is Alzheimer’s. It is growing at least as fast as diabetes.

Here is average weight and prevalence of diabetes among adults in our county (slide 7). You can see that over a period of time, from 1997 to 2005—an eight-year period—there was an average gain of six pounds. The adult population of L.A. gained 44 million pounds. That’s a lot of pounds. And, the diabetes prevalence during the same period went from 5.7 to 8.1. That’s roughly a 40% increase.

It would be nice if all that increase in weight was attributable to muscle, but I’ve been told on good authority that it’s not. This is a very serious development. We looked at overweight among Los Angeles County school children based on the physical fitness testing. You can see where we are headed (slide 8). The Healthy People 2010 goal is less than 5%, but what we can see is that we’ve gone from 18% in 1999 to somewhere above 23% today. What is this saying about the future?

Here are rates for gestational diabetes (slide 9). This is even more disturbing. It went from about 14½ % in 1991 to almost 50% in 2003.

So, what’s at stake (slide 10)? We know that overweight kids become overweight adults. Not

always, but unfortunately at a much heightened rate. We know what’s associated with overweight during adulthood—heart disease, stroke, diabetes, arthritis, cancer, etc. We know that now the effects are starting to show up during childhood. I’m a pediatrician. When I trained at the Boston Children’s Hospital, I never saw Type II diabetes in a child. It didn’t exist. There was only Type I. Now Type II is common, very common. I talked to my friend, Dr. Fran Kaufman, who is the former president of the Diabetes Association, and wonderful in treating diabetes. She hadn’t seen Type II when she started, either, and now it’s become the norm. So we have, during childhood, hypertension, Type II diabetes, insulin resistance, asthma, hormonal changes. Menarche is occurring at earlier and earlier ages among young women. Well, obesity is probably the cause, although hormones and other environmental factors may be connected.

So what about the social impact? One estimate by Ken Thorpe, a very reputed economist, is that over 25% of the growth in healthcare spending in the U.S., from 1987 to 2001, is because of the overweight and obesity epidemic. So, those of you who are concerned about what can we do about health care costs, runaway healthcare costs, and affordable health care, this is one place to start looking.

What you can see here (slide 11) are the hazard ratios from the body mass index for boys and girls, and the chances they’re going to have coronary heart disease as adults. You can see, as you get further along in age, from age 7 to 13, that if you’re still overweight, your chances of having coronary heart disease go up tremendously. You see that it is at least as steep for girls as it is for boys, although it starts at a slightly lower level. This is, again, very troubling, because we are seeing the path, the life course trajectory, of our children.

Here’s the population, the percent of U.S. population over age 65. It’s the fastest growing segment (slide 12). And here’s the prevalence of chronic conditions (slide 13). One can see, not surprisingly,

“FOR THE POPULATION AS A WHOLE, WE’VE MADE UNPRECEDENTED GAINS IN TERMS OF LONGEVITY. AND THIS IS THE BEST STORY YOU’VE NEVER HEARD.”

that there's at least a linear, and sometimes a logarithmic, increase in the frequency of having one or more chronic conditions with increasing age, and having two or more chronic conditions. For those age 65 and over, almost three quarters have at least two chronic conditions. And that's the fastest growing population.

Here's per capita spending by a number of chronic conditions (slide 14). Not surprisingly, we go from under \$1,000 if there's no chronic condition, to almost \$17,000 with the five-plus chronic conditions. So, we have an aging population. You can see that the costs go up very markedly with increasing numbers, and you see that we have a very, very steep curve there with an aging population—more and more chronic conditions.

This is the estimated number of new Alzheimer's cases in thousands. You can see that it is going up very, very rapidly (slide 15). Look at what's projected for 2040 and 2050—more than doubling the number that we have in 2010. And care of these individuals is very expensive, very time-consuming, but more than that, it is just very crushing and heart-breaking for families to experience.

Here's the impact of Alzheimer's disease (slide 16), medical care and hospitalizations and all those things that you know about. But, the personal cost is memory loss, wandering, behavioral problems, loss of self and injury, and the depression that oftentimes accompanies. And then we have all the problems of caregivers, let's not forget that. Caregivers give out, too. And also the unpaid costs of care giving. I know a number of people who have given up their own careers to care for an older parent with dementia, with Alzheimer's disease. There's also a lot of cost to business. So this is a very, very serious chronic disease problem, not sufficiently recognized.

Here are U.S. healthcare expenditures (slide 17). It's not entirely surprising that they're not going down, but see how quickly they are going up. This is very disturbing, because the spending per capita has gone up about 18-fold in the last 35 years. We talk about inflation. Nothing that we even thought of over that period of time went up as much as healthcare spending per capita. As a percentage of GDP, it has more than doubled. We're now at 15%–16%.

This hurts our competitiveness with all the OECD (Organization for Economic Co-operation and Development) countries. I don't know if any of you saw the very interesting article in the *New England Journal of Medicine* by David Cutler (Harvard economist) on the cost per additional year of life and what we're spending. It is quite remarkable how that has increased.

What that tells me is we're not going to be able to solve this problem, or even reduce this problem, this chronic disease burden, simply by saying, "Well, we've got to get more care to more people." We have to look at what some of the underlying factors are, and that's why the Evans-Stoddart model (slide 18), with its many variations, I find still to be very helpful, because, number one and number two have to be the social and the physical environment in terms of things that we as a nation—not just we as public health people—but we as a nation, can make a difference in.

It's very easy for libertarians and some others to say that individual behavior is simply a question of will. But we know better. All the social science literature tells us that this is not the right way to think about it. Our behaviors are, in large part, a product of the social and physical environments, and that affects our health and function in different ways. What we all want is not just health—we all want health because we want to do things we want to do, and health allows us to do them. We need to change how people think about health and why it's important.

On the Spectrum of Prevention (slide 19), there are a whole bunch of different ways to think about it, so I want to focus really on the last two. We have to think about changing organizational practices, changing norms to include health and safety, and we have to influence policy and legislation. So much of the progress we have made over the last 150 years in public health has been in changes in policy, changes in laws, a lot of them at the local level, and many others at the state level. Most of them haven't originated at the national level. So, we in this room are the ones that start those balls rolling. I hear that oftentimes they roll from west to east in our country.

Let's look at tobacco and cigarette consumption (slide 20). You can see what happened in the Great Depression. Quite interesting. You can see that the first smoker's cancer concern was raised in Britain in the 50's. Then, of course, you have the Surgeon General's report in 1964. That's when things started to go the other way. Then we put anti-smoking ads on television and the tobacco industry said, "We'll stop advertising on TV if you do," because they realized the anti-tobacco ads were more effective than the pro-tobacco ads. I think it was a bad decision to agree to not have anti-tobacco ads. Then we started the non-smoker's rights movement, the great American smoke out, and an increase in federal tax. Subsequently we had tax at the state level increasing, Proposition 99 here in California and others. We've made huge progress. We've cut down this problem to under 14% smoking rate in California, but we have not solved it. In Finland, it costs about \$9 a pack, but still some people smoke. So, if you have affluent societies, price is not the only issue, although certainly price is important. We should feel very good about the decline in lung cancer mortality. You can see here the U.S., and at the top California, and Los Angeles at the bottom (slide 21). We've made huge progress and California deserves credit as a real leader in this.

Also, look what would happen if we had just a straight line in the heart disease rate (slide 22). If we had a straight line, we would be at an adjusted rate of 700 to 100,000 population. If you just kept the peak rate, we would be at 425. But, the actual rate is somewhere a little above 300, so again we've made huge progress. We don't get credit for it, because nobody talks about it. We need to start talking about it and use this as a model to think about other chronic diseases.

The Ford article in *New England Journal of Medicine* suggested that roughly half of the decrease in coronary heart disease mortality is attributable to treatment (slide 23); that is, secondary prevention and also post-MI, initial treatment, heart failure, revascularization. About another half is due to risk factor reduction, lipid lowering, blood pressure—high amongst them—reduced smoking prevalence, of course, and reduction in physical inactivity. But,

those are being offset by increases in the BMI and diabetes. So, on the one hand, we're making progress and, on the other hand, we are destroying the progress we're making by the fact that we're getting bigger in terms of our girth.

How can we build on successes (slide 24)? I think there are three levels with respect to chronic disease. One is chronic disease management, the second is initial risk factor reduction, and the third is focusing on the environmental influence—the physical and social environment, the underlying health determinants. The latter will require influencing decision-making in the other, non-health sectors. We will not be able to solve this problem in the public health and healthcare sector alone. We can't. The only way we're going to solve the problem is by getting to decision-makers in other sectors—in business, in education, in social policies, in transportation, in land use, in tax policies.

The good news is there is synergy, things that we can do at the individual level, at the community level, and organizational practices and policies can all work together. So much of what we've done in looking at the evidence suggests that it takes local types of intervention to be effective. A single one may be totally ineffective, but coupled with others, the combination can make a big difference.

Look at chronic disease self-management programs (slide 25). This is a larger view that was done by Joe Chodosh in the *Annals of Internal Medicine*. He looked at the effects of self-management, and it showed in fact that self-management can be important. You can reduce hemoglobin A1C by about .8, you can reduce systolic blood pressure by a small amount, and you can reduce diastolic by a small amount as well. This is not a lone prescription for most people with high blood pressure, although it certainly can be important.

We also looked at what we could do that we're not doing now that would make the biggest difference. Here's one example: We found basically that 100,000 deaths per year could be averted if we did very simple things. If you look last year, 2005, 28% of smokers were offered help to quit in the past 12 months (slide 26). But if you increase that to 90% to offer help to quit, you could save an additional

42,000 lives a year. Now, Hispanics are 50% less likely to have been offered quit assistance. So, when you look at some of the inequalities, inequities, disparities, you have to start looking at prevention as well.

Here's probably the best example (slide 27): Only about 40% of the adult population is taking a baby aspirin. But 45,000 lives could be saved annually if everybody increased their aspirin use, if we got it to 90% from the 30% that's there now. Once again, Hispanics are 24% less likely, and Asian American 40% less likely, to use aspirin daily or every other day, compared to non-Hispanic Whites. Again, a great opportunity.

Let's discuss physical activity (slide 28). There are so many benefits of physical activity that you know very well, but not everybody understands these. Not everybody in the population knows that it can reduce hypertension, heart disease and stroke, and it can also help prevent diabetes, reduce risk of colon cancer and some other kinds of cancers. It improves mental health, it increases lung mass, it improves the immune function, and reduces health care costs. Wow. Seems like the Holy Grail, doesn't it? Sounds like magic.

Here is my exercise prescription (slide 30). I have to get up 15 minutes earlier than usual, followed by 10 minutes of fun exercise that makes you breathe hard, an additional three minutes of stretching, repeat two or more times over the course of a day and enjoy the day—excuse me, I have to leave now, I have to exercise—and repeat four to six days a week. How many of you have a physician that gave you an exercise prescription? Very few.

Take another perspective (slide 31). Look at the advantages of addressing the underlying factors. The advantages are that they can affect a wide variety of diseases and injuries. The problems are that it's difficult to understand the complex relationships. These determinants are not covered by the money we get in public health. I haven't gotten a dime to work on the social determinants of health. And, it requires working on issues where we don't have a lot of expertise. How many of you are experts in transportation policy? How many of you are experts in urban design? Well, we have a few

people here but not very many. We have to work out of our comfort zone, which means we have to be very strategic with our partners. Sometimes that's an uncommon act.

We in Los Angeles County developed a beginning effort that focuses on the physical environment. Over a period of six months, under Paul Simon's direction, we've developed specific focus areas (slide 32): land use policies, health impact assessments that I'll get to in a couple of minutes, the city health initiative, transportation policies, workplace. I don't want to overstate what he's done, but we're starting to make some progress. We also have a program to promote active communities and environments. That program was established in this division of Chronic Disease and Injury Prevention. It's a very powerful group.

We also have a health inequity work group we've established that concentrates its focus on the social determinants. So, we have the physical determinants, and now the social determinants. These efforts have been encouraged through grant-funded projects. I want to thank the California Endowment, but it's also through collaboration with the Bay Area Regional Health Inequities Initiative, the National Association of County and City Health Officials and other partners.

Take the example of air quality (slide 33). There is very good research that small particle pollution contributes to excess mortality. In Los Angeles County, studies at USC and UCLA have shown that proximity to highways and exposure to particulate matter increase asthma incidents in children. I've just been involved with a school board member who wanted to make the siting requirements for schools different, so that they're not all sited right next to freeways, or on reclaimed land. It's an important regional issue, also, because, as far as I know, air pollution doesn't respect county borders. It's something we have to work on together.

What about water? We are in for a big shock with respect to water quality. There are still major issues with respect to water quality, especially in some places, or some parts of the county.

What about the global warming issues? Finally, they are taking center stage. We're talking about

catastrophic events, about hurricanes, heat waves, and other phenomena that could devastate urban areas, including extended droughts and worsening weather patterns.

Urban planning and land use (slide 34). We are focusing on walkability. We're focusing on places where physical activity is encouraged, access to mass transit—we don't have enough of it, but it's growing—and zoning requirements. We're also focusing on neighborhood safety. A lot of people say they can't exercise, or they don't want to walk

and it's higher in a lot of parts of our jurisdiction. This affects employment, poverty, health insurance, etc.. I can tell you that in Los Angeles County the middle class is disappearing. That is a health issue, as are wealth distribution and poverty. We have to talk about these things. Health insurance obviously is important, it should be a basic right.

Overall, if people ask me what's the leading cause of disease in Los Angeles County, it is clearly substance abuse. Substance abuse is a chronic disease—in fact, substance abuse is the number one

“ LOOK AT THE ADVANTAGES OF ADDRESSING THE UNDERLYING FACTORS . . . (BUT,) I HAVEN'T GOTTEN A DIME TO WORK ON THE SOCIAL DETERMINANTS OF HEALTH. ”

outside, because in fact, actually, it's too dangerous. Then we have housing. We can go back to the 18<sup>th</sup> century and look at the crowded conditions which contributed to disease. We still have that in parts of our county. I hope you don't have it in yours but I suspect you may. So, the availability of affordable housing and quality housing remain big public health issues.

Here's some of the adverse impacts of poor community design (slide 35). I don't have to read those, you know them all. But remember, many of them lead to increased rates of cardiovascular disease and cancer. Also, we as individuals and as members of a community are not as socially connected as we could be. Remember the early studies that found that social connectedness is a predictor of mortality and of health behavior. That's really important work.

Health and sprawl (slide 36). We know that people are more likely to be overweight by six pounds on average if they in fact live in areas that are marked by sprawling developments, they're more likely to have high blood pressure and they spend more times in their cars honking at other people and breathing in the fumes.

And there are problems in other areas of our social environment (slide 37). The Los Angeles Unified School District has about a 30% dropout rate,

chronic disease. There's a whole other talk that I could give on that. I won't. But I wanted to make sure you put it front and center. It is mainstream. It is the number one cause of preventable disability.

Here's kids living in poverty, by race and ethnicity. You can see that there are huge differences (slide 38). Forty-three percent of Latinos versus 5% of Whites. Thirty-eight percent of Blacks versus 10% of Asian Pacific Islanders. Could you see greater contrasts?

So we know what we can do. If you're talking about poverty, for example, we can advocate for evidence-based social programs, such as center-based early childhood development program, parental assistance programs, etc. How many of you know the Moving to Opportunity study? Extremely important. I'm not going to say anymore because I want you to go look at it.

Now, of course, we have issues of the food environment (slide 40). The percentage of total energy intake from restaurant and fast food consumption increased by nearly 300% among adolescents over a 20-year period. Portion sizes have increased. There's less access to healthy food. I struggle with my two teenagers to get them to eat right. It is always a struggle. We estimate that there are four times as many fast food restaurants and convenience stores than supermarkets and produce vendors in Los

Angeles County. As you can see, the fast food chains are not dummies. You can see when these high school kids are old enough to get out of school and go and walk around and get their own food from fast food restaurants, they are much more likely to have a restaurant within 400 meters at a high school. And fast food restaurants are more concentrated in low-income areas than in high-income areas - three times as likely (slide 41).

Here's food insecurity (slide 42). This is very serious. We are having more and more problems with food insecurity. Unfortunately, the public says, "How can it be? We have all these obese kids, they're not food insecure? And adults." And I said, "Now wait a minute. What's the cheapest food you can buy per calorie? Soda." All that wonderful hyped up high fructose corn syrup. We eat fatty foods like chips. That's what they're filling up on. Do you think it's fruits and vegetables? People don't understand that you can be fat and still be in this kind of category of food insecure. That's another opportunity for us. And look, everybody's going natural (slide 43). Check out our TV ads, now 100% natural. Isn't that great? And then, of course, you have very enlightened people who say that obesity is all hype (slide 44). They've been fed all this by the food police. We're part of the food police, by the way, along with trial lawyers. Check out [www.consumerfreedom.org](http://www.consumerfreedom.org). If you think that we're giving the only message that people are listening to, look at that.

Here are some things we can do (slide 45). We can place limits on marketing of junk food to children. We've already changed what goes on in the Los Angeles County schools with vending machines. It has taken the junk out of vending machines. We have to promote local public markets. We have to provide incentives to businesses that provide healthy food. We have to change the subsidies. And you know what? It's not easy. Look at the Farm Bill that just went through. They've made very fledgling steps in that direction, but not enough. Then, of course, we have the proliferation of fast food restaurants. Now, if they were selling primarily salads, maybe it would be a good thing. If not, maybe we should look at the zoning issues.

So, we have to determine the effects of inter-

vention (slide 46). What's the research base? Unfortunately, there are few good studies and many of the relevant studies are not in public health, so you need to be an expert in the transportation literature, in the economic development literature, or have people on your staff who are. Many times you're not going to be able to use a clinical trial.

I'm going to end by going over just a few opportunities that I see. One is using information from the Guide to Community Preventive Services (slide 47). It is a 15-member panel, staffed by Centers for Disease Control staff and assisted by other agencies. You can look at the article we published in the Annual Review of Public Health in 2004 (Briss PA, Brownson RC, Fielding JE, Zaza S. *Developing and using the Guide to Community Preventive Services: lessons learned about evidence-based public health*. Ann Rev Pub Health 2004;25:281-302). It will give you good sense of message.

Here's an assembly of findings for promoting physical activity (slide 48). On the left-hand side are those that are recommended, community-wide information campaigns, point-of-decision prompts. In the San Diego fitness study, when they put prompts on the stairs people used the stairs more. Individually adapted health behavior change, school-based physical education. A lot of what is touted as physical education in schools isn't. Social support and prevention in community settings, increasing access to places of physical activity with equal outreach and urban planning approaches.

On the right-hand side, you also have what hasn't worked alone or those interventions with insufficient evidence. Health education campaigns alone don't work. Health education with TV and videogame components are in that category. We don't know that they don't work, but if you have a choice I'd rather see the things on the left than on the right. If you're going to do things on the right-hand side of this slide, then let's do the study, let's make sure it's part of a well-designed research study.

A very new tool, very exciting is health impact assessment (slide 49). You know that it basically systematically evaluates, synthesizes and communicates information about health impacts and decisions there are made in other sectors. This is

really critical. For example, what are the health consequences of the high drop-out rate from high school? What elements does school site design have that influence health? This is the kind of information we need, so we can show people in other sectors—our legislators, our boards of supervisors, our city councils, our other elected officials—that decisions they’re making in other sectors are affecting the health of everybody in their jurisdiction. Then they’ll start listening. It’s not just an agricultural decision or an economic development decision or an education decision. It is a decision that is going to affect the health of everybody in my district. That changes the message.

Here’s an example (slide 50): We did a living wage HIA. Looking at employees working on city contracts—this is Los Angeles City—they had to be paid \$7.99 an hour and provided health insurance for an additional \$1.25 an hour or the employers could provide it. It covered about 10,000 workers with city contracts. Health insurance coverage was found to be more cost effective in reducing excess mortalities than an equivalent amount of increase in wages—by a factor of about four or five to one. So, any changes to the ordinance should consider increasing the health insurance coverage. San Francisco has done a very good job in looking at living wage as well.

We just received funding through UCLA, working closely with the State Public Health Department and our department, to categorize and catalog and summarize all the existing HIAs in the USA that have been published. We’re in the process of doing that. We’ll have a good website available for you in the very, very near future, so more to come.)

Here’s what we need to do going forward (slide 51). We need organizational culture change. You have to think of policy and systems. We also have to deal with funding priorities. How many of you are spending a lot of your time on emergency preparedness? Yeah, we all are. It is extremely important. The public thinks it’s job number one, and frankly, I agree. But we need to have a balance. We have to figure out how, in the face of diminishing public health resources, we can get more flexible funding streams. It’s ridiculous to have so little for chronic

conditions and nothing for underlying problems. We need a broader range of partnerships.

Paul Simon and I had an article in *Health Affairs* (Simon, P, Fielding, J. Public health and business: a partnership that makes cents. *Health Affairs*, 25, no. 4 (2006): 1029-1039) on why business should support public health. We need to get that message out. We joined the chamber of commerce. We were the first agency in our county to join the local chamber of commerce. How many of you are members of the chamber of commerce in your counties? Two. I think there’s some room for improvement. That’s one of the ways to get them interested.

We have to influence the non-health sectors. We need new skills, new knowledge, new kinds of expertise in our department. We need partnerships (slide 52) that know urban planning, communications strategy, public health law, sociology, anthropology, economics, community development—all this is important. If we don’t have that varied expertise inside, we need to get it by partnering outside. But, we also need a shared vision. Our job is to create a vision that everybody can buy into. I already explained that we need to involve everybody in those kinds of decisions. It’s important for all of us, I think, to maintain a balanced portfolio (slide 54). How do you make sure we’re spending an appropriate amount of time and attention on chronic disease, along with the other priorities that we have? The funding agencies oftentimes tell us we can’t use their categorical money for anything else. They have all these reporting requirements. We have to be able to have flexibility, but we also have to be concerned about block grants, because that’s a good way to shrink budgets.

So, for all these reasons, I’m very excited to be part of what you represent, to be part of CCLHO, part of CHEAC. We stand ready to work with you, to learn from you, and to partner with you, so that two or three years from now we can not only talk about the progress that can be made and might be made, but we can talk about the progress that has been made and that we can all feel good because we know we’ve changed the nature of the vision and the dialog.

**LINDA RUDOLPH:** Thank you very much. I think we have time for about two questions. While Dr. Fielding is taking a couple of questions, I'd like to ask the people in the morning panel to come on up so that we are ready to go. So, people could come on up and take your seats. Question?

**JONATHAN FIELDING:** I'll repeat the question. "If you were going to do an HIA, how can we get help in doing that?" I am the Principal Investigator on this HIA work and Brian Cole is the project director. He's done a wonderful job. We have a number of articles out on how to do it, but articles alone aren't sufficient. We've also had the support over time from The California Endowment. We hope that we'll get more support for that very purpose of helping others. We can give a modicum of support at this point and steer you to resources. My hope is that we'll be able to get more support from foundations to be able to provide technical assistance. We've done that for some community organizations, and we'd love to help all of you. Maybe there's some efficient way that we could do it with a bunch of you—you know, start with maybe some conference calls and just talk through some of the issues. We can continue to do HIAs, and then catalog them. In some cases, we can, in fact, take what's been done elsewhere and modify it to your own purposes. What we're trying to do is develop, in fact, a stable of HIAs that can be done in kind of common areas of interest, so that you can easily adapt them to make a webpage tool to do that. But that's not there yet. So e-mail us.

**JONATHAN FIELDING:** "Is my PowerPoint available?" Yes, anything's available for a price. And the price is you have to look on your computer. We'll put this up on our website ([www.lapublichealth.org](http://www.lapublichealth.org)).

**LINDA RUDOLPH:** We'll also put it up on the CCLHO website ([www.dhs.ca.gov/cclho/](http://www.dhs.ca.gov/cclho/)).

**JONATHAN FIELDING:** Again, thank you very much. It was exciting to be with you.

**LINDA RUDOLPH:** Thank you.

# Chronic Disease, the Determinants of Health, and the Challenge for Local Health Departments

Jonathan E. Fielding, MD, MPH, MBA  
Director and Health Officer  
Los Angeles County Department of Public Health  
Professor, UCLA Schools of Public Health and Medicine

January 22, 2008

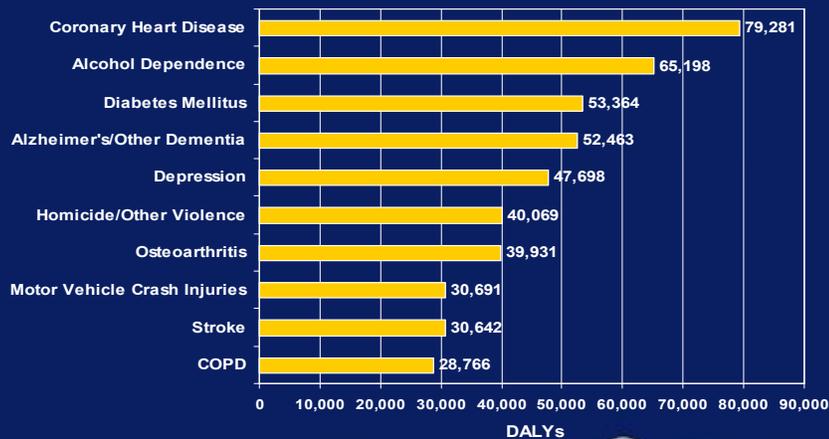


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1

Slide 1

## Leading Causes of Disability-Adjusted Life Years (DALYs) in Los Angeles County, 2005

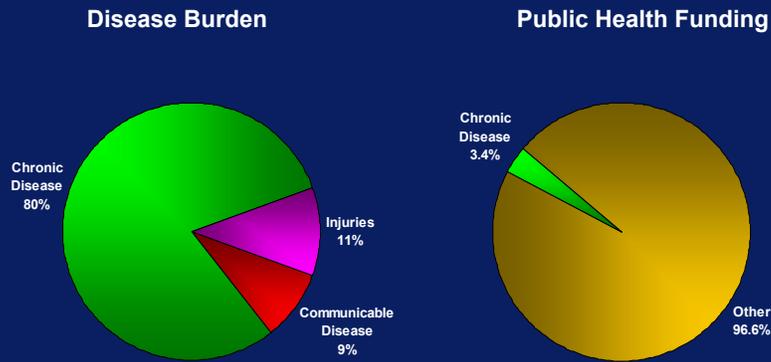


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2

Slide 2

## Distribution of Disease Burden (Based on DALYs) in Los Angeles County vs. Public Health Dept. Funding



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3

Slide 3

## Actual Causes of Death in the United States in 2000

Cause	Deaths	
	Estimated No.	Percentage of Total Deaths
Tobacco	435,000	18.1
Poor diet and physical inactivity	400,000	16.6
Alcohol consumption	85,000	3.5
Microbial agents	75,000	3.1
Toxic agents	55,000	2.3
Motor vehicle	43,000	1.8
Firearms	29,000	1.2
Sexual behavior	20,000	0.8
Illicit drug use	17,000	0.7
<b>Total</b>	<b>1,159,000</b>	<b>48.2</b>

Source: Mokdad et. Al., JAMA 2004



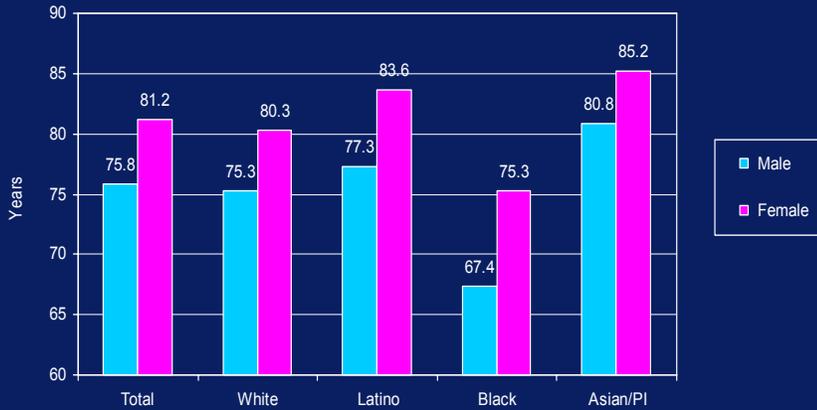
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4

Slide 4

## Life Expectancy at Birth by Sex and Race/Ethnicity, Los Angeles County, 2000

Life expectancy in LA County increased by approx 2.6 years from 1991 to 2000



Source: 1991 PEPS and Census 2000 Summary File 1  
Los Angeles County Public Health, Office of Health Assessment and Epidemiology



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5

Slide 5

## Trends in the Leading Causes of Death, Los Angeles County, 1994-2004

Cause of death	Rate (per 100,000) *		Percent change
	1994	2004	
Coronary heart disease	276	176	-36.2
Stroke	63	48	-23.8
Lung cancer	48	35	-27.1
Emphysema	35	31	-11.4
Pneumonia/Influenza	44	26	-40.9
Diabetes	20	25	+25.0
Colorectal Cancer	20	16	-20.0
Alzheimer's Disease	5	16	+220.0
Breast Cancer (female)	30	23	-23.3
Homicide	17	10	-41.2
HIV/AIDS	27	5	-81.5

\* age-adjusted to year 2000 U.S. standard population



Los Angeles County Public Health, Office of Health Assessment and Epidemiology

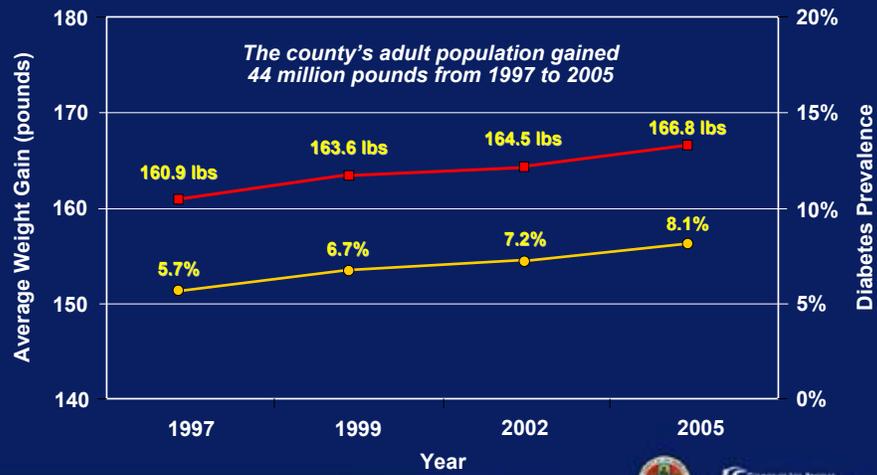


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6

Slide 6

## Average Weight and Prevalence of Diabetes Among Adults in Los Angeles County



Los Angeles County Public Health, Office of Health Assessment and Epidemiology

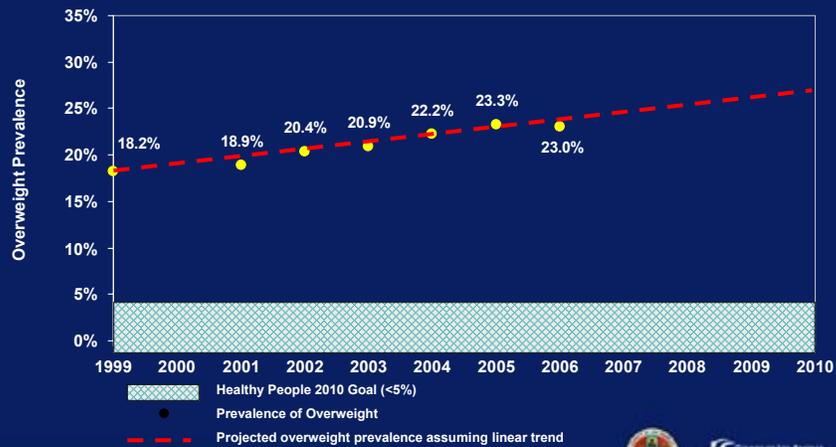


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7

Slide 7

## Prevalence of Overweight Among Los Angeles County School Children California Physical Fitness Testing 1999-2006

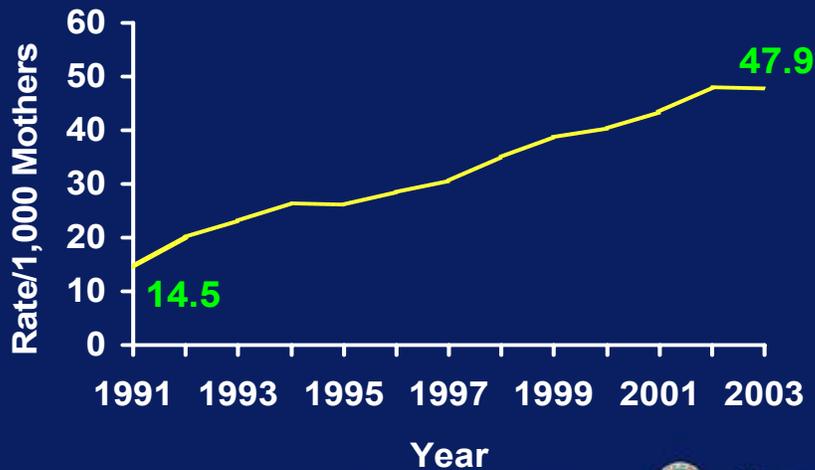


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Slide 8

## Rates of Gestational Diabetes, Los Angeles County



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9

Slide 9

## What's at Stake?

- Overweight children → overweight adults
- Overweight during adulthood associated with heart disease, stroke, diabetes, arthritis, and cancer
- Adverse effects during childhood
  - ◊ medical (hypertension, dyslipidemia, type 2 diabetes, insulin resistance, asthma, hormonal changes)
  - ◊ psychosocial (reduced HRQOL, stigma and social marginalization, poor school performance)
- Inflation-adjusted hospital costs associated with obesity among children tripled during the 1980s and 1990s (Wang & Dietz, Pediatrics, 2002)
- Obesity epidemic accounted for 27% of the growth in health care spending in the U.S. from 1987 to 2001 (Thorpe, et al. Health Affairs, 2004)

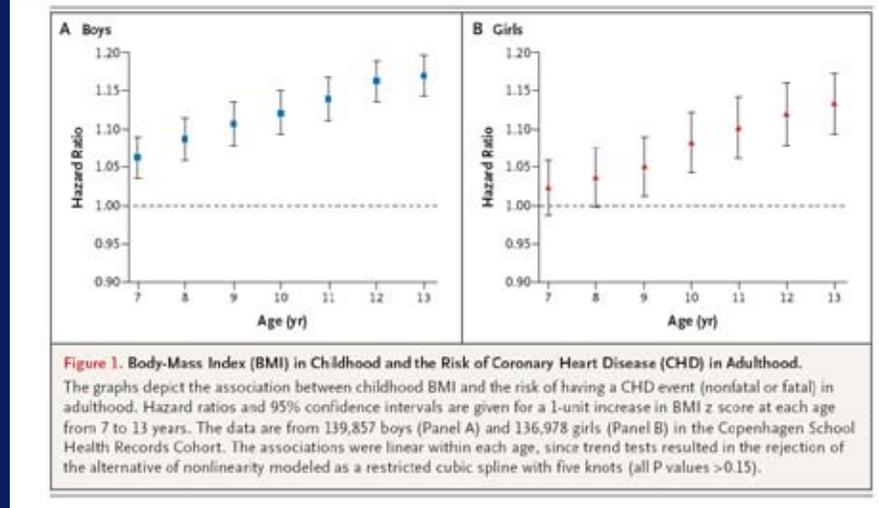


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10

Slide 10

## BMI in Childhood and Risk of CHD in Adulthood



Source: Baker et al., New Engl J Med (2007)

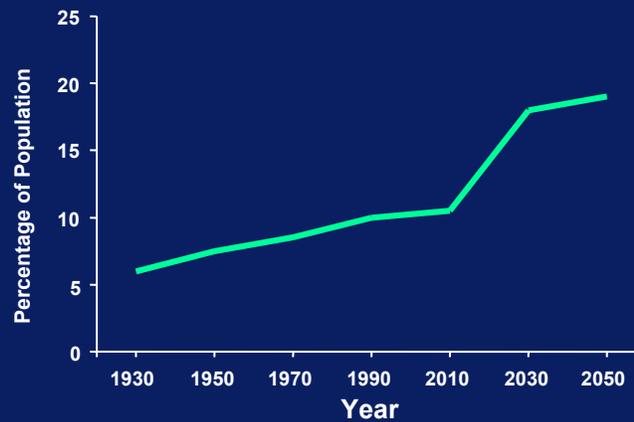


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11

Slide 11

## An Aging Population Percentage of U.S. Population over Age 65



Source: From Baby Boom to Elder Boom: Providing Health Care for an Aging Population  
 Copyright 1996, Watson Wyatt Worldwide.

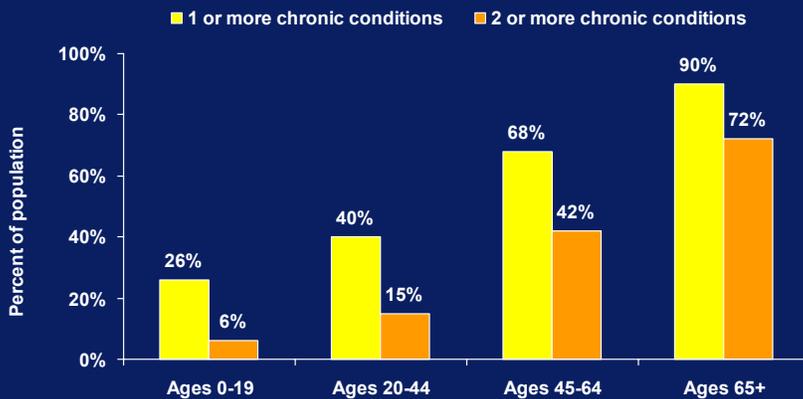


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12

Slide 12

## Prevalence of Chronic Conditions in the U.S. by Age Group, 2004



SOURCE: Medical Expenditure Panel Survey, 2004  
Anderson, G., Public Health Reports, 2007

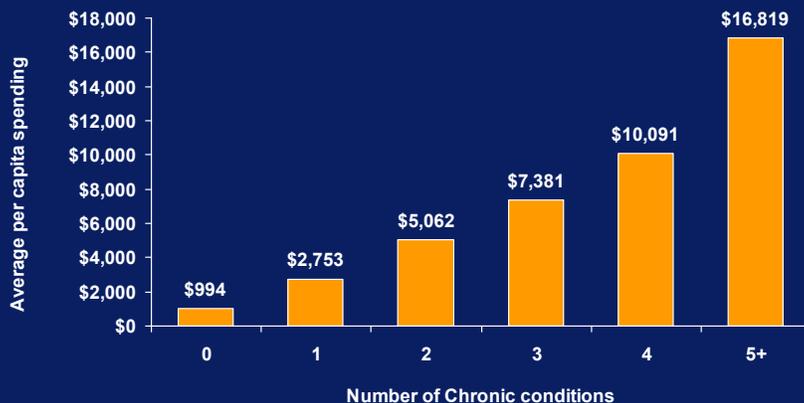


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13

Slide 13

## Per Capita Healthcare Spending in the U. S. by Number of Chronic Conditions, 2004



SOURCE: Medical Expenditure Panel Survey, 2004  
Anderson, G., Public Health Reports, 2007

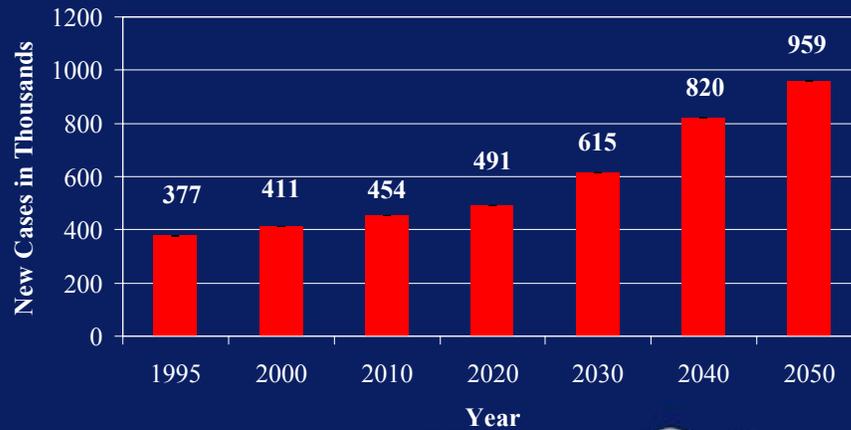


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14

Slide 14

## Estimated Number of New Alzheimer's Cases (In Thousands), United States



Source: Hebert et al. (2001). Alzheimer's Disease and Associated Disorders, 15(4), 169-173.



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15

Slide 15

## Impact of Alzheimer's Disease

- Healthcare costs – medical care; hospitalizations; skilled nursing; home care; long term care costs often lead to depletion of patient's personal savings and assets
- Personal costs – disease progression with memory loss, wandering, behavioral problems, injuries, depression
- Caregiving – caregiver stress, caregiver illness, paid and unpaid costs of caregiving
- Costs to businesses – absenteeism due to caregiving, etc.



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16

Slide 16

## U. S. Healthcare Expenditures, 1970-2004 (Smith, et al., Health Affairs, 2006)

	<u>1970</u>	<u>1980</u>	<u>1993</u>	<u>2000</u>	<u>2004</u>
Total spending (billions \$)	75	255	917	1,359	1,878
Spending per capita (\$)	357	1,106	3,461	4,729	6,280
Spending as percent of GDP	7.2%	9.1%	13.8%	13.8%	16.0%

**83% of all healthcare spending directed to persons with chronic conditions** (Partnership Solutions. Chronic Conditions: Making the Case for Ongoing care-September 2004 update. Baltimore, MD: Johns Hopkins University, 2004)

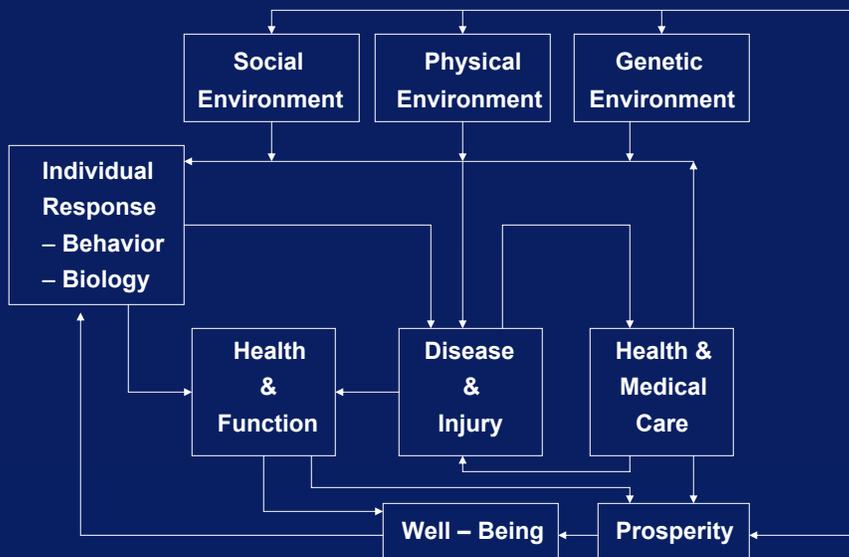


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17

Slide 17

## Determinants of Health (Evans - Stoddart Model)



18

Slide 18

# Spectrum of Prevention Framework

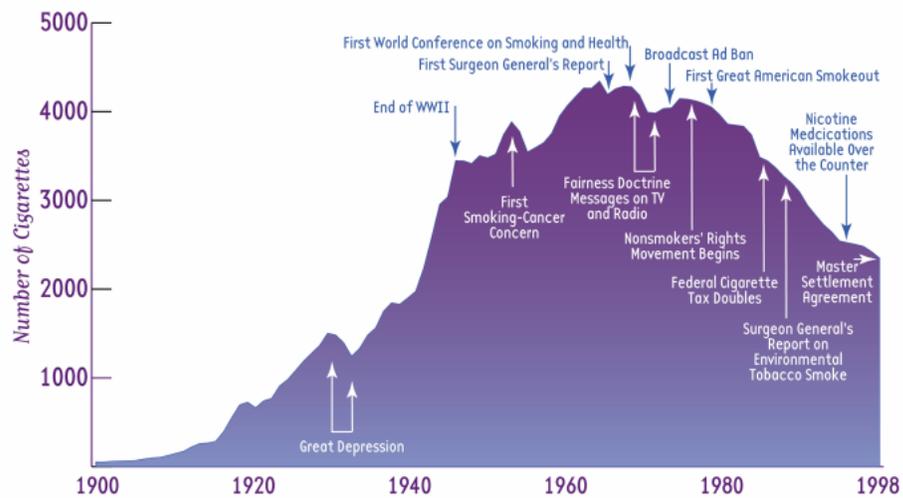
Figure 1: Spectrum of Prevention

Level of Spectrum	Definition of Level
1. Strengthening Individual Knowledge and Skills	Enhancing an individual's capability of preventing injury or illness and promoting safety
2. Promoting Community Education	Reaching groups of people with information and resources to promote health and safety
3. Educating Providers	Informing providers who will transmit skills and knowledge to others
4. Fostering Coalitions and Networks	Bringing together groups and individuals for broader goals and greater impact
5. Changing Organizational Practices	Adopting regulations and shaping norms to improve health and safety
6. Influencing Policy and Legislation	Developing strategies to change laws and policies to influence outcomes



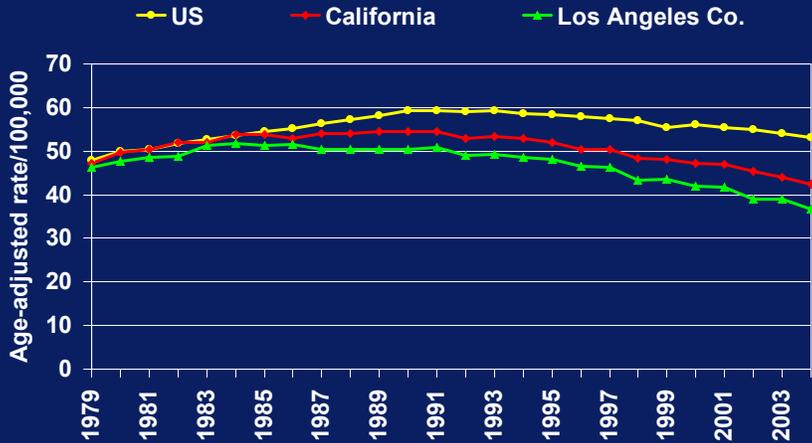
Slide 19

## Annual Adult per Capita Cigarette Consumption, United States, 1900 - 1998



Slide 20

## Trends in Lung Cancer Mortality 1979-2004



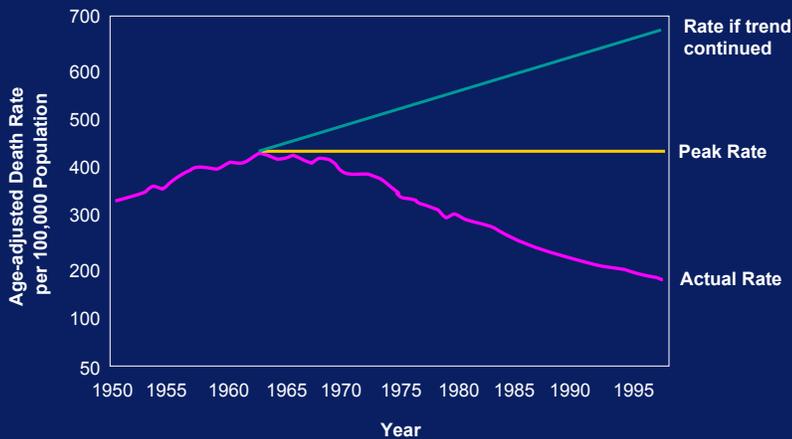
Source: CDC, National Center for Health Statistics. Compressed Mortality File 1979-1998.  
 CDC, National Center for Health Statistics. Compressed Mortality File 1999-2004.



21

Slide 21

## Heart Disease Success Story Actual and Expected Death Rates for Coronary Heart Disease, 1950 - 1998



Source: Marks JS. The burden of chronic disease and the future of public health. CDC Information Sharing Meeting. Atlanta, GA: National Center for Chronic Disease Prevention and Health Promotion; 2003.



22

Slide 22

## Explaining the Decrease in Coronary Heart Disease Mortality

- 47% attributable to treatments (e.g., secondary preventive therapies post-MI, initial treatments for acute MI, treatments for heart failure, revascularization for chronic angina).
- 44% attributable to risk factor reduction
  - lipid lowering (24%)
  - blood pressure control (20%)
  - reduced smoking prevalence (12%)
  - reductions in physical inactivity (5%)
- reductions partially offset by increases in BMI (8%) and diabetes (10%)

Source: Ford, et. al., NEJM, 2007



23

Slide 23

## How Can We Build On Past Public Health Successes?

- Need to address three levels
  - chronic disease management
  - individual risk factor reduction
  - environmental influences (i.e., physical and social environments)—underlying health determinants
- The latter will require influencing decision-making in “non-health sectors” (e.g., business, education, social policy, transportation, and land use)
- Synergistic impact of intervening at different levels: individual, community, organizational practices, policy and legislation, etc.—no single approach will work



24

Slide 24

## Effectiveness of Chronic Disease Self-Management Programs

- Of 780 studies screened, 53 studies contributed data to the random-effects meta-analysis
- Data on diabetes, osteoarthritis and hypertension:  
Self-management interventions led to a statistically and clinically significant pooled effect size of:
  - 1) -0.36 (95% CI, -0.52 to -0.21) for hemoglobin A1c, equivalent to a reduction in HgbA1c level of about 0.81%.
  - 2) Decreased systolic blood pressure by 5 mm Hg (effect size, -0.39 [CI, -0.51 to -0.28]).
  - 3) Decreased diastolic blood pressure by 4.3 mm Hg (effect size, -0.51 [CI, -0.73 to -0.30]).
  - 4) Data on osteoarthritis statistically significant but clinically trivial for pain and function outcomes.

Chodosh et al. Meta-analysis: chronic disease self-management programs for older adults. Ann Intern Med. 2005;143:427-438.



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25

Slide 25

## High Impact, Low Cost Clinical Preventive Services – Smoking Cessation

### Smoking Cessation Advice and Help to Quit

HEALTH IMPACT			
Population	% of Smokers Who Were Offered Help to Quit in Past 12 Months (2005)	Lives Saved Annually if % of Smokers Offered Help to Quit Increased to 90%	Lives Saved Annually Per 100,000 Smokers if % Offered Help to Quit Increased to 90%
All Adult Smokers	28%	42,000	43

**Hispanics** are 55% less likely to have been offered assistance to quit smoking by a health professional compared to non-Hispanic whites.

Source: Dr. Eduardo Sanchez, National Commission on Prevention Priorities, Partnership For Prevention (2007)



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26

Slide 26

## High Impact, Low Cost Clinical Preventive Services – Aspirin Use

### Aspirin Use to Prevent Heart Disease

Population	% Currently Reporting Daily Aspirin Use (2005)	HEALTH IMPACT	
		Lives Saved Annually if Daily Use of Aspirin Increased to 90%	Lives Saved Annually Per 100,000 if Daily Use of Aspirin Increased to 90%
Men 40+ Women 50+	40%	45,000	23

Hispanics are 24% less likely and Asians are 40% less likely to use aspirin daily or every other day compared to non-Hispanic whites.

Source: Dr. Eduardo Sanchez, National Commission on Prevention Priorities, Partnership For Prevention (2007)



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27

Slide 27

## Benefits of Physical Activity



- Increased life span and improved function
- Reduced hypertension, heart disease, and stroke
- Prevention of diabetes and related complications
- Decreased risk of colon cancer
- Improved mental health
- Body weight maintenance and obesity control
- Increased bone mass
- Improved immune function
- Reduced health care costs

Surgeon General's Report, 1996



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28

Slide 28



San Diego, California

Slide 29

## One Way to Increase PA

Jonathan Fielding, MD, MPH, MBA  
 8/14/06  
 unlimited

Arise 15 minutes earlier than usual.  
 Follow with 10 minutes of fun  
 exercise that makes you breathe  
 hard with an additional 3 min  
 of stretching. Repeat 2 more  
 times over the course of the  
 day. Enjoy day!  
 Repeat 4-6 d/week  
 Susan Kaplan

The Best Neighborhood  
 Opportunities for Children

Participation is valid if the number of days prescribed is met.



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 30

Slide 30

## Another Way to Approach Disease and Risk Factors

- Focus on the underlying determinants of health
  - Pros:
    - Addressing the underlying determinants of health can affect positive change for wide variety of diseases
  - Cons:
    - Difficult to understand the complex relationships of the underlying determinants and interrelated factors that affect health
    - Traditional sources of public health funding will not cover cost of these efforts
    - Requires working on issues that require knowledge and actions in non-health and non-public health sectors



Slide 31

## LA County Public Health Strategic Planning: Focus on the Physical and Social Environments

- Physical environment workgroup met over a period of 6 months
  - action plan developed with specific focus areas (staff training, health impact assessment, cities health initiative, transportation policy, schools, and workplace)
  - PLACE (Policies for Livable Active Communities and Environments) Program established in the Division of Chronic Disease and Injury Prevention
- Health inequity workgroup recently established with a concentrated focus on social determinants
  - efforts supported by The California Endowment
  - process also supported through collaboration with BARHII (Bay Area Regional Health Inequities Initiative) and NACCHO



Slide 32

## Physical Environment

- **Air quality**
  - New research showing that small particle pollution contributes to excess mortality
  - LA area studies showing that proximity to roads increases asthma incidence and symptoms
  - Regional ramifications as pollution does not respect jurisdictional borders
- **Water quality**
  - Issues of quantity and conservation
- **Climate**
  - Global warming impacts public health
  - Catastrophic events (e.g. hurricanes, heat waves) have had devastating effects on urban areas



Slide 33

## Physical Environment (cont.)

- **Urban Planning/Land Use**
  - Walkability
  - Places for physical activity
  - Access to mass transit (impacts access to work and health care services)
  - Zoning requirements
- **Neighborhood safety**
  - Can impact likelihood of residents being physically active
- **Housing**
  - Crowded conditions influence communicable diseases
  - Availability of affordable housing and housing stock



Slide 34

## Multiple Possible Adverse Health Impacts From Poor Community Design



- ↓ traffic safety
- ↑ air pollution
- ↓ water quality & quantity
- ↑ obesity & chronic disease
- ↓ physical activity
- ↑ crime & violence
- ↓ social capital
- ↓ elder health & mobility
- ↓ mental health
- ↑ health disparities



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35

Slide 35

## Health and Sprawl

People living in counties marked by sprawling development:

- Walk less in their leisure time
- Are more likely to have high blood pressure
- Have higher body mass indexes
- Are more likely to be overweight (average 6 pound difference)



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36

Ewing R, et al: American Journal of Health Promotion 18(1) Sept/Oct 2003

Slide 36

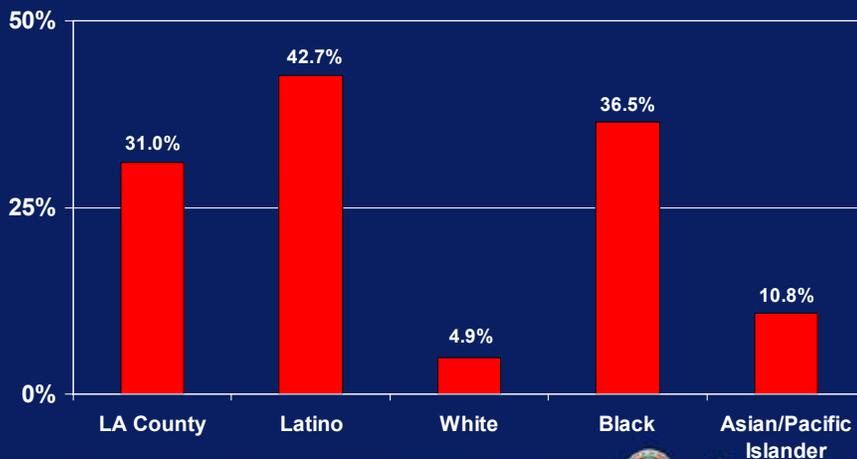
## Social Environment

- **Education**
  - LAUSD has over 25% dropout rate
  - Key determinant of health because it affects employment, which affects poverty/ health insurance/ gang membership/ criminal activity/ drug use etc.
- **Employment**
  - Middle class is disappearing in Los Angeles
- **Wealth distribution and poverty**
- **Health insurance**
- **Social support and connectedness**
- **Substance abuse**
  - Drug overdose was the 7th leading cause of premature death in Los Angeles County in 2004 (17,591 years of life lost)



Slide 37

## Percent of Children Living in Poverty (<100% FPL) by Race/Ethnicity, Los Angeles County, 2005



Slide 38

## Improving the Social Environment

### How it affects health

- *Poverty* – poor access to healthy food, housing, clean air, medical care
- *Safety* – violence, no opportunity for physical activity
- *Social Networks* – isolation, lack of social support
- *Education* – high drop out rates; poor school readiness

### What can be done

- Advocate for evidence-based social programs such as center-based early childhood development programs or rental assistance programs
- Assess and explain how educational/ tax/ social policies affect health and disparities



Slide 39

## Dangers of Poor Food Environment

- **More Americans eating food prepared outside the home, typically higher in fat and calories and lower in nutrients<sup>1</sup>**
- **Percentage of total energy intake from restaurant and fast foods consumption increased by nearly 300% among adolescents from 1977 to 1996<sup>2</sup>**
- **Portion sizes have increased**
- **Less access to healthy and affordable food options in lower income neighborhoods<sup>3</sup>**
- **Estimated to be 4x as many fast food restaurants and convenience stores as supermarkets and produce vendors in LAC<sup>4</sup>**

1 (Guthrie et al. 2002 J Nutr Educ Behav)

2 (Nielsen, et al., 2002 Obesity Research)

3 (Baker et al. 2006 Prev Chronic Disease; Powell et al. 2006 Preventive Medicine)

4 ('Searching for Healthy Food: The Food Landscape in California Cities and Counties', 2007, CCPHA brief)



Slide 40

## Proximity of Fast Food Restaurants to Public Schools in Los Angeles County

	% of schools with 1 or more FF restaurants within 400 meters
<b>School Type</b>	
elementary	21.7%
middle school	24.3%
high school	31.2%
<b>Neighborhood Income*</b>	
quantile 1 (lowest)	38.4%
quantile 2	24.4%
quantile 3	19.8%
quantile 4 (highest)	12.2%
<b>All Schools</b>	<b>23.4%</b>

\* Based on the median household income of the census tract in which the school is located

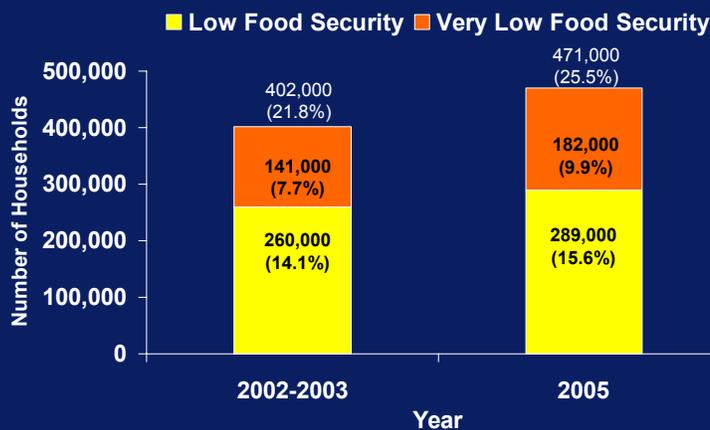


County of Los Angeles  
Public Health

41

Slide 41

## Number and Percentage of Households <300% FPL\* That are Food Insecure in LA County, 2002-03 & 2005



\*Based on U.S. Census 2003 Federal Poverty Level (FPL) thresholds for a family of four (2 adults, 2 dependents) correspond to annual incomes of \$18,700 (100% FPL), \$37,300 (200% FPL) and \$56,500 (300% FPL).

Source: Office of Health Assessment and Epidemiology. Los Angeles County Health Survey, 2002-03 & 2005



County of Los Angeles  
Public Health

42

Slide 42

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Slide 43

**Obesity:**

~~**“Epidemic”**~~

~~**“Problem”**~~

~~**“Threat”**~~

~~**“Issue”**~~

**“Hype”**

Americans have been force-fed a steady diet of obesity myths by the “food police,” trial lawyers, and even our own government.

Learn the truth about obesity at:

**ConsumerFreedom.com**

The Center for Consumer Freedom is a nonprofit organization dedicated to protecting consumer choice and promoting consumer education.

**Center for the American Public Health**

44

Slide 44

## Strategies for Improving the Food Environment

Current	Environmental Change
Increased marketing of junk food, tobacco, and alcohol	Place limits on marketing of junk food to children (around schools, parks...)
Decreased access to fresh, nutritious, affordable food	Promote local public markets Provide incentives for businesses that provide healthy food
Proliferation of fast food restaurants	Use zoning tools to limit the location and density of fast food restaurants

Source: Public Health Institute



County of Los Angeles  
Public Health

45

Slide 45

## Determining Effective Interventions

- Where is the research base?
- Relatively few studies
- Many studies not in “health” or “public health” literature
- Not amenable to design and methods used in most clinical trials



County of Los Angeles  
Public Health

46

Slide 46

## The Guide to Community Preventive Services: One Example

- Expert task force, staffed by CDC, assisted by other Federal/ state agencies

- Study methods well defined

The main steps in a *Community Guide* review are:

1. selecting topics,
2. convening a systematic review team,
3. developing a conceptual model for each topic and intervention,
4. defining and selecting interventions for review,
5. conducting a search for relevant scientific information,
6. evaluating the quality of, and abstracting data from, included studies, and
7. summarizing information on:
  - a. effectiveness,
  - b. applicability of the effectiveness results,
  - c. other effects (side benefits and harms),
  - d. cost and cost effectiveness, and
  - e. barriers to implementation.

Source: Briss, et. al., Annual Review of Public Health, 2004



County of Los Angeles  
Public Health

47

Slide 47

## Community Guide – Promoting PA: Summary of Findings

- Recommended:
  - Community-wide info campaigns
  - “Point-of-decision” prompts
  - Individually-adapted health behavior change
  - School-based physical education
  - Social support interventions in community settings
  - Increasing access to places for PA with info outreach activities
  - Urban planning approaches (zoning and land use)
- Insufficient Evidence:
  - Classroom-based health education focused on info provision
  - Mass media campaigns
  - Health education with TV/video game turnoff component
  - College-age physical education/health education
  - Family-based social support
  - Transportation policy & infrastructure changes to promote non-motorized transit



County of Los Angeles  
Public Health

48

Slide 48

## New Tools Health Impact Assessment (HIA)

- HIA is tool for systematically evaluating, synthesizing, and communicating information about potential health impacts for more informed decision-making, especially in other sectors.
- An HIA might ask:
  - What are the health consequences of high rates of students dropping out from high schools?
  - What elements of school site design are most cost-effective in encouraging physical activity?
- Why use an HIA?
  - It influences decision makers using a broad understanding of health and a wide range of evidence – it places public health on the agenda
  - It highlights potentially significant health impacts that are unknown, under-recognized, or unexpected
  - It facilitates intersectoral working and public participation in decision making



Slide 49

## Living Wage HIA

- **Employees working on city contracts must be**
  - Paid at least \$7.99/hr
  - Provided health insurance, or an additional \$1.25/hr
- **Covers approximately 10,000 workers**
- **Health insurance coverage is more cost-effective in reducing excess mortality than an equivalent amount in the form of wages**
- **Any changes to the ordinance should consider increasing health insurance coverage**
- **Applicability: many living wage ordinances throughout the U.S.**



Source: PFP/UCLA HIA – Living Wage in LA

Slide 50

## Future Challenges

- Need for organizational culture change (policy/systems orientation vs. service delivery)
- Competing demands (e.g. emergency preparedness)
- Diminishing public health resources (need for revenue generation strategies and more flexible funding streams; must leverage resources to attract investment by non-health sectors)
- Must establish a broader range of partnerships
- Must not only engage but also influence non-health sector decisions
- New knowledge and skills required (implications for training and recruitment)—e.g., need expertise in urban planning, communications, public health law, sociology, anthropology, economics, community development, business



51

Slide 51

## Opportunities

- **Intersectoral cooperation (examples)**
  - Working with Chambers of Commerce, other employer groups
  - Faith based organizations—
  - Regional planning---
  - Social services (public and private)---
  - Transportation
  - Education
- **Develop shared vision of future and admit interdependency (e.g. need skilled and healthy workforce)**



52

Slide 52

## Opportunities (cont.)

- **Involve elected and appointed decision makers at all levels of government**
  - Show why health consequences should be considered in deliberations on issues as diverse as:
    - Farm subsidies
    - Tax policy affecting wealth distribution
    - Nutritional labeling in fast food restaurants
    - Zoning/ developer incentives
    - Bonds to increase mass transit
  - Education about sources of best evidence



53

Slide 53

## Opportunities (cont.)

- **Maintain a balanced health improvement portfolio**
  - Physical/social environment vs. risk reduction vs. improved treatment/disease management
  - Short, intermediate and long term benefits
  - Regulation vs. voluntary with and without economic incentives
  - Attention to entire population vs. disparities
- **Monitor key indicators of population health status and determinants, and feed back into civic health improvement process**



54

Slide 54



## MORNING PANEL

# BUILDING LOCAL HEALTH DEPARTMENT CAPACITY FOR CHRONIC DISEASE PREVENTION (PART 1)

JEFF BROWN, MPH, DIRECTOR  
NEVADA COUNTY HEALTH & HUMAN SERVICES AGENCY

FRIMA STEWART, MSW, PUBLIC HEALTH DIRECTOR  
MARIN COUNTY HEALTH & HUMAN SERVICES AGENCY

WENDEL BRUNNER, MD, PHD, MPH  
PUBLIC HEALTH DIRECTOR  
CONTRA COSTA COUNTY HEALTH SERVICES AGENCY

TERRI FIELDS-HOSLER, MPH, RD, DEPUTY DIRECTOR  
SHASTA COUNTY DEPARTMENT OF PUBLIC HEALTH

JEFF BROWN

## Building internal capacity in a rural health department.

- I was relatively new to Nevada County—worked previously at the Alameda County Public Health Department, which provides important contrast to differences with smaller, more rural counties.
- It is important to resist the urge to just start new programs—you first have to establish a foundation.
- We conducted an initial internal assessment of the health department using the Spectrum of Prevention to consider skills of the workforce.
- We also conducted an assessment of the local cultural and political climate—sometimes the broad environmental change strategies employed in large, urban counties are perceived as infringements on personal freedoms in smaller, rural counties. Framing the issue is extremely important, such as making it easier for people to make healthier choices.
- Best practices were explored so there was no need to reinvent the wheel.
- An inventory of local community effort was conducted to avoid duplication and to find natural partners.
- We identified local champions to help the health department carry out its plans.
- A strategic planning process was conducted that consisted of three steps:
  - Data gathering to provide the evidence base for health department work.
  - Development of a draft logic model to serve as a road map.
  - Engagement with the community to get their perspectives and recruit partners.
- It is important to get the right people for the right job—we recruited people into some key leadership positions.

- We established trainings for existing staff to help change the internal culture of the health department.
- We sought out allies from within local government structure.
- Outreach and training was extended to community residents so they would be better partners.

FRIMA STEWART

## Finding the right mix between individual services and community-based prevention, and integrating upstream chronic disease prevention into existing programs.

- It is important to begin by acknowledging the current context of challenges:
  - Funding streams and mandated programs that limit flexibility;
  - Lack of consistency in staff training;
  - Lack of staff orientation to core public health concepts;
  - Staff do not always reflect the communities they work in; and,
  - Lack of flexible funding.
- Health department emphasis on community capacity building and building of partnerships and collaboration to address health issues of the 21st Century can cause tension with the need to continue providing core public health services—the challenge is to find the right balance.
- We need committed leadership, and the ability to connect with like-minded public health officials—we have had that opportunity by participating in the Bay Area Regional Health Inequities Initiative (BARHII).
- We cannot afford to wait until there is a dedicated funding stream for more upstream

work. We just have to say we are going to do it, which might require thinking about how local general fund is used.

- It is important to identify champions on the staff and give them the space to work.
- It is also important to find new tools that understand that treatment has a role to play in prevention while acknowledging that at its heart public health is about social justice and it depends on vibrant, empowered and resilient communities.
- Marin County is trying to integrate these principles in a new comprehensive health campus that will include public health, child welfare, mental health and other services. It is seen as a portal that welcomes the community—it is more than a collection of services.

- We have to learn how to blend these categorical funding streams, but it is important to blend them with some source of flexible funding, which can be general fund, realignment or generic grant funding. Many grants are also categorical, so they need to be worked into the blend as well.
- Work on the built environment is a good example. No one has any funding for this work, but there are some health department programs that can provide partial support, such as Network for a Healthy California, funding from the Office of Traffic Safety, childhood injury prevention, funding from CalTrans, CalEPA, HazMat fees and grant programs.
- It is important to cobble together these funding streams, supplemented by general fund when possible, while we wait for dedicated funding from the legislature.

“ . . . (U)NTIL WE CAN DEMONSTRATE TO LEGISLATORS AND OTHER POLICYMAKERS THAT WE WOULD KNOW WHAT TO DO WITH THESE (NEW) FUNDING STREAMS, WE WILL NOT GET THEM. IN THE SHORT RUN, WE WILL HAVE TO MAKE DO WITH THE FUNDING STREAMS WE HAVE NOW. ”

WENDEL BRUNNER

### Creative financing strategies.

- We do need a policy agenda to develop adequate funding streams, but we will not get that soon; in fact, until we can demonstrate to legislators and other policymakers that we would know what to do with these funding streams, we will not get them. In the short run, we will have to make do with the funding streams we have now.
- We do have some we can use—tobacco, Network for a Healthy California, Maternal/Child/Adolescent Health, even funding for health emergencies and bioterrorism.

- Some people say they do not have local general fund, but what they really mean is that they don't have general fund in the health department that is not already committed to a required match. Everyone has some general fund, so it is a matter of deciding priorities. It is important, though, that we not stop providing essential services, so creating flexibility must be done as part of a balanced strategy.

## Strategies for organizational change.

- Since the phrase “individual responsibility” was probably coined in Shasta County, it has not been easy to re-orient the health department toward environmental approaches.
- A vision was cast in the early 1990s that the health department had to focus more on population-based programs, a paradigm shift in a small, rural, conservative county. They were accustomed to providing direct services.
- With limited resources, the decision to focus more on population-based programs meant it had to come from a reallocation of resources from existing programs. That meant consideration of limiting CHDP exams, STD clinics, family planning, home visiting—all hot button issues. The services were not eliminated, but rather shifted to community-based organizations. It was still very unpopular, and resentment about no longer doing home visits continues to the present, in part because that is what some people did for their entire careers.

“ . . . (R)ESENTMENT ABOUT NO LONGER DOING HOME VISITS CONTINUES TO THE PRESENT, IN PART BECAUSE THAT IS WHAT SOME PEOPLE DID FOR THEIR ENTIRE CAREERS. ”

- The new direction for the organization began with creation of a community education division over 10 years ago. The small county had to grow health educators, and find funding to support them, such as First 5 Shasta. Project Lean and Network for a Healthy California funding allowed the addition of an entire team of non-WIC dietitians able to focus on nutrition prevention and policy issues.

- They also created an assessment and evaluation unit to compile local data that could help identify the major health problems for the community and engage support from local stakeholders. They recruited an epidemiologist from the Midwest and hired data analysts.
- They also created a community relations unit to help tell their story, particularly the importance of prevention and population-based approaches.
- To educate the current staff, they developed a Public Health 101 employee orientation that every employee participated in to help make sure everyone was on the same page. The Spectrum of Prevention was an important tool in that process, and they consistently asked themselves how they could work up higher on the spectrum.
- They created new job classifications, such as Community Development Coordinator, Community Organizer and Community Health Advocate and established Regional Offices throughout the county.
- They began a strategic planning process in 2000 and began to reorganize the department in line with that strategic plan. It is evidence-based and focused on health outcomes.
- They retreated from being organized by discipline and instead created multi-disciplinary teams in a Chronic Disease and Injury Branch, which has a Healthy Communities unit that does much of the environmental work.
- In summary, they started with leadership, vision and commitment, and institutionalized changes for almost ten years.
- Chicken or egg question: Did structure come first, or funding? They began to change their internal structure in a way that made them more fundable, such as Partnership for the Public’s Health, Healthy Eating, Active Communities and new work on health inequities.

## Question and Answer

**QUESTION:** How do you deal with the fluctuation in amount and timing of grant funds?

**BRUNNER:** Contra Costa made a decision not to go after money just because they can get it. They rely primarily on categorical programs with some sources of flexible funding to get the most out of them as a source of stability.

**QUESTION:** Jonathon Fielding talked about the importance of mental health and substance abuse. How does public health coordinate its work with these other agencies?

**FIELDS-HOSLER:** Shasta County is now a combined Health and Human Services agency, where the Mental Health (including Alcohol and Other Drugs), Social Services and Public Health departments report to the former public health director. Also, Public Health is revising their strategic plan to incorporate the prevention piece of substance abuse as a new focus area, forming new community and agency partners.

**BRUNNER:** Much of the integration in Contra Costa County is through the homeless program, which is part of public health. It requires cooperation with mental health and substance abuse. That has also been true in HIV/AIDS services. In addition, the health department works with some community-based organizations that provide mental health and substance abuse services, along with their environmental justice advocacy and community organizing.

**STEWART:** It is important to remember that some counties, including Marin, have consolidated agency structures, which makes communication more possible. However, it is also true that the siloed nature of public health can make collaboration with those other programs more challenging. Marin is trying to use the new wellness campus as a way to improve the integration.

**QUESTION:** Has there been much success introducing population health perspectives into mental health and substance abuse?

**BRUNNER:** Mental health funding can be even

more categorical than public health. The Mental Health Services Act, for example, requires the tracking of individuals and providing them intensive services. Violence, however, is a major issue in the county, and mental health and substance abuse could play a significant role, but their funding makes it difficult.

**FIELDS-HOSLER:** In the new Health and Human Services agency, they are trying to use the lessons learned in public health to guide the agency, but it will take time. For example, health educators have been hired to do community relations specific to mental health and substance abuse. Mental health and substance abuse are also using data to support their incorporation into the strategic planning process.

**QUESTION:** Does anyone know of examples where public health has been a major catalyst in improving education?

**STEWART:** In Marin County, there is a strong relationship with the superintendents, but there are 19 separate districts, which presents a challenge. But, building the relationships is necessary if they are ever going to address the big issues together, such as significant disparities in educational attainment.

**RUDOLPH:** In Berkeley, they have used public health data on inequities to help drive discussions at school board meetings. That has created support for an integrated plan for universal learning that incorporates a whole child model and includes behavioral, emotional, social and educational issues. We'll see.



# KEYNOTE PRESENTATION

## THE CRITICAL ROLE OF PUBLIC POLICY IN CHRONIC DISEASE PREVENTION

HAROLD GOLDSTEIN, DrPH, EXECUTIVE DIRECTOR  
CALIFORNIA CENTER FOR PUBLIC HEALTH ADVOCACY

**HAROLD GOLDSTEIN:**

I think there is an incredible opportunity for local health departments to take leadership on this whole chronic disease prevention issue, especially with a focus on public policy. Jonathan's talk this morning set the stage for all of this. What I'd like to do is expand on it.

Briefly, the California Center for Public Health Advocacy was established in 1999 jointly by the Northern and Southern California Public Health Associations specifically to promote the establishment of public health policies at both the state and local levels (slide 3). Julie Williamson was one of our founding board members and is still an active member of our board. Thank you, Julie, for all of that. Julie and I had coffee together one day, and we said, "Hey, we ought to start an organization like this." What I'd like to do is talk just very briefly about health disparities and their relationship to the social determinants of health, and then some more about the crucial role of public policy in addressing those social determinants, the unique perspective of public health, and local health departments as leaders (slide 4). My task here is to give a call to action.

How many of you know the document, "Health for All, the California Strategic Approach to Eliminating Racial and Ethnic Health Disparities," that was put together by the state health department and APHA, and coordinated by the Prevention Institute (slide 5)? How many of you know of this document? Great. I think it provides a nice overview and perspective on what it is that we're talking about today. They identified nine health priorities (slide 6), all of these that have pretty dramatic racial and ethnic disparities, economic disparities that you'll see, but also almost entirely chronic diseases—and ones that fit into the discussion today. It then went on to look at the leading causes, the actual causes of death, which are really those environmental and behavioral causes (slide 7). They also suggest that those aren't actual causes. They're just the immediately preceding causes.

By way of illustration, I can talk some about the issues that I've certainly been most involved with over the last many years—nutrition and physical activity (slide 9). If you look at those as environmen-

tal and behavior factors, they impact most of those nine priority areas. But, those environmental and behavioral factors, themselves, are some combination of social determinants. There are a lot of social determinants that impact those environmental and behavior factors. Yes?

They went on to describe the social determinants of health as a combination of the built environment, services and institutions, social capital, and structural factors. They just very briefly highlight some of what they're talking about with those. The built environment is so many of the things that Jonathan mentioned this morning—housing, transportation, community design, environmental quality, product availability (slide 10). This is really what's physically present in the community that we live in and that health departments have responsibility for influencing and supporting. Another one is in institutions, a whole range of services and institutions (slide 11). In some ways, we start identifying places where partnerships would be really helpful in developing public policy—public safety, education, cultural institutions. Social capital, we're talking about social norms, civic participation, the whole sense of collective efficacy (slide 12). Do we have a sense that we can impact things starting right here? Do we have a sense that we can really influence public policy, or is it really for somebody else to do? Structural factors, all those economic factors, all the media and marketing (slide 13). Racial/ethnic relations—there's so much going on that influences all of this. So enough of this kind of academic background.

Just as an example, we are certainly living in the United States of Obesity (slide 14). We now have a culture that I would suggest assures that large numbers of people will be overweight. I sometimes start presentations by saying, "Imagine no kids are overweight today, but that 25 years from now we want to guarantee that 50% of kids will be overweight." So, no kids are overweight now. Twenty-five years from now we want to ensure that 50% of kids will be overweight. What would we have to do? The answer is, we would have to do everything we're already doing. Right? So, in some ways, we've been conducting an experiment. The results are in, and it worked. We have created exactly what would be

required to have 50% of Californians overweight, almost a third of kids overweight.

So let's just go over quickly what some of these are. Junk food is everywhere (slide 15). We see it everywhere. I was just at a Kragen's Auto Parts Store. What's there at the cash register? A whole display of candy. Right? Now, it's not exactly what I went to the Kragen's Auto Parts store for. It is everywhere.

Portion sizes (slide 16)—\$10 billion a year advertising food and beverages to children (slide 17). So, just in case kids aren't attracted to it enough, we've got to hire Ph.D. psychologists to figure out exactly how to manipulate them, and get them to manipulate their parents. Also, the school system is where you build brand loyalty. Schools are a perfect place to get kids eating this kind of junk (slide 18).

Limited access to healthy foods—in a lot of communities it is as difficult finding fruits and vegetables, and other healthy food (slide 19). Driving from here in Sacramento down to Los Angeles, has anyone tried to get something healthy on Highway 5? Right? It is virtually impossible. That's what most communities are like. We did this study that was released just about a year ago now on the balance of what kind of food options are available (slide 20). We looked at fast food restaurants and convenience stores and compared them to grocery stores and produce vendors (slides 21-27). This is the retail food environment index that Jonathan mentioned, too. California has four times as many unhealthy outlets as healthy ones, and you can see what they are. Mostly, it's fast food restaurants combined with convenience stores. You see that's really three-quarters of the retail food outlets. So, when someone walks out their door, or when any of us walks out our door, we're four times as likely to see a fast food restaurant or convenience store than a healthy food option. In some communities, it's five or six or seven times as likely.

So, weapons of mass destruction, mass expansion (slide 28). We found them. They're everywhere, and they're pretty much on every street corner. And it's not just food. It's also community design. Cities are designed for cars and not people (slide 29). Is this really physical education (slide 30)? It is for that one girl. I would imagine it must take her—what?—

about three-quarters of a second to push the ball up and come down. There's her physical education for the day. One more point I didn't notice until just recently—actually, Jim Sallis noticed—that the PE teacher actually was wearing high heels.

As the Institute of Medicine has said, and you all have heard, "it is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change" (slide 31).

So, that really is a summary of the social determinants. This is what we're up against. This applies as much to nutrition and physical activity, as to any of the other chronic diseases. We're talking about public health as having a very important perspective on what's going on here.

So, the bad news is that the earthlings are a violent, ruthless, club-wielding species. The good news is that most of them are overweight and out-of-shape (slide 32). I showed this slide for years until someone said those are golf balls. I didn't actually understand that. So we're violent. We have all of these major chronic conditions, and there's not a lot we can do about it.

The discussion is generally framed as "Is this individual behavior or the environment (slides 33, 34)?" We argue about this as a culture. Political discourse is about which one of these it is. So often we in public health say, "It's the environment!" And they say, "Is it only the environment and you're not making any choices yourself?" I'd like to suggest it's individual behavior within the context of the environment. It's not either/or, it's both/and. It's all of those social and economic and political factors that influence our behaviors and our choices. And the extent to which it's the environment is the extent to which public policy plays a role. Whether it's 5% on a given issue or 95%, the role of public policy is specifically to address all of those social, economic, and political factors. That's where public policy comes in. We talked before—Jonathan mentioned it, too—about the Spectrum of Prevention (slide 35). How many of you use the Spectrum of Prevention, see it as a framework for the work you do? If we want to have the most global influence, it's about policy and legislation.

There have been a lot of public health movements over the last 100 years or so (slide 36). I'd like to suggest there are some common lessons, universal lessons that have come out from all of those (slide 37). First, is that none of them would ever be solved if we addressed them only as a matter of personal responsibility, or only by just educating people a little bit more. None of them would have been solved that way. But all of those social, cultural, and economic norms had to be changed so that personal responsibility could more easily be exercised. And, again, the role of federal, state, and local policies is vital. So often it's what happens at the local level that comes up to the state level, that then comes up to the national level. We saw it in tobacco over and over and over again. In some ways what's happening at the local level drives the entire national policy debate.

We, in public health, really have quite a unique perspective (slides 38, 39). We focus on communities. We genuinely look at the big picture. Whereas

without that bigger picture. And from that bigger picture, we can see and know what's going to happen.

Just looking at diabetes, for example, the long-term consequences of not addressing all of the social and economic factors that are breeding this problem will be staggering (slide 43). People with diabetes have two-and-a-half times greater healthcare costs (slide 44). Twenty cents of every healthcare dollar is already spent on people with diabetes. In the 1990s, there was a two-thirds increase in diabetes in California. We all know diabetes is now in epidemic proportions among kids, 50% of new cases. Right now, depending on the setting, 5-8% of Californians have diabetes, and yet it's expected that between a third and a half of kids born in the year 2000 will have diabetes sometime in their lives (slide 45). If we're already spending 20% of our healthcare dollars on people with diabetes, what's going to happen when diabetes rates go up from 8% to 10%, or 15% or 20% or 25%? Staggering. It could quite literally be the first generation of

“ THERE HAVE BEEN A LOT OF PUBLIC HEALTH MOVEMENTS OVER THE LAST 100 YEARS OR SO . . . NONE OF THEM WOULD EVER BE SOLVED IF WE ADDRESSED THEM ONLY AS A MATTER OF PERSONAL RESPONSIBILITY, OR ONLY BY JUST EDUCATING PEOPLE A LITTLE BIT MORE. ”

medicine is doing vital work one-on-one with people (slide 40), it's as if we're in an airplane looking down on our community. We see what it looks like, and we see how things change over time. You know, I've shown these maps 10,000 times, and you've probably seen them 20,000 times (slides 41, 42). But it's pretty remarkable that in 1991, there were no states that had more than 20% of their population obese, and by 2006, there was only one state that had less than 20% obese. We bring a public health perspective. That means we're looking at this, and we see what's going on. We have an opportunity to investigate what's going on, and to find solutions to what's going on that nobody looking at individual factors would ever see. A physician very easily could just have people coming in, deal with this one-on-one

children to have a shorter life expectancy than their parents (slide 46). So this is, as Jonathan described so well, not only about obesity and diabetes, nutrition and physical activity, but for so many chronic conditions. It is the issue of the day. What do you want to be if you grow up (slide 47)? It's no joke.

Unlike virtually anybody else in the political discourse, we in public health are interested only in the public good (slide 48). Eric Schlosser gave the commencement address at the Yale School of Public Health. I talked to him soon after that, and he said, "Wow! You guys in public health are really strange." And I said, "What are you talking about?" He said, "You're the only people I've ever met who as a discipline have the common good as your foundation." It really got me thinking. Corporations have priorities,

too. As the Nobel Prize Winner in Economics, Milton Friedman said, "There's one, and only one, social responsibility of business, and that's to increase profit (slide 49)." Right? Who's got the most influence in politics today? What are their priorities and what are our priorities? In public health, it's really simple: It really is about healthy people and healthy communities (slides 50, 51). As somebody said earlier, this is a social justice calling for all of us. It's healthy people and healthy communities, period (slide 53). That's it. We have no other ax to grind. We're not beholden to anyone else or to anything else. It is a unique calling.

That puts us in an incredibly unique position (slide 54). We have the data, we have the training, we have the credibility, we have the physicians and communities to build partnerships, and we have linkages to each other. If we didn't have a public health system in place and you said, "We've got to start from scratch," and if we could develop leaders who understand these things, who have the credibility, can build the partnerships with the communities, and can come together and support each other in doing this work, we'd say, "Wow! We'd really be able to have an impact."

So we have these opportunities to develop and advocate for the upstream policy solutions to address these huge social determinants (slide 55). We've done it over and over and over again (slide 56). Worker safety. These are just some examples: OSHA law. Right? It wasn't that long ago that businesses said if someone is working on the assembly line or if large numbers of people are working on assembly lines and they keep getting their arms cut off that they just need to be more careful. Right? That was the argument. Clean air and clean water, all the pollution standards—not that long ago. What are we talking about? Forty years ago. Auto safety—seatbelts and air bags. Why were people getting injured in car crashes and dying in higher numbers in car crashes? "People were just driving too fast. They were just being careless." We couldn't possibly require seatbelts and air bags—equally true for seatbelts as air bags, mind you, just years before. It would cost too much. "The auto industry would go out of business if we had to put those costs in there."

Remember air bags? Air bags were not that long ago. Drunk driving, Mothers Against Drunk Driving, and the work they did on blood alcohol limits. In a 20-year period, from 1982 to the late 1990's, alcohol-related deaths on the road dropped by 60%. What was the alcohol industry saying the entire time? "This is all a matter of individual responsibility. We just need to educate people more." Right? Lead poisoning. Violence prevention. All the gun safety stuff. It still needs to happen, so many more gun laws needed. Tobacco control is another great example where we made a huge difference doing a whole list of things, including setting age limits, adding sales taxes and everything else. In just 15 years we dropped smoking rates in half in California. Unprecedented.

It brings us to obesity and chronic disease. We can do it here, too. We've got decades, we've got a century behind us that shows us that we can do it.

Who would have thought we could require every family to put their kids in these (slide 57)? What this means is if you have more than two kids, you have to buy a minivan. Right? I mean, it's true. And how many kids' lives will be saved as a result?

Tobacco advertising—it was a long fight (slide 58). Right? We don't see this kind of stuff anymore. Tobacco sales to minors—I remember going to restaurants when I was a kid. How many people remember the vending machines in restaurants (slide 59)? Every restaurant had to have a tobacco vending machine. Give me a break. In my high school campus in the late 70's, we had a smoking area. Right? And that was Oakland High School. In hospitals, too.

School food—we've started making some progress (slide 60). But, it is not a lot of progress we've made on obesity prevention. I want to be really clear, we have made the smallest of smidgeons of policy changes. There is so much more to do. But there is a trajectory here, we're on a course.

So, next steps (slide 61). I'm not going to give you the suggestion of what should be on your policy agenda. I'd love to work with you on it. And, I'd love to be in Sacramento, and at the local levels, helping you get it passed. My suggestion is develop a long-range agenda—5-, 10-, maybe a 25-year plan.

What do you want to see? What are the resources you need to do it? Let's develop a strategy to get those resources. Let's start building the community partnerships with cities, folks who do land use, schools, the environment, businesses, as Jonathan was saying. We don't have to do it by ourselves. But, again, we in public health are going to bring a very unique perspective to it. And let's support one another, let's build on each other's successes. Let's create this domino effect of one city doing something, one county doing something, and then there's this competition, more and more and more, and then it happens at the state level, and then it happens at the federal level.

I'd like to suggest there is an alternative (slide 62). If you all don't take this call, if local health departments don't become the leaders in this, there's a default, and it will happen. It doesn't have to be you. There are a lot of people who would love to speak about public health issues. And these are the tobacco executives testifying before Henry Waxman's committee in 1994, with their scientific expertise describing that nicotine is not addictive (slide 63). The alternative is to let big business know best (slide 64). They are more than happy to speak from their perspective as well. The alternative is to not quite do what it is that needs to be done to counteract what has become the widely spoken-about position of government as "nanny state." It is government that's big brother (slide 65), right? "I pulled you over because you're not wearing a seatbelt. In addition, you're overweight, you eat too much fast food, you don't exercise enough, and you probably smoke (slide 66)." If we don't heed the call and become the leaders out there in communities pushing for the public policy changes that need to be made, this is part of the alternative.

Big business is your friend (slide 68). Jonathan had that great slide of what Consumer Freedom said about the obesity epidemic. Here's Consumer Freedom's statement about what they're all about (slide 69). How many of you know who Consumer Freedom is? This is the big front group, an industry front group. Just like the tobacco industry had a front group. Consumer Freedom... great frame, huh? They're about consumer freedom, right? These are the major food

and alcohol industries that pay for a front group to get their message out. What they say is, "We are firm believers in the right to have a good time. Defending enjoyment is what we're all about." And there's John Belushi who died of a drug overdose, right? "Hey, this is all about having a good time. What are you trying to do? Are you the police?" Big business knows best (slide 70). They're more than happy to get their message out. When it came to sodas in schools, they let us know that their scientific evidence shows it was the couch not the can (slide 71).

On menu labeling, the head of the restaurant association, from her scientific, public health background said that SB120 ignores the true issues behind obesity (slide 73). It's not that we spend 50% of our food dollars away from home, and there is no nutritional information available to us.

So, as a way of closing, the Surgeon General issued his first report on smoking in 1964 (slide 74). Immediately thereafter cigarette consumption rates began to go down (slide 75). How did it happen? A whole, wide range of tobacco policies (slide 76). Similarly, the Surgeon General issued a report on diet in 1988 (slide 77), another one on obesity in 2001 (slide 78), and immediately thereafter absolutely nothing has happened (slide 79). Newt Gingrich, of all people, has said we need very big public policy changes to stop diabetes and obesity from ruining our young people (slide 80). It's true about all the chronic diseases. We need big public policy changes to address these chronic disease issues.

The subtitle of my talk was "The Opportunity for Local Health Department Leadership (slide 81)." I should change it to "The Imperative of Health Department Leadership (slide 82)." You've got the knowledge, you've got the skills, you've got the physicians in your communities. Now let's work together to make sure you have the resources and that we really build the agenda that's needed to have the impact on these chronic diseases. That needs to happen now.

**LINDA RUDOLPH:** We have time for two questions. Comments?

**HAROLD GOLDSTEIN:** The question was about the prospects for a menu labeling bill. Menu labeling.

How do I want to go at this? When SB19 was first introduced, the first school food bill in 2001, the bill made it entirely through the state senate first. I got a call from Amanda Purcell, who is now our policy director. She was working at Project Lean at the time. She said, "You know, this bill might make it through. We might ban soda and junk food from California schools." The thought had never crossed my mind that we'd get a bill through in one year. That was 2001. It then took four more years to get soda and junk food bills passed through the Legislature. The fact that we got SB120—this bill that went up not just against the soda and junk food companies, but against restaurants—is remarkable. And, you all know better than anybody the power of restaurants at the local level and the state level, that we got this bill through the legislature in one year is truly remarkable. It's thanks to all of you. I've talked to many of you, and I know you're sending letters and organizing other people. We got it through in one year. But no surprise, we're in this for the long haul. It's going to take however long it takes to make these kind of major policy changes.

So we're working on two tracks now. There likely will be another bill this year. But at the same time, we need to be organizing. You all hear this as the rallying call for getting these policies moving at the local level as well, just like with tobacco, where it started—where?—in Lodi? That's the usual story, right? It started in Lodi, banning smoking indoors at workplaces. We have to do the same thing on menu labeling. There is an opportunity for locals all over the state to pass ordinances that will then build to support what goes on at the state level. San Francisco has already introduced a menu labeling bill. Santa Clara is talking about doing it. There's a small caveat, which is the legal rationale for locals to do this—there's a question of whether locals are pre-empted or not. That is a legal question that will be answered in court. We want to make sure that whoever it is that passes this first has the legal capacity to defend that lawsuit. As soon as that happens, and I'm hoping that will be San Francisco in a matter of months, we want the biggest pile-on of all times.

So, start getting ready, get in place. It's going to take awhile for all of you to do this, too, but let's

have as many local menu labeling ordinances as possible. Let's show the Legislature that at the local level folks want nutritional information on menus.

So the answer: We're going to continue working at the state level, working at the local level to get that message up there, so that if the restaurant association puts a bill up before the legislature that specifically pre-empts that there will be a lot of cities and counties that say, "Do not take away our rights to do this."

**HAROLD GOLDSTEIN:** I was just told to repeat the question. I think the short of the question is what are we going to do to raise a billion dollars for chronic disease prevention? Is that right? Something like that.

And what roles can health departments play in that? From my perspective, this is what we're all working for. This isn't just about getting junk food out of schools, and it's not just about menu labeling. This is a movement, and it's a movement that's addressing obesity prevention in a bigger way, chronic disease prevention, and in a lot of ways, the general social, economic, and political factors that impact all public health. What are we going to do to get the money we need to do this?

We actually have a grant from The California Endowment to begin researching that. What are some funding strategies? What could be done over the long-term to raise the kind of money that's needed for obesity prevention and chronic disease prevention? I see that when it comes down to whatever it is that we work on that it's all of you in local health departments that will be the local leaders to make that happen. That's the big enchilada. You know, that's the big win that we're working for.

So, as you see this movement building, have a sense of this movement building, that's what it's building for, and we've got that on our radar screen, you've all got it on your radar screen. When I put that piece about what kind of resources do you need to do it, let me know. I'm serious. Tell me. What kind of resources do you need to do it? Because what we want to do is help find a way to get you those resources, and you will all work on that together.

Is that it? Anything else? My pleasure. Thanks for being here.



**California Center for Public Health Advocacy**

# **The Critical Role of Public Policy in Chronic Disease Prevention**

**CCLHO / CHEAC / HOAC Conference**  
Sacramento, CA  
January 22, 2008

**Dr. Harold Goldstein**  
Executive Director  
California Center for Public Health Advocacy

Slide 1



**California Center for Public Health Advocacy**

# **The Critical Role of Public Policy in Chronic Disease Prevention**

**The Opportunity for Local Health Department Leadership**

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Slide 2



*Promote the establishment of  
public health policy at both the  
State and local levels*

Slide 3

## **OVERVIEW**

- 1. Health Disparities / Social Determinants of Health**
- 2. Crucial Role of Public Policy**
- 3. Unique Perspective of Public Health**
- 4. Local Health Departments as Leaders - Call to Action**

Slide 4



# Health for All:

## California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities

The California Campaign to Eliminate Racial and Ethnic Disparities in Health

November 2003

*Coordinated and written by APHA and Prevention Institute*

Slide 5

# 9

## Priority Health Issues

1. Cardiovascular disease
2. Breast cancer
3. Cervical cancer
4. Diabetes
5. HIV/AIDS
6. Infant mortality
7. Asthma
8. Mental health
9. Trauma



[www.preventioninstitute.org](http://www.preventioninstitute.org)

Slide 6

## Actual Causes of Death United States, 1990

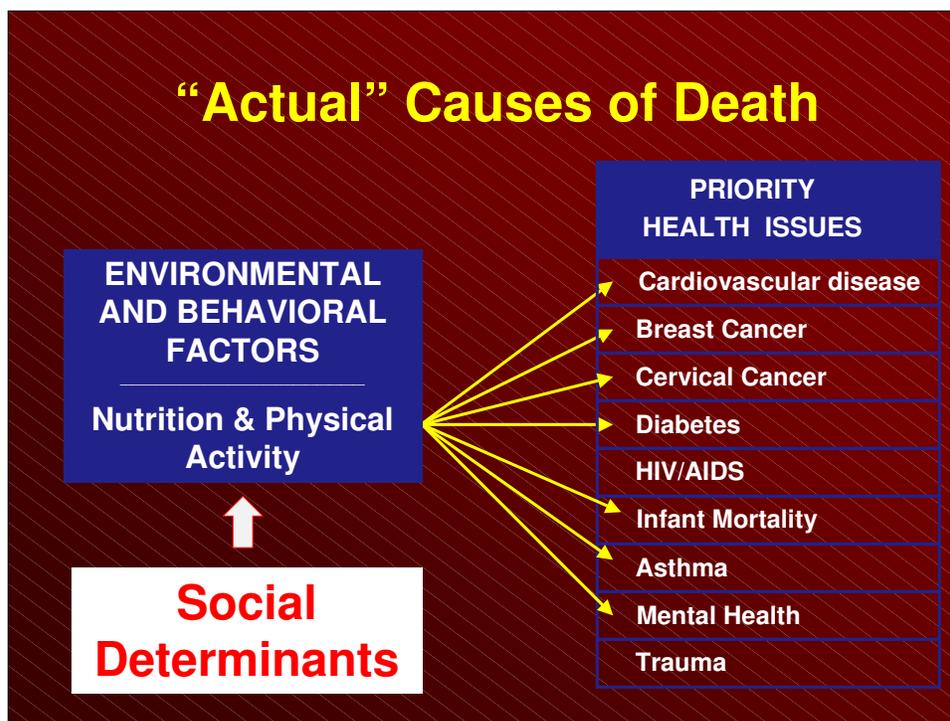
Env't / Behavioral Causes	#s
Tobacco	400,000
Diet & activity	300,000
Alcohol	100,000
Microbial agents	90,000
Toxic agents	60,000
Firearms	35,000
Sexual behavior	30,000
Motor vehicles	25,000
Illicit use of drugs	20,000

Source: McGinnis & Foege, 1993



Slide 7

## “Actual” Causes of Death



Slide 8

## Social Determinants of Health



**Built Environment**

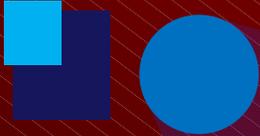
**Social Capital**

**Services & Institutions**

**Structural Factors**


[www.preventioninstitute.org](http://www.preventioninstitute.org)

Slide 9



### BUILT ENVIRONMENT

- Housing
- Transportation
- Community Design
- Environmental Quality
- Product Availability


[www.preventioninstitute.org](http://www.preventioninstitute.org)

Slide 10

**SERVICES & INSTITUTIONS**

- Health and Human Services
- Public Safety
- Education
- Cultural Institutions

 [www.preventioninstitute.org](http://www.preventioninstitute.org)

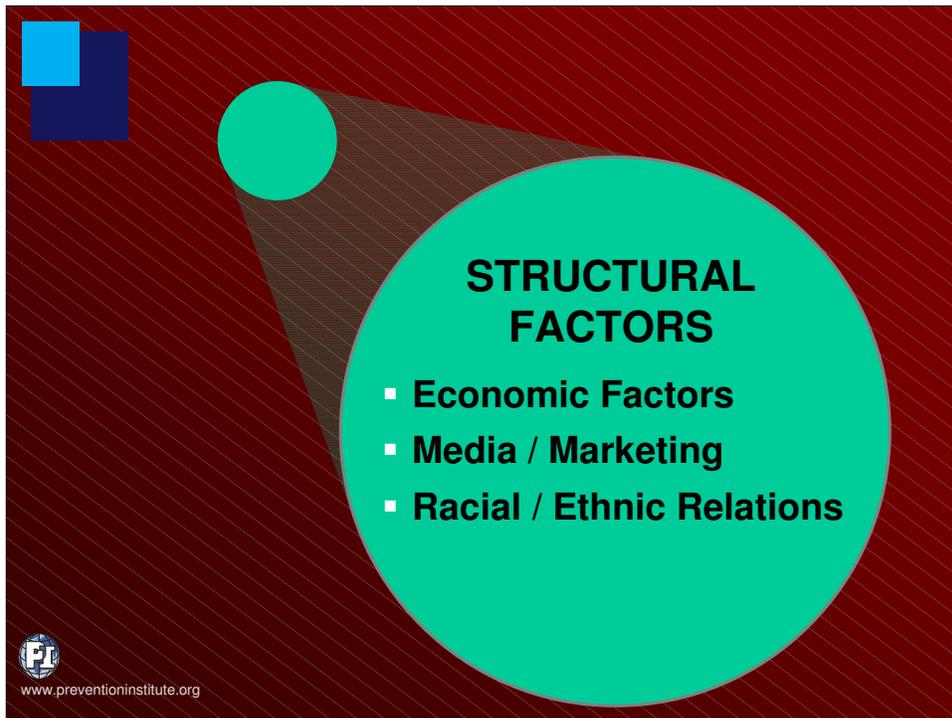
Slide 11

**SOCIAL CAPITAL**

- Positive Social Norms
- Civic Participation
- Social Cohesion
- Collective Efficacy

 [www.preventioninstitute.org](http://www.preventioninstitute.org)

Slide 12



## STRUCTURAL FACTORS

- Economic Factors
- Media / Marketing
- Racial / Ethnic Relations

 [www.preventioninstitute.org](http://www.preventioninstitute.org)

Slide 13



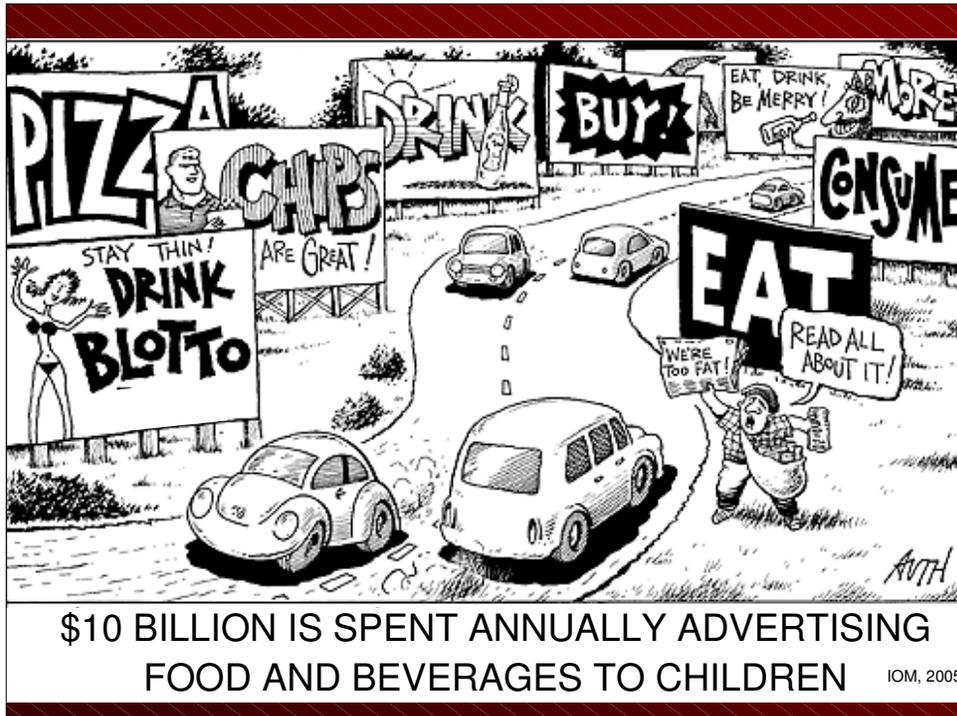
Slide 14



Slide 15



Slide 16



Slide 17



Slide 18

## Limited Food Access



Slide 19



## Searching for Healthy Food

*The Food Landscape in California Cities and Counties*

POLICY BRIEF Nº 5

JANUARY 2007

### SUMMARY

California is in the midst of a growing obesity epidemic. There is increasing evidence that what we eat and the likelihood of being obese are influenced by the foods available in neighborhoods—what we call the food landscape or food environment. The California Center for Public Health Advocacy (CCPHA) conducted a study of the food environment in California as revealed by the distribution of retail food outlets—fast-food restaurants, convenience stores, supermarkets and produce vendors—and found that in 2005, the state had more than four times as many fast-food restaurants and convenience stores as supermarkets and produce vendors. There was substantial variability in the ratio of retailers across cities and counties. Steps must be taken to ensure that every California community has a healthy food environment.

Slide 20



**Fast Food Restaurants**

Slide 21



**Fast Food Restaurants  
+ Convenience Stores**

Slide 22

**Fast Food Restaurants  
+ Convenience Stores**

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Slide 23

**Fast Food Restaurants  
+ Convenience Stores**

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**Grocery Stores**

Slide 24

**Fast Food Restaurants  
+ Convenience Stores**  

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**Grocery Stores + Produce Vendors**

Slide 25

**Fast Food Restaurants  
+ Convenience Stores**  

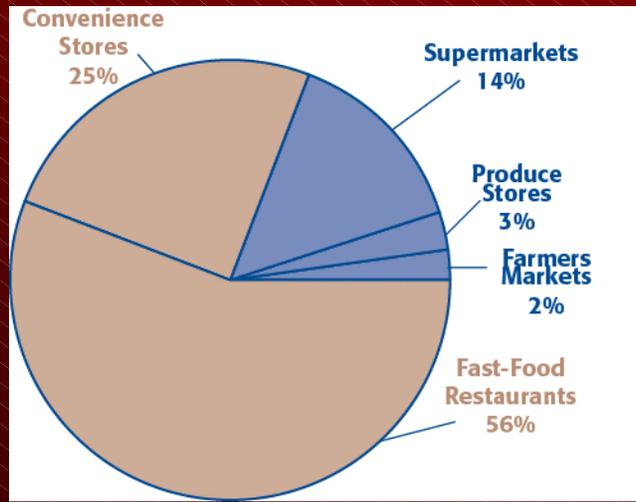
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**Grocery Stores + Produce Vendors**

**California: 4.18**

**Retail Food Environment Index**

Slide 26

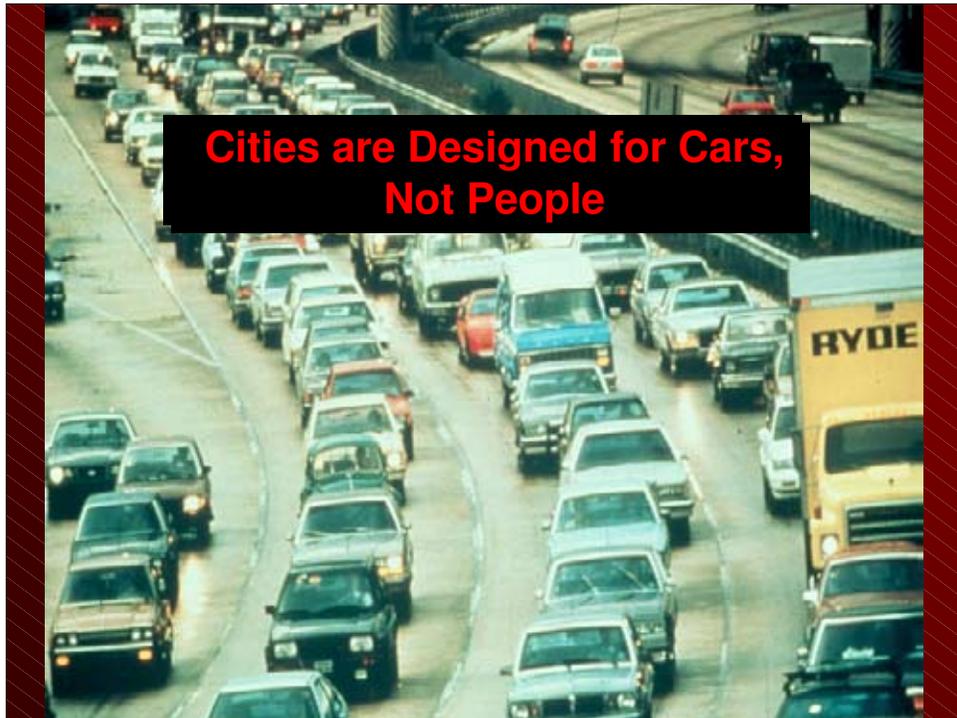


**RFEI = 4.18**

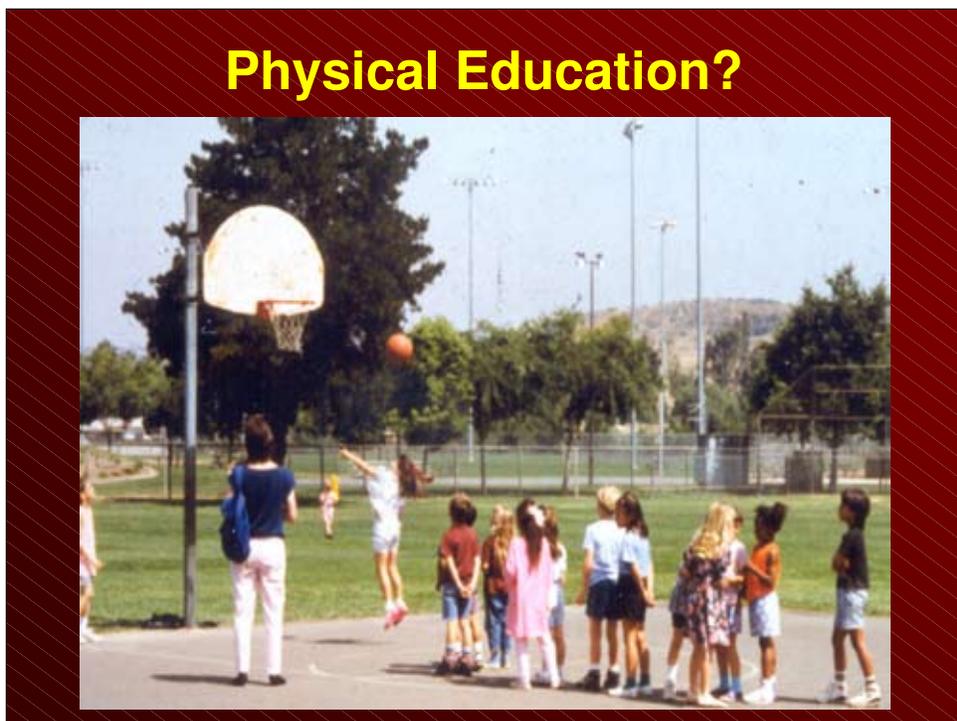
Slide 27



Slide 28



Slide 29

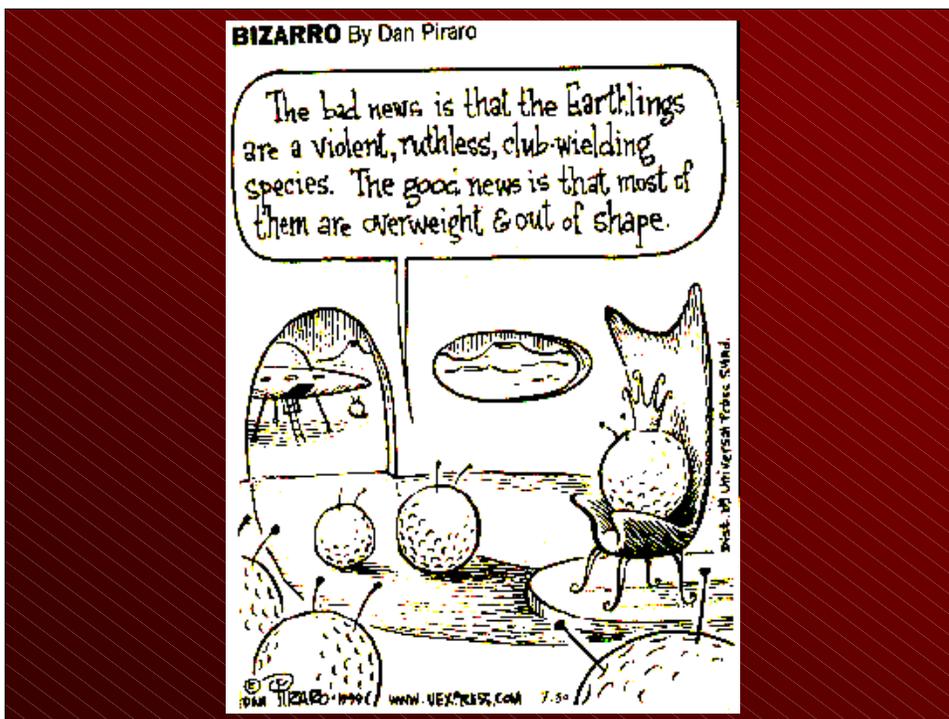


Slide 30



*“It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change.”*

Slide 31



Slide 32

**Individual Behavior**  
or  
**The Environment**

Slide 33

**Individual Behavior**  
WITHIN  
**The Environment**

The social, economic, and political  
context in which we make our food  
and activity choices

 **Public Policy**

Slide 34

## The Spectrum of Prevention



- Influencing Policy and Legislation
- Changing Organizational Practices
- Fostering Coalitions & Networks
- Educating Providers
- Promoting Community Education
- Strengthening Individual Knowledge & Skills



www.preventioninstitute.org  
PILC2048-08 09/99

Slide 35

## Major Public Health Movements

- Sanitation
- Worker Safety
- Clear Air / Clean Water
- Auto Safety
- Drunk Driving
- Lead Poisoning
- Violence Prevention
- Tobacco Control
- Obesity / Chronic Disease

Slide 36

## Universal Lessons

- NOT only a matter of personal responsibility and “more education”
- Social, cultural, and economic norms must be changed so personal responsibility can be more easily exercised
- Federal, state, and local policies play crucial role

Slide 37

## Unique Perspective of Public Health

Slide 38

## Unique Perspective of Public Health

### 1. Focus on communities: BIG picture

Slide 39

Medicine  
focuses on  
individuals

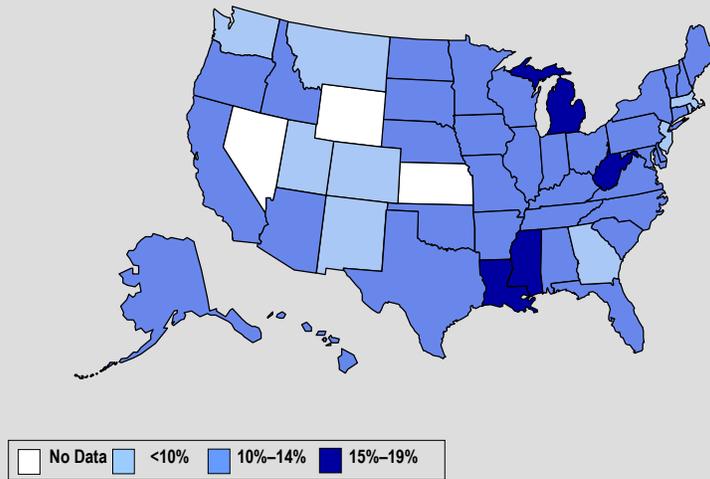


Slide 40

# Obesity Trends Among U.S. Adults

## BRFSS, 1991

(\*BMI ≥30, or ~ 30 lbs overweight for 5' 4" woman)

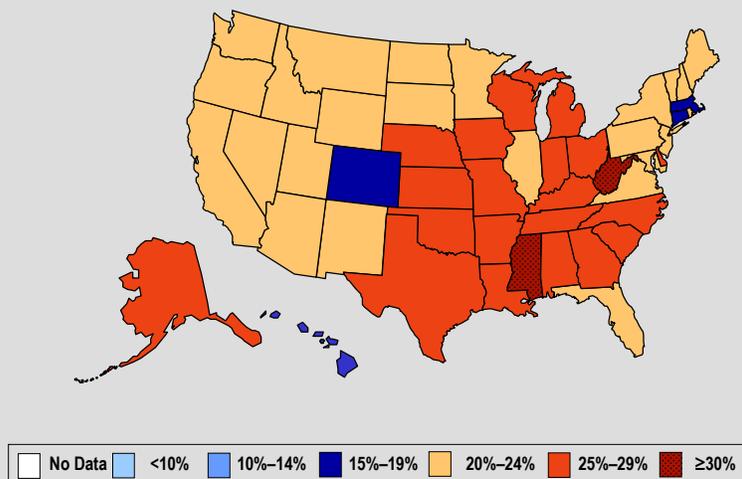


Slide 41

# Obesity Trends Among U.S. Adults

## BRFSS, 2006

(\*BMI ≥30, or ~ 30 lbs overweight for 5' 4" woman)



Slide 42

**If these problems go unchecked:**

**The long term consequences  
will be staggering**

Slide 43

## **Economic Cost of Diabetes**

- **2.4 times greater health care costs**
- **20¢ of every health care dollar**

Slide 44

## **Diabetes Epidemic (Type II)**

- 67% increase in CA (1990-1998)
- Type II among children (50% new cases)
- 5-8% of Californians (2001)
- To 33% boys, 38% girls born in 2000
  - 50% of African American / Latino children

Slide 45

***This generation of children could  
be the first in the history of the  
United States to live . . . shorter  
lives than their parents.***

David Ludwig  
New England Journal of Medicine  
March 17, 2005

Slide 46

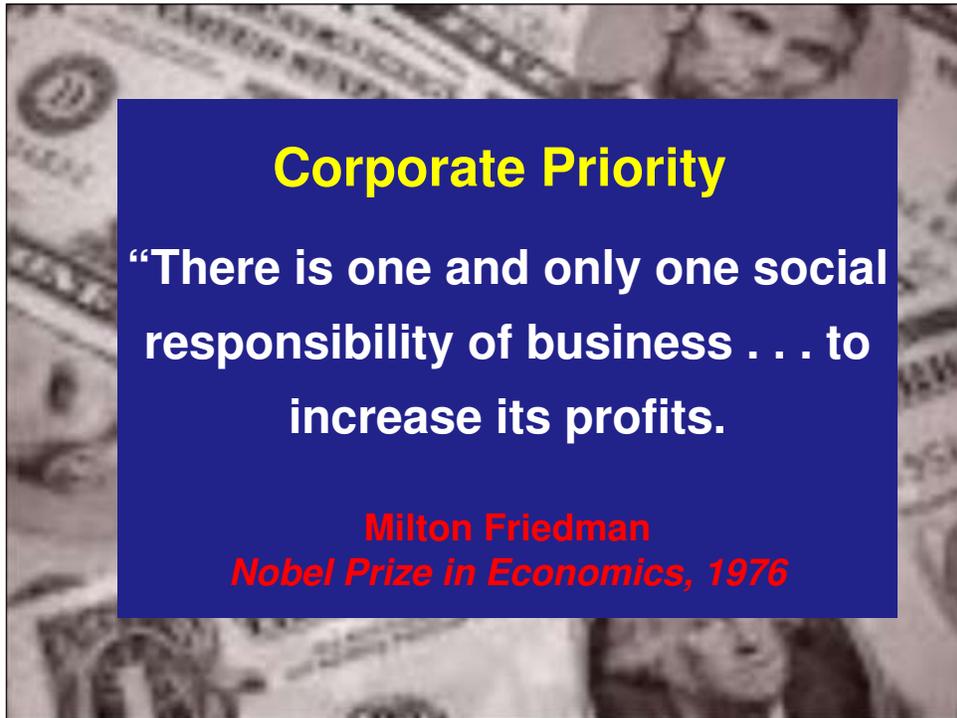


Slide 47

## Unique Role of Public Health

1. Focus on communities: BIG picture
2. Interested ONLY in the public good

Slide 48

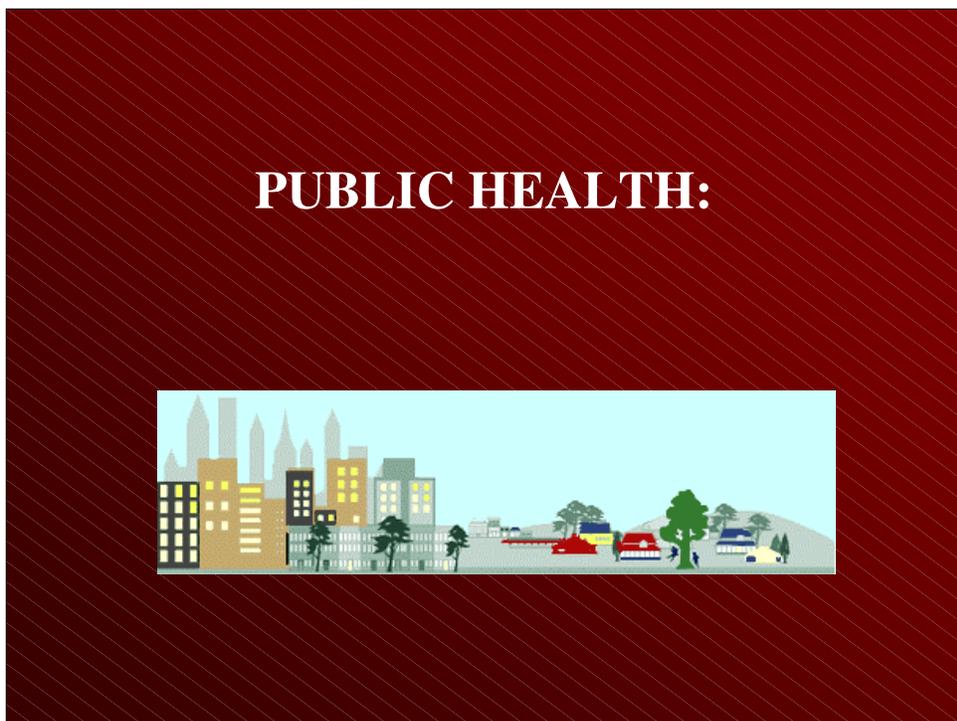


**Corporate Priority**

“There is one and only one social responsibility of business . . . to increase its profits.

**Milton Friedman**  
*Nobel Prize in Economics, 1976*

Slide 49



**PUBLIC HEALTH:**



Slide 50

**PUBLIC HEALTH:**  
*Healthy people  
in healthy communities.*



Slide 51

**Unique Role of Public Health**

- 1. Focus on communities: BIG picture**
- 2. Interested ONLY in the public good**

Slide 52

## Unique Role of Public Health

1. Focus on communities: BIG picture
2. Interested ONLY in the public good – beholden to no one / nothing else.

Slide 53

## Unique Role of Public Health

1. Focus on communities: BIG picture
2. Interested ONLY in the public good – beholden to no one / nothing else.
3. Uniquely positioned: data, training, credibility, potential for partnership building, linkages to each other

Slide 54

## Unique Role of Public Health

1. Focus on communities: BIG picture
2. Interested ONLY in the public good – beholden to no one / nothing else.
3. Uniquely positioned: data, training, credibility, potential for partnership building, linkages to each other
4. Opportunity to develop and advocate for upstream / policy solutions to address the social determinants to health

Slide 55

## Major Public Health Movements

- Worker Safety: OSHA laws
- Clear Air / Clean Water: pollution stds
- Auto Safety: seat belts, airbags
- Drunk Driving: blood alcohol limits
- Lead Poisoning: lead out of gas/paint
- Violence Prevention: gun safety
- Tobacco Control: age limits, taxes, etc
- Obesity / Chronic Disease

Slide 56

## Car Safety



Slide 57

## Tobacco Advertising

Every doctor in private practice was asked:  
—family physicians, surgeons, specialists...  
doctors in every branch of medicine—  
“What cigarette do you smoke?”

According to a recent Nationwide survey:  
**More Doctors  
Smoke Camels**  
*than any other cigarette!*

Not a guess, not just a trend... but an actual fact based on the statements of doctors themselves to 3 nationally known independent research organizations.

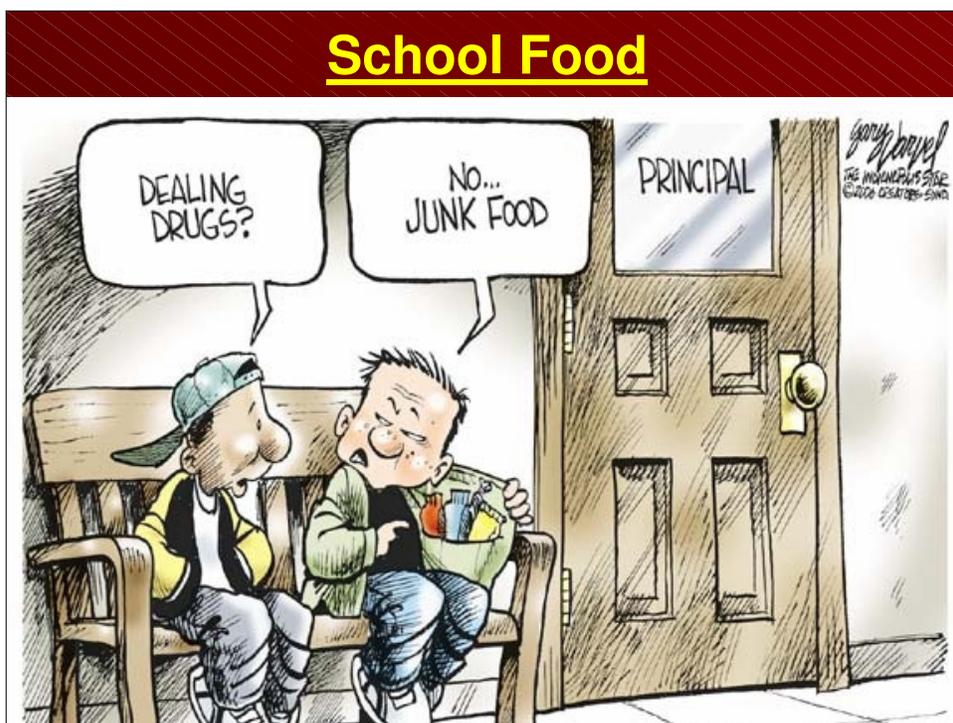
THE “I-ZONE” TEST WILL TELL YOU

Yes, your doctor was asked... along with thousands and thousands of other doctors from Maine to California. And they've named their choice—the brand that more doctors named as their smoke is Camel! Three nationally known independent research organizations found this to be a fact. Nothing unusual about it. Doctors smoke for pleasure just like the rest of us. They appreciate, just as you, a mildness that's cool and easy on the throat. They too enjoy the full, rich flavor of expertly blended camel tobacco. Next time, try Camels.

Slide 58



Slide 59



Slide 60

## **Chronic Disease Policy Agenda**

### **Next Steps**

- 1. Develop 5-10 year policy agenda**
- 2. Determine resource needs and develop strategy to get them**
- 3. Build broad community partnerships: cities, land use, schools, environment, business**
- 4. Support one another: build on each other's success, build toward state policy reforms**

Slide 61

**The Alternative To  
Local Health Dept  
Leadership**

Slide 62



**Tobacco executives testifying before congress that nicotine is not addictive (1994)**

Slide 63

## **The Alternative**

- **Big Business knows best**

Slide 64

## The Alternative

- Big Business knows best
- Government is Big Brother

Slide 65



Slide 66

## The Alternative

- Big Business knows best
- Government is Big Brother

Slide 67

## The Alternative

- Big Business knows best
- Government is Big Brother
- Big Business is your friend

Slide 68

***We are firm believers in the right to  
have a good time. Defending  
enjoyment is what we're all about.***



**ConsumerFreedom.Org**

Slide 69

## **The Alternative**

- **Big Business knows best**
- **Government is Big Brother**
- **Big Business is your friend**
- **Big Business knows best**

Slide 70

**SODAS IN SCHOOLS**

**“It’s the couch,  
not the can.”**

Slide 71

**Menu Labeling**

Slide 72



## Menu Labeling

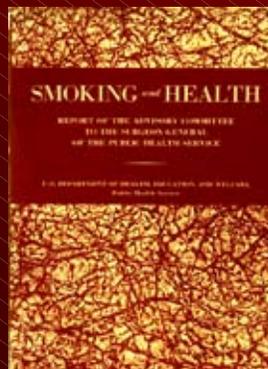
“[SB 120] ignores the true issues behind obesity ...”

Jot Condie, CEO  
(9/12/07).

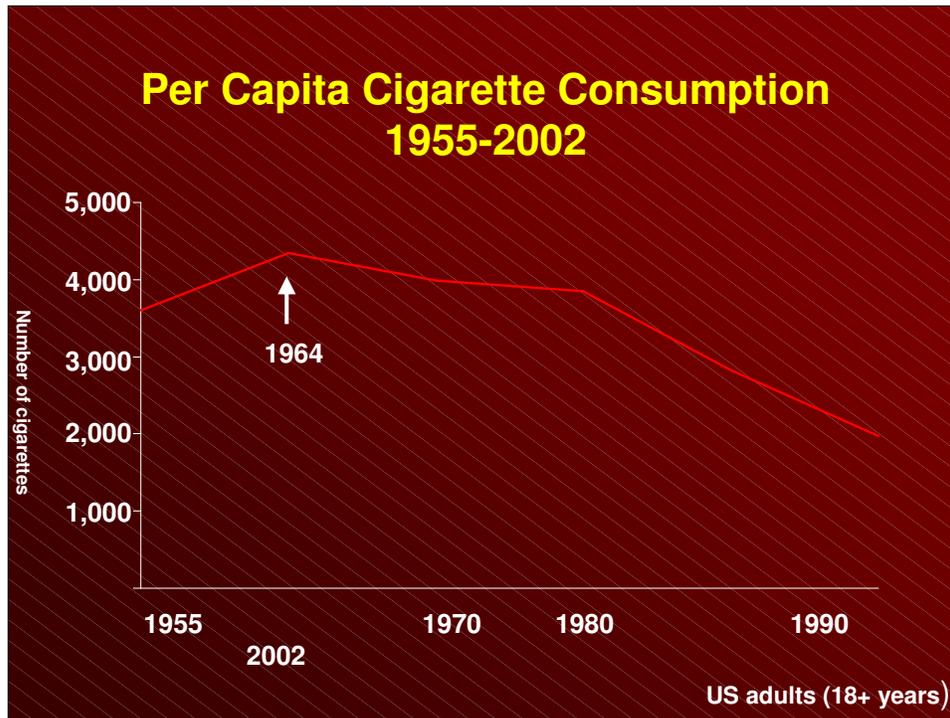
Slide 73

## Surgeon General on Smoking: 1964

“...cigarette smoking contributes substantially to mortality from certain specific diseases and to the overall death rate.”



Slide 74



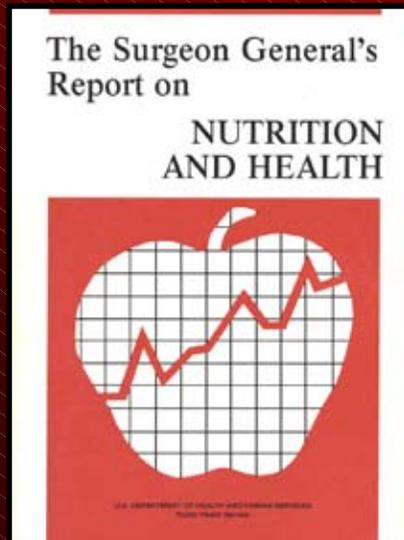
Slide 75

### Tobacco Policies

- Smoke-free schools, workplaces
- Extensive K-12 education
- Health care sector participation
- Advertising restrictions
- Warning labels
- Tobacco taxes (CA Prop 99)
  - funding state/local programs
  - anti-tobacco ads

Slide 76

## Surgeon General on Diet: 1988



*“...over consumption of certain dietary components is now a major concern for Americans.”*

Slide 77

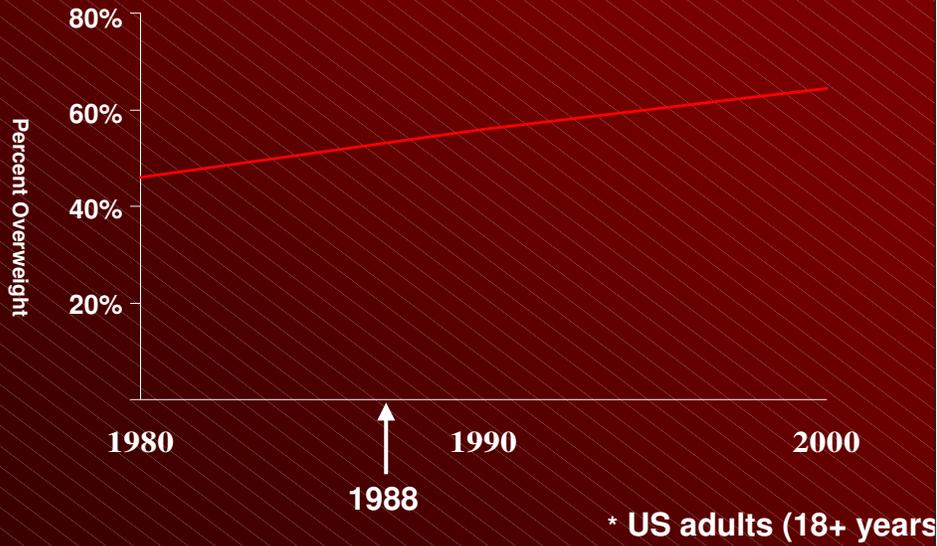
## Surgeon General on Obesity: 2001



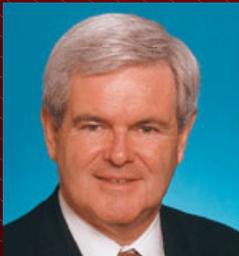
*“Overweight and obesity have reached epidemic proportions nationwide.”*

Slide 78

## Overweight Prevalence\* 1980-2000



Slide 79



Newt Gingrich  
Tavis Smiley Program, NPR  
June 11, 2004

**“ We need very big  
PUBLIC POLICY CHANGES  
to stop diabetes and obesity from  
ruining our young people.”**

Slide 80



**California Center for Public Health Advocacy**

## The Critical Role of Public Policy in Chronic Disease Prevention

**The Opportunity for Local Health Department Leadership**

**CCLHO / CHEAC / HOAC Conference**  
Sacramento, CA  
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**Dr. Harold Goldstein**  
Executive Director  
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Slide 81



**California Center for Public Health Advocacy**

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**The Imperative of Local Health Department Leadership**

**CCLHO / CHEAC / HOAC Conference**  
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Executive Director  
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Slide 82





## AFTERNOON PANEL

### BUILDING LOCAL HEALTH DEPARTMENT CAPACITY FOR CHRONIC DISEASE PREVENTION (PART 2)

TONY ITON, MD, JD, MPH  
DIRECTOR AND HEALTH OFFICER  
ALAMEDA COUNTY PUBLIC HEALTH DEPARTMENT

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## TONY ITON

### Changing the culture of a local health department.

- There are three necessary components critical to changing the culture of a health department:

Leadership  
Good data  
Participatory processes

#### ■ Leadership

- We established health equity as a focus of the Alameda County Public Health Department

We shared a vision with other health departments through the Bay Area Regional Health Inequities Initiative (BARHII)

- The focus on health equity emerged from data showing a widening discrepancy in life expectancy between African Americans and whites

The discrepancy was narrower in the 1960s, so it is not a fixed fact of life—it is changing, and can be changed

- The case for a focus on health equity was strong because of the data, but executive leadership must be inspirational—it is not sufficient to be just a bureaucrat

#### ■ Data

- Examining the data on discrepancies in life expectancy demonstrated that it was due primarily to chronic disease. Even when removing homicide and AIDS, there was no significant reduction in the gap. It was driven largely by cardiovascular disease and to some extent cancer.
- The inequities in life expectancy were also tied to income. For example, we calculated that \$12,500 of household income buys one extra year of life in Alameda County.

#### ■ Participatory processes

- If you try to tell people what to do, you will fail. In fact, to many people in our health department, I am largely irrelevant to their existence—their bosses are in Sacramento or Washington, DC.
- Organizational change processes need three things: power, resources and charm. You can do it with two, but not one.
- Participatory processes slow things down, but they give staff the opportunity to consider new ideas for themselves. It also allows good ideas to generate up from people working in programs.
- If you're just the health officer trying to jam things down people's throats, you won't get very far.

## WILMA WOOTEN

### Developing chronic disease capacity in San Diego County.

- The Health and Human Services Agency plan fits into the County of San Diego strategic plan.
- In January, 1998, the County of San Diego Board approved an integrated, regional model for programmatic and service delivery. Priorities can be carried out and customized at the regional level, such as Healthy Eating, Active Communities in the South Region. Regional work also encourages collaboration with municipalities, including city councils and other local government agencies. In some cases, the Agency enlists Board champions for strategic countywide issues.
- Chronic disease work in San Diego gains support from the county's Childhood Obesity Initiative. The countywide initiative has partners from the community, city and county government, healthcare systems, schools, childcare providers, faith-based organizations, businesses and media. Public Health Services officials and

staff, in collaboration with community partners, serve in leadership positions in the county planning process.

- Public Health Services also has a Reduce or Eliminate Disparities Initiative (REDI), which was created in 2001. It was modeled after the federal initiative that had six priorities—cancer, heart disease and stroke, diabetes, HIV/AIDS, immunizations and infant mortality. San Diego added four health priority areas—suicide, lead poisoning, obesity and asthma—based on stakeholder interviews.
- In order to carry out chronic disease initiatives, it is important to get buy-in from the board of supervisors. In San Diego County, the Board of Supervisors is committed to chronic disease initiatives as reflected by their support and advocacy of many chronic disease initiatives, such as REHDI and Cancer Navigator.
- It is also important to emphasize public/private partnerships in San Diego. When project work involves specific municipalities, it is also important to get buy-in from those entities and enlist their support to help residents in their community. An example of collaboration with a municipality is our work in the Southern Region of the County on Healthy Eating, Active Communities.

CLEOPATHIA MOORE

### Working with community.

- The challenge of involving community in the work of a health department can be summed up in a quote from Machiavelli in 1505: “There is nothing more difficult to take in hand, more serious to conduct, or more uncertain in success, than to take the lead in the introduction of a new order of things, because the innovator has enemies who all did well under the old conditions . . .”
- There were many reasons for resistance to bringing community into the health depart-

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ment: There’s not enough time. We don’t know where to start. We don’t have enough staff. They haven’t been trained. We are professionals who have learned how to do the work.

- Stanislaus County used the Mobilizing for Action through Planning and Partnerships (MAPP) process to formally involve community in health department strategic planning. It allowed us to determine if the community thought we were effective, or if they even knew who we were, and to help us determine our priorities. They often had better ways of asking questions about what is important in the community, because they live it, and they were talking about social determinants of health before we made the connections with diseases that are the work of health departments.
- The MAPP process also spells out the larger public health system and the partners that need to work together.
- We tried to identify staff who were already doing community work, such as outreach workers or public health nurses. We tried to squeeze some time out of their categorical funding to work on issues identified by the community, with limited success. Sometimes the community is in a better position to get funding that allows the broad work on chronic disease, so we lend our expertise to help in their fundraising.
- The health department has also conducted trainings on cultural competency, or cultural

humility, and invited community partners to participate in those trainings. It supports collaborative leadership.

- Beyond all the specific strategies, however, the most important thing is a vision that supports community collaboration.

**ED MORENO**

## **Building community and political support for chronic disease prevention.**

- For the Fresno County Department of Public Health to build community and political support for chronic disease prevention, there are at least four strategies to consider:

- Align the department's agenda with the priorities of chronic disease prevention;
- Identify and influence the powers that affect the things we are trying to do;
- Make an honest assessment of the health department's own capacity and what role it can play among other agencies in the community; and,
- Assess and accept a certain amount of risk.

### **Aligning the agenda**

- A change in focus had to be consistent with the priorities for chronic disease prevention.
- We began a strategic planning process that acknowledged the need for a cultural change to deal with chronic disease. It was important to involve senior managers to gain their support. It was also important to acknowledge individuals who were committed to the work of chronic disease prevention and give them opportunities to lead.
- It was also important to look a level above categorical programs in order to create a structure that would support the direction we are headed in.

### **Identifying and influencing those in power**

- We had to attend a lot of meetings about things we didn't necessarily understand. We needed to see who came to the meetings, and who seemed to exert influence. In the Central Valley, representatives of the agricultural community are noticeably influential.
- We've also worked closely with judges, law enforcement and public safety officials. As the outsiders, we had to enter their territory. It is important in these situations to remain the trusted public health expert and not try to do too much. We also try to maintain that honesty when dealing with the media.
- It is also important to be predictable and consistent with the board of supervisors. They don't want to be broadsided. There needs to be a basis of trust in order to try something new without provoking resistance.
- There is a group of people with delegated power who have access to resources, such as city managers, transportation engineers, facility and safety directors, etc. There are 15 cities in Fresno County, so it is important to develop relationships with city managers.

### **Being honest about our own capacities**

- Other agencies, such as planning, have expertise, resources, mandates, fees, etc. that enable them to provide services to communities. The health department doesn't have any of that. It is the role of the health department to contribute its own expertise, not claim to be what it is not.

### **Assessing and accepting risk**

- There is a certain amount of political risk if the board of supervisors and people in other agencies feel threatened. It is important to assess the risks and potential benefits. There has been a growing willingness to understand and accept the value of risk over the

last four years. That will vary, depending on the environment, situation, timing, etc.

- There are also risks of introducing organizational and cultural change in a health department if staff feel threatened—you are changing the things they have become comfortable with. Also, the risk of inviting people to participate in the process is that they might make you feel uncomfortable by challenging what you are trying to do. It is part of the process.

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—Machiavelli

## Questions and Answers

**QUESTION:** Can you each say a little more about the need for cultural change in your own organization, and how you approach it?

**WOOTEN:** When I first joined the county in 2001, discussion of racial and ethnic disparities was challenging. With education, it is now more understood and embraced. There is support at the federal and state levels, so it has become the norm.

**ITON:** We come from different parts of the state and have different organizational cultures. My experience was entering a culture where there was no accountability. The amount of money we got was not tied to any objective or useful result. People were held accountable for X number of brochures, or

Y number of people contacted through outreach. When I asked for evidence of any measurable benefit, they acted like I was the devil, or on drugs, or both. Why are we here? Is it just to hold health fairs and count them? We need to be accountable to the community, and to funders, for improvements in community health. If we are part of a national public health system, and the second goal of Healthy People 2010 is to eliminate health disparities, then we need a practice that can do that—and hold ourselves accountable to it.

**MOORE:** It helps to have leadership that believes in accountability. We, as local health departments, are about to have accreditation, although probably not before the current leadership retires. But, programs and projects must be evidence-based so we can prove that what we are doing is what we are supposed to do. We are moving toward more evidence-based accounting with the support of our management team.

**MORENO:** When I arrived, the culture of the health department was to remain silent. You never heard from the health department until something went wrong, and then you tried to take care of it without too much attention. Now “no comment” is no longer an option when dealing with the media. We are moving away from that culture—this is the health department, this is what we do, and we will talk to you.

**WOOTEN:** One final comment. It’s important to emphasize leadership, and having a strong team and trying to change culture by promoting accountability. It is also important to promote employees’ strengths and help them see how what they do on a daily basis fits into a larger plan.

**QUESTION:** What work is the Fresno County health department doing with city managers?

**MORENO:** We are trying to collaborate with city managers, planners and developers all together. It’s the next step in walkability and community task force meetings. We are trying to get them all to the table. This is where it is important to acknowledge what they have to offer, and to be clear what the public health role is.



FINAL PANEL  
LOCAL/STATE/FEDERAL COLLABORATION\*

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DAVID SOULELES, MPH, PRESIDENT  
COUNTY HEALTH EXECUTIVES ASSOCIATION OF CALIFORNIA

MICHAEL SAGE, MPH  
OFFICE OF THE DIRECTOR  
CENTERS FOR DISEASE CONTROL AND PREVENTION

“ CCLHO LEADERSHIP AND THE CHRONIC DISEASE COMMITTEE NOT ONLY SUPPORTED STRONG LANGUAGE ON CHRONIC DISEASE PREVENTION (IN THE GOVERNOR’S HEALTH CARE REFORM PROPOSAL), BUT ALSO MADE SURE THERE WAS A PROMINENT ROLE FOR LOCAL HEALTH DEPARTMENTS. ”

**BONNIE SORENSON**

- Based on discussions at our table, the consolidated contract in pilot counties was actually multiple, separate contracts combined into one package. In Florida, where county health departments were made up of state employees, the contract between the state and county was a one-page spreadsheet.
- Tony Iton mentioned that he has 77 separate contracts. We have a great deal of common interest in streamlining this process. Contract management is one of the top priorities at the California Department of Public Health.

**MIKE SAGE**

- This is another role the CDC can play. There are a number of states that have gone toward consolidated contracts with counties, so there are some business best practices we can help disseminate.
- Another challenge in California is that it is not one of our comprehensive grant program states. Mark Horton and I have discussed how we can get California to that point.

**MARK HORTON**

- We have had discussions with CCLHO about the legislation that allowed four counties to pilot the concept of consolidated contracts. Each has taken a somewhat different approach. After listening to Mike Sage, I think we need to re-invigorate those efforts. My commitment to you is to move forward on that.

- At the federal level, we did get passed by on the CDC consolidated contract for chronic disease. I am committed to working with CDC to gain the benefit of best practices in consolidated contracts, performance standards, agreements and business practices.

**Questions and Answers**

**QUESTION:** Has CDC made any effort to work with the U.S. Department of Agriculture to better coordinate funding and programs?

**MIKE SAGE:** We are very interested in engaging the USDA on all the issues we share in common. There are, for example, issues related to the WIC program and chronic disease. The CDC chronic disease center director is very interested in meeting with USDA. More generally, there is interest in building bridges. One potential area for collaboration is public health law and chronic disease.

**MARK HORTON:** There is reason for optimism. The expansion of the WIC food guidelines to include more fruits and vegetables is a step forward. We hope this is a sign of a sea change in which we can work with USDA on food commodities, food stamps, WIC program and other federal programs that are related to chronic disease.

**QUESTION:** How can we incorporate public health and chronic disease prevention into healthcare reform proposals?

**DAVID SOULELES:** CHEAC has been very engaged in healthcare reform. We are concerned that the current healthcare reform package contemplates the transfer of huge sums from local government to support the package. We have to be sure local

health departments have sufficient resources to carry out our responsibilities. However, we very much support the language in healthcare reform that incorporates obesity prevention and other issues related to chronic disease.

**MARK HORTON:** The governor's healthcare reform package has strong policy language to address obesity, diabetes and tobacco control. We will continue to send the message that you cannot have healthcare reform without addressing the issue of prevention.

**ANN LINDSAY:** CCLHO picked up immediately on the governor's healthcare reform proposal. CCLHO leadership and the Chronic Disease Committee not only supported strong language on chronic disease prevention, but also made sure there was a prominent role for local health departments. We think we had some influence in the legislature, getting them to accept the concept of chronic disease prevention and the role of local health departments.

**MIKE SAGE:** This question has national significance. California can be a leader here. No matter who gets elected, there will be kind of healthcare reform revisited. In some of the backroom discussions, virtually all of the focus was on access to care. Public health leadership and organizations need to push to make sure prevention is part of the discussion.

**QUESTION:** **Since Medicaid and Medicare would benefit from chronic disease prevention, has there been any discussion of how they might help finance it?**

**MIKE SAGE:** I have not been part of any discussions about how Medicaid and Medicare would provide grants. The discussion usually centers around structuring payments for clinical prevention. We need to look at innovative approaches around the country.

**MARK HORTON:** The diabetes initiative in the governor's healthcare reform proposal provides incentives for both beneficiaries and providers to screen individuals for risk factors for pre-diabetes and refer them to community programs. It at least begins to acknowledge that part of addressing diabetes is to provide resources to community programs.

**MIKE SAGE:** From a CDC perspective, we invest over \$10 billion, but it varies substantially. Our grants, for example, make up about 5% of New York's public health budget, but 96% in Arkansas. We have to think about how to maximize our investment.

**DAVID SOULELES:** CCLHO and CHEAC have discussed how we might engage in dialogue with senior management at CDC to move forward on the portfolio management process in California. We would like to be part of that process.

**MIKE SAGE:** Four states—California, New York, Texas and Florida—make up 50% of CDC's investments. If we can make an impact there, we can influence the others.





