Public Health in the 21st Century

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I'd like to highlight selected public health challenges in the 21st Century from my vantage point, to highlight nutrition and nutritionist opportunities, and to address some strategies. These challenges are terrorism and public health, the aging of America, chronic disease prevention and control, nutrition and physical activity, racial ethic health disparities, and universal healthcare.

Terrorism

First, let me address terrorism. The events on September 11th stunned the world and put a bright spotlight on public health and our readiness to respond. Never has public health been put in such intense and constant media scrutiny. I attended a meeting with the Hollywood Health & Society Advisory board about a month ago. At that meeting of producers, writers and actors they had a dinner that honored Jeff Copeland, the former director of CDC. At the end of the dinner Jeff had an opportunity to make some remarks. That was followed by questions and answers. The questions that he got were really quite interesting, but one of the most prominent questions was, "Are we really prepared for bio-terrorism? Is the public health system really prepared?" So I turn to my public health audiences and I ask this question.

We worked very hard at the American Public Health Association to lobby congress to get funding for state and local health departments to build a public health infrastructure for bio-terrorism. The challenge now is in your hands because the money is beginning to flow from the federal level down to the state and local levels. In terms of emergency response for example, are we ready to act quickly to assess the situation and mobilize medical public health and other responses?

From a nutrition perspective, are we ready to mobilize the food supplies to feed rescuers, to feed victims that are displaced from their homes? Because the bottom line is by the time these events occur it's too late to begin wondering, "What am I supposed to be doing?" We need to have a plan in place and it needs to include a nutrition and feeding component.

Are we ready in terms of health, environmental and food surveillance? Because certainly food can be a biological terrorist agent and terrorism can be delivered through food. Are we doing what we need to raise awareness of this possibility? And are we raising awareness to make sure surveillance mechanisms are in place so that if food is used as a biological agent, it is detected early and contained? In terms of investigation, it boils down to the same things. When an act of terrorism occurs, do we have investigative methods in place to trace it to foods and to quickly identify it, confirm and then act on that?

Risk communication is something that I personally am passionate about. When 9-11 occurred we were all following it in the media. In my view, the media was trying to be helpful and informative, but they were also being extremely irresponsible, pushing

the government and public health officials for answers that weren't there, pushing for a situation of questioning when answers were provided. In an environment where you have a public that's fearful, we are also adding fear. The question here in terms of bio-terrorism preparedness in your state is what are you doing as nutritionists in working with the bio-terrorism response planning on issues like what do you tell the public about the safety of the food. Where do you tell them to go get food? In terms of safe water as well. All of these issues need to be addressed now.
We're also talking about issues related to partnerships. Traditional public health partnerships are no longer adequate when it comes to bio-terrorism. We need to work with hospitals, with EMTs and ambulances, with the police, firefighters, the FBI, the Red Cross and all kinds of people in our community. Something else that the HHS is looking at as well is to develop a new public health retired workforce where people who are retired can volunteer and sign up. They go into their two weeks of training every year for terrorism response and they're there to supplement whatever workforce is out there.

The two most important points I do want to mention though is that because terrorism puts a spotlight on health, it provides an opportunity for the public to understand public health is, that it has emergency response components, surveillance components, public communication components, partnership components and so on. But if we in state and local agencies are not diligent in making sure that the funds provided by congress are earmarked specifically for their intended purposes instead of being used to build roads like some of the tobacco settlement money, then the spotlight will once again be on public health and it will affect nutrition also because they will also draw questions about the ability of public health to follow through on other areas.

Terrorism provides an opportunity for heightened awareness about public health; this is a tremendous opportunity for all of you to educate the public that terrorism is not all there is to public health. We have maternal and child health. We have chronic disease issues to address. We have hunger issues to address. It's a platform from which I think we can really take advantage of the current media attention to springboard onto educating the public that public health is not just about terrorism.

Aging

The second challenge is aging. This is my mother. My mother is 91 this year. Until the last three months or so she was healthy. She had no major illnesses except high blood pressure. She was active, independent. She shopped on the city bus. The city bus was her personal limo and she went everywhere with it. She had a large vegetable garden and flower garden that she grew for everybody around her. When I first started giving this talk across the country she was still living that way. Now she's in an assisted living facility. But my view in putting her in my talk is to say I think all American elders, should be as healthy and active as my mother until they are in their 90's. America is aging and today's Baby Boomers will be tomorrow's elder boomers. In sheer numbers it will overwhelm an unprepared society and healthcare system.

The percent of 65 and older will rise from 12% to 19% of the U.S. population by the year 2030. This aging trend is mirrored in many countries around the world. So it's not just an American problem; it's a global trend. On the whole, older adults are healthier and they're living longer today.

Life expectancy has increased from 47 years in 1900 to 76.6 years in 1998. Americans 85 and older are the fastest growing segment of our society, and by the year 2050 they are projected to number 18.2 million. In 1990, just a decade ago, they only numbered 3 million. As you can see from this slide, the per capita healthcare cost rises with age reaching 14 to 16 thousand dollars a year by the age 75 to 79 years. With the growing number of elderly, it doesn't take a mathematician to predict that healthcare will be a major economic burden on the United States. An estimated 400 to 500 billion dollars has been projected for elder care in future years.

So what are the implications of our elder boom? I've already mentioned the escalation in healthcare costs. I'm talking here about chronic care costs, end-of-life care costs, expensive high-tech treatments at end of life. I'm talking about the availability of facilities and services, because one thing that helps to contain costs is to keep our elders as independent and living on their own as possible. But they need support to do that. So is there adequate transportation support, house-cleaning support, meals like Meals On Wheels programs, cooking support, adult daycare? Is there availability and adequacy in terms of the healthcare workforce? It doesn't matter what state or what city I'm in, a newspaper article usually pops up that is relevant to the elderly issues. Everywhere I go there are great concerns about nursing shortages, nursing home aide shortages and high turnover. Do we have an adequate workforce? What are the issues related to quality of care? Because I do travel a lot now, often times in my hotel room I'm watching a lot more TV, and you see ads for nursing home abuse hotlines, which is something in our country that shouldn't happen. You're seeing issues now related to the interests in issuing quality indicators for nursing homes. Disabilities and dependency is another area. If we don't address these issues we will have greater dependency on family, on friends and we don't have a society prepared to deal with it.

The sandwich society is another issue that's very relevant today. People are trying to raise young children and trying to care for elder grandparents and elder parents. So they don't know what to do. They don't know what to expect. They don't know how to deal with the stress and the expense. At CDC for example, at the same time we have a room set aside for breastfeeding moms, we also have classes on elder care. That's a trend that I think you'll see throughout the country in the workplace. People will ask for time off to take care of elder parents in the same way they ask for time off to take care of sick children. In this country, we are fixated on staying young and the aging of America will have a profound affect on this nation and around the world. So what is the role of public health, and what is the role of public health nutritionists? And will we be prepared as a society?

Chronic Disease Prevention and Control

This leads me to our next challenge of chronic disease prevention control. This is the picture of what I would like to see as the future of the elders in America. They're healthy. They're happy. They're active. They're engaged. And they're living life to the fullest. If we're going to help achieve a population of healthy elders, we basically need to address issues related to chronic disease prevention and control and healthy lifestyles, specifically nutrition and physical activity. Unless we begin with adults and kids to promote healthy lifestyles, we will not have healthy elders.

In the U.S. 54% of deaths are due to cancer and heart disease. This year alone 1.1million

Americans will have a heart attack. This year alone 600,000 Americans will have a stroke. Every hour cardiovascular disease kills more than 100 Americans and every minute someone in the United States has a stroke. Many excess deaths due to chronic disease are preventable, as you all know. In addition, consider the compromised quality of life among those living with a chronic health condition. Tom Pitts, an endocrinologist I worked with in diabetes, said that from his many years of work with people with diabetes that he really doesn't believe that people fear dying from diabetes or related conditions. What they fear is becoming disabled and becoming dependent on family or friends where they can't do anything by themselves because they're blind or they are in a wheelchair. So diabetes I think is a great example of what I'm talking about. If not controlled, diabetes can have devastating consequences including, as I mentioned, blindness, amputation and kidney failure. A worrisome trend is that diabetes trends in this country are rising and rising sharply, as you can see from this chart. Worse yet, the obesity trends among adults in this country are rising in the same way. Their graphs parallel one another. Diabetes is an enormously expensive disease costing the U.S. 100 billion in direct and indirect expenditures annually. And yet it was only last year that the American Dietetic Association and other advocates were able to successfully convince the Health Care Financing Administration to reimburse for medical nutrition therapy. The two things that they need the most – dieticians and nutritionists to guide food eating relative to diabetes and diabetes educators – were not reimbursed. It was appalling. And it was a big uphill battle to get medical nutrition therapy covered.

McGinnis and Faghey reported over a decade ago that three factors are the underlying causes of cardiovascular disease in this country. That includes tobacco, poor diet or lack of exercise. However, the aging of America and goal of healthy elders is not the only reason to invest in the health of adults and kids. The poor health of many American children is in itself alarming.

Overweight and obese children are an epidemic and the trends are not encouraging. Today, minority teens who are obese are presenting with Type II diabetes, an adult onset disease. This disease doesn't usually show up until you're in your late 40's or 50's, but teenagers are presenting with it in their physicians' offices. When I was doing diabetes, the public health and diabetes communities were scrambling to try to define the problem and to characterize it and what to do about it. A particular alarm is that when you get diabetes as a child it means that you are going to be living with the disease longer. You'll likely develop the complications of diabetes much younger in adulthood. So imagine developing blindness or getting amputations when you're in your late 20's or early 30's. Poor nutrition and physical inactivity are at the root of the problem. I'll never forget the time at CDC when we brought in a number of pediatric endocrinologists who examined the trends and issues. When I asked questions about what they did about it, they didn't know. What they did is give children drugs that were not even tested for kids. These were adult drugs. They saw them in their offices, they sent them home, they came back six months later for a checkup, but nothing happened in between. This is the place where nutrition plays a critical role in promoting healthy eating and physical activity.

Unhealthy eating and physical inactivity are enormously difficult behaviors to change, and environmental influence doesn't help.

Just look at the fast food restaurants at every street corner, take-out foods in supermarkets, snack foods at gas stations, and more often than not, as you know, these foods are high in calorie, high in fat and high in salt and at the same time we're a society of couch potatoes glued to televisions, VCRs and computers. So what do we need to do in the area of nutrition? What's really exciting about talking to all of you is that there has been so much spotlight on nutrition that the doors of opportunity are opening and it's up to us to do something about it and take action. Capitalize on the recent media buzz. For one thing, in the last couple of years, there were more studies being released on how many people are obese in this country, and the trends are going up, up and up. I guess I, like anyone else, love epidemiology and having numbers and science to support the fact that there is a problem. But what's beginning to really bother me is we get numbers, but we're not doing enough strategically as a nation about fixing the problem. We need to turn our attention to doing that.

There is also more media buzz about alarming trends in obese children. Everywhere I go I see news stories and what local communities are trying to do to grapple with the problem. There are two new books I know you're real familiar with that I love. One is *Fast Food Nation* by Eric Schlosser. The other one is *Food Politics* with Marion Nestle. I really like the fact that these two books and the issues they raise are initiating debates across the country about this problem. Because until we as a country recognize that there is a problem and what that problem is and that we don't like it, then nothing is going to happen. So more than anything I love these two books for its accomplishments in those areas.

There has been recent news coverage about portion size increase and some underlying societal challenges. The first is that is in this country we don't save money and we live on borrowed dollars and credit card debts so we can enjoy the pleasures of today. In the same way we're living dangerously to enjoy the immediate pleasures of eating that apple pie or enjoying the sedentary living that we have of watching a TV show. And we are also surrounded by opportunities to eat that tempt our temptation to limit consumption. So there is a big disconnect between what we do now and how it affects future life. I do believe that people in this country have heard the words if you continue to gain weight, if you continue to eat this you'll have a heart attack tomorrow. But somehow there is a missing passion component that motivates them to act.

Pharmaceutical companies are investing heavily in doing research and development on finding that magic pill because they surely know that there is a huge market for it if they can find the magic pill that can help people to lose weight and at the same time is a safe product. They know they're going to be billionaires and they're gambling on investing in the research to develop that product. We're a society that relies on cosmetic fixes, you know, "It's okay if I gain a few pounds and get a love handle. I'll just go get liposuction and I'll be in good shape again." Those are all false. It doesn't change the fact that the way people eat and the lack of physical activity is contributing to their long-term health condition. But we do need to address all of these issues as we begin to address the issue of obesity.

There are also environmental realities that nutritionists need to pay attention to. Number one is the demand for convenience foods because more women are working. We're not at home cooking any more. We

live in a technology-paced society. Everything is about how fast you can get it done and how many more things can you get done in the same amount of time. So that has led to consumer demands for convenience. And the trend in Atlanta is nearly every grocery store now has prepackaged take-out food. I'm one of the consumers of them, except I select better. But the point being, it's a choice. They're choosing a fast-paced life, and they're choosing to cut back on things that took time that they don't have time to do any more. There are also advances in food technology and production that's made a difference on all the new foods available in the market place. And probably most important is we live in a democracy and we live in the free enterprise system. What that basically means is entrepreneurs are encouraged to be creative and design products and services that the public wants.

Essentially, what the food industry is doing, the restaurant industry and so on, grocery industry, is they're meeting the demands. There is a demand. They're going to supply it. At the same time they want to make a profit. They want a greater market share. So they're influencing demand through advertising and through their marketing type practices. Many times I think the public isn't totally aware of the influence of this advertising. I was talking to the manager of the assisted living facility that my mother is in right now. He was talking about how drug costs are enormously expensive, and one of the problems is because the pharmaceutical industry has been marketing drugs direct to consumers. So they have patients going in and saying, "I have symptoms A, B and C. I want Zantac." Or "I want Allegra" or whatever. And rather than fight them on the issue, they just prescribe it. So when you look at the sales of certain pharmaceutical products, directly as a result of direct consumer advertising, the use of those products and prescriptions of them have skyrocketed.

So we do need to address these realities if we're going to try to address the problem. And then recent debates in solutions I think are interesting. I've been listening to a number of radio debates about it as well as some of the e-mails going back and forth. Sin Tax is the strategy of taxing fast foods, snack food, and soda. California recently introduced Senate Bill 1520 to put a tax on soda, and then having the revenues from those taxes be reverted back to support school programs, nutrition and physical activity intervention programs. There is evidence to show that when there are taxes on certain products it prices the product high enough where people do cut back on their consumption. This has been demonstrated with tobacco and alcohol. In the California case, what was particularly good is the revenues were being redirected back into intervention programs for kids.

Class action lawsuits are something else that's being debated out there by a lot of advocate type groups. The idea being that we have successfully sued the tobacco industry. Well gee, how about suing fast food industry, snack food industry, soda industry. But I think there is much less agreement on whether that's a good idea or not, partly because of the issue that where as only a quarter of this country smoked for example, everybody eats. So there are very tough issues. The most important issue that these raise is the use of regulatory approaches to eating. You're going to set rules and have taxes to regulate or to control or to contain what people eat. But there is no change in consumer passion about wanting to eat healthy. There is nothing changed about their knowledge level and their skills to enable a healthy lifestyle. So even if we move towards lawsuits and taxation as

strategies to address the issue, we still need to address the issue of nutrition education, health education, physical activity and so on. Public health nutritionists I think must help and find a way to effectively empower people with the passion, the knowledge, the skills and the environmental support needed to willingly choose healthy eating and engage in regular physical activity.

Health Disparities

A fifth issue of, a priority for me, is racial ethnic health disparities. Racial ethnic health disparities are a pervasive problem like obesity. Disparities raise healthcare costs and compromise quality of life. Minorities experience a greater disease burden for many health conditions. It doesn't really matter what health condition you're talking about. For the most part they have higher prevalence, more serious treatment outcomes and more deaths. Contributing factors include less access, less quality and culturally and linguistically inappropriate care. To be effective in public health and public health nutrition, we need to have culturally and language appropriate messages, materials and strategies. In diabetes we did a lot of focus groups with different minority populations asking them about their diabetes, how they controlled it and so on. Over and over again we heard that what was being presented to them was not culturally appropriate. For example, when someone was diagnosed with diabetes, they would see a dietitian at the instruction of their doctor, but they're given an American diet to follow. They don't eat toast or drink orange juice. So they don't know how to translate it into their foods of their own culture.

There are generational considerations. We forget that just because someone has been in this country a long time, it doesn't mean that they're necessarily acculturated. So the idea of social marketing approaches and really knowing the consumer and adapting intervention to their needs is something that we need to do a better job of including in the area of nutrition.

We need culturally competent and diverse healthcare workforce. Ideally in the future we will have a healthcare workforce that mirrors the population that we're serving. We all know that in America we are becoming a much more diverse country. We need ethnically friendly healthcare settings, especially when you think about people who come from other countries, and in particular recent immigrants, because everything is foreign to them, everything is scary to them. We need to make the environment where we work and provide WIC services and nutrition services welcoming and friendly to them. We need to have more community empowerment and partnerships so that if you don't have someone on staff that speaks Vietnamese, perhaps someone in the community does.

We need more racial and ethnic disparities research to better understand not just the problem, but what to do about it. There are two reports that came out in March that I think are really important, and they happened to come out the same month. One of them is the Institute of Medicine report confronting racial and ethnic disparities in healthcare. The Institute of Medicine brought an expert group together and they reviewed over 100 studies of people that were insured and different ethnic populations. It wasn't surprising to hear about cultural disparities due to language barriers, but what was really surprising was the pervasiveness of the disparities in treatment across many health conditions. So when you have people with equal income and you have people with equal insurance coverage, minorities received fewer

diagnostic tests. They received less sophisticated treatments. They were more likely to receive inadequate or inappropriate medications. When they interviewed some of the providers they found classic negative stereotyping of minorities that affected treatment decisions. That's not acceptable.

The Commonwealth Fund 2001 health quality survey called *Diverse Communities Common Concerns: Assessing Healthcare Quality for Minority Americans* was completed the end of last year. In a survey of minority populations they kept hearing very common themes in the responses. Patients generally feel disrespected by providers and believe that if they were white they'd get better care. When it came to chronic diseases, the minority populations' care was compared to majority populations; chronic diseases were poorly assessed and poorly monitored. Again, that is inappropriate in this country. Quality care should be provided based on standards of care, regardless of who the individual is. We as nutritionists also need to raise awareness that these biases exist, but we also need to ensure that standards of care, including have inclusion of appropriate nutrition services.

Universal Healthcare

Universal healthcare is another area that is particularly important. When I first became involved in APHA National a decade ago, healthcare reform was headline news with Hillary Clinton involved and leading the way. You all know that this failed politically, and then came along managed care. What struck me about that time is public health was not ready for those trends and public health panicked because we feared the loss of Medicaid revenues to managed care. All over the country organizations were writing primers on managed care. What is managed care? What does it mean to public health? Everywhere I went there were conferences and workshops on managed care. Again, what concerned me was public health didn't have a clue, and I was among them. We're all part of the bigger healthcare system, although our specialty is in public health, and we didn't have a clue what managed care was, what it meant for public health in terms of if that trend continues how it would affect our services and the people that we serve. In the long run managed care failed to gain public trust. They failed to gain trust in terms of access to care, in terms of quality of care and in terms of choice. All of that controversy is really what led to congress looking at issues like patient bill of rights to ensure access to the care that they need. And again, we shouldn't have to deal with that in this country.

Managed care also failed to contain healthcare costs. So healthcare costs leveled off for a few years, but now healthcare cost is rising again at double-digit rates. The costs are rising dramatically and it's got the attention of everyone. And that's another topic that I find in the news everywhere I go. Because in this country what we have for the most part is we have an employer-based healthcare system. When healthcare cost goes up, employers are the ones that have to pay for it. Or if you are in a government supported healthcare program, the government supports it. Cost drives decisions and costs are consistently going up. So you also have the aging challenge. As the population gets older they're going to be sicker and they're going to need more healthcare, and that drives up cost. So it's not unusual to hear that HMOs in a particular city are dropping their Medicare managed care because of high cost and lack of reimbursement from the federal government through Medicare. It's not unusual any more to hear about pharmacies that are threatening the same because of the

inadequate coverage of drugs that are prescribed to elderly populations. The system keeps changing quickly trying to keep up and trying different experiments to see what's going to contain healthcare costs. But we're already seeing things such as higher employee premiums, deductibles and co-pays. Even the federal government employees, who probably have the most generous selection to choose from, are experiencing it in the last go around when we chose our health insurance in November. We experience higher premiums, higher deductibles, higher co-pay as well as less services in the benefits packages that were offered. Employer defined contributions is something similar to managed care. That's the biggest new hot trend in insuring America's population, but the idea behind it is that employers would define a dollar amount that they'll pay for their employees' health insurance. So let's say if I as a single person would get $5,000 a year, they'll give me my $5,000 and I get to do whatever I want with it. I buy my own insurance. Or if I were a family it might be $6,000. But the point being that they define up front how much they are going to pay, and they're not going to pay a dime more than that. Employers are getting out of the business, or there is a trend towards getting out of the business of investigating all the various plans and plan options, and giving the best plan options to the employee to choose from. They're saying, "Here is the money. You go figure it out." My understanding of the trend is that that's becoming more and more popular. But there are great concerns I think relative to public health. One is what is the affordability, because at least when your employer buys for a group of employees, be it 500 employees or 1,000 or 2,000, you have the option of using the leveraging of buying access for that many people to bring costs down and to bargain for greater benefits, a richer benefits package. But if people are out there buying their own insurance, what does it mean.

The second issue is eligibility relative to pre-existing conditions. If you had a pre-existing condition, and your employer moves to a defined contribution approach to providing care, will anyone even sell you insurance if you have poor medical history? There is nothing to stop the companies from offering fewer services for the same price or for a higher price. I might add that managed care has actually been good for prevention because preventative services was given a higher priority within managed care, although it's still inadequate.

Consumer driven Internet marketing of health plans is another trend. It is not unusual to go onto the Internet, look up any insurance company and see thousands of health plans and what each of them costs. I consider myself a relatively educated person, but I don't understand any of it. It's like reading legal documents. Health plan options are not presented in the same way. So even if it's the same plan, same benefits package by two different companies, you'd never know it because the way they write it up is so different. So there needs to be a lot more done in terms of consumer literacy relative to the whole issue of insurance/insurance coverage.

Nutritionists have an opportunity to talk to consumers about the importance of prevention and the importance of buying coverage for nutrition services when they buy their benefits package. There is also the concern of young healthy employees because when you're young you feel invincible. You think you'll never be sick. So what's to stop them from pocketing the money and not even buying health insurance, and then find that they need it? One of the reasons we're able to contain

healthcare costs is the limited use of insurance by young, healthy employees offset by the higher use by older, sicker employees. Then obviously I can't go without mentioning that in a country as rich as ours we really need to have basic care for everyone, and we don't. This has actually become a greater issue, even for employers and other groups, because in the recent economic downturn there has been more people laid off, more people unemployed, and more people uninsured. And then the COBRA insurance doesn't last long enough.

So there are two things happening that are really worth noting. The Robert Wood Johnson Foundation has launched an initiative called Covering America's Uninsured Campaign. You may have seen these ads in magazines and TV. But basically what's happening here is people that don't have insurance, they basically don't go and get healthcare and they end up in emergency rooms where by that point in time their healthcare cost is skyrocketing. These costs are being passed off to employers through higher rates for employees that are insured. So employers are a part of the coalition with Robert Wood Johnson. They're very concerned that higher emergency room costs translate into higher hospital costs, higher costs for them and for their employees.

Another unusual member of this coalition are unions. When unions are bargaining for their employees they want to bargain for higher salaries and higher benefits. They don't want to be arguing over healthcare. So if the cost of healthcare is skyrocketing, employers are certainly going to play the game of saying, "Well, I'll increase the defined contribution to $6,000 for a single, but there will be no salary increase for the next five years." They don't want to hear that. So they have joined the coalition as well as many other organizations that normally are not partners.

The Institute of Medicine also has a new initiative studying the uninsured. Over the next two years they will issue six reports on the uninsured in America, trying to characterize the problem, why it's happening and what to do about it. They have already issued their first report. So both of these efforts are very much worth noting, worth supporting and worth getting involved with.

So what is the role for nutritionists in this arena? I think that we have a great responsibility to raise awareness about access concerns, not just to nutrition services, but access to health services in general. We need to be relentless advocates for improved access. We need to insure the inclusion of nutrition and care standards and protocols and in benefits packages that are offered through managed care and insurance companies, because if it's in the required standards of care it will more likely happen. We also need to educate policy makers and consumers on the importance of prevention and nutrition services, specifically when it comes to making sure it's covered in the insurance plans that they have, because if they don't check off the box that they want to have prevention services covered then it won't be paid for. If it's not paid for, you won't be doing it.

Finally, we need to advocate for reimbursement of nutrition and dietary services, and dietary support. I already mentioned the challenge in diabetes where nutritionists and diabetes educators are probably two of the most important people to a person with diabetes. And yet, those are the services that are not reimbursed. So through recent changes, there is reimbursement for medical nutrition therapy

for dieticians. There is still no reimbursement for diabetes educators, which is pretty appalling. We need to stand together with our other disciplines in this advocacy for reimbursement. But most important I think for a nutritionist is that we have the opportunity to reframe the healthcare cost containment story. The bottom line is prevention is an untapped health cost control strategy. We need to start reframing that argument so that instead of cutting services and cutting access to physicians and so forth, why not try prevention as one way of containing healthcare costs.

Successful Strategies for Nutritionists

So I'd like to end my talk by just touching on a few success strategies that I think are important for nutritionists. As a discipline, we need to think big. We're so used to thinking small. In my current job, the youth media campaign has a year one budget of 125 million, a year two budget of 68.4 and hopefully the year three budget will go back up to 125. When I worked in the breast and cervical cancer early detection program we started with 50 million. By the time I left four years later we had approximately 125 million. Now the program is funded up to 200 million. So the bottom line being having money is a little better than not. But more money means more accountability. So I think you have to think big. I think we're so used to thinking small that if we go after a 25,000 grant, it will buy us a lot. It doesn't. So why not get together, strategize and go somewhere, a foundation, the government or wherever and ask for a million dollars, two million dollars. But we've got to start thinking bigger than we do right now.

I think the second thing is that we have to be creative. I already said that one thing that bothers me is seeing all these words about how to eat right and how to exercise. Quite honestly, I don't read any of those articles; I just look at the titles. I ask you guys, every one of you, how often you've read the latest article you've seen on "Follow these tips for healthy eating." We have all these words out there, but something is missing. I think we need to be extra creative in trying to figure out how to tap into the passion that people need to have in order to care enough to act on the suggestions that are in those words, because words are not doing it. We need to sit up and pay attention to the fact that words alone are not doing it.

And finally, I think we need to be strategic. There's a right time to do something. There's the right people to work with. There is the right approach. So for whatever issue in nutrition you're working with, it's really important for us to be strategic. Often times being strategic means helping the other person in their cause in order to benefit your own cause.

So, I think nutritionists really have great opportunity to lead the way to raising awareness, lead the way in strategic intervention, strategic partnerships and effective execution. By strategic partnerships I also mean don't just talk to people like yourself because there are so many people out there who care about nutrition or who are already working in nutrition. Why not work with them? They bring new perspective. When I was in diabetes we had an advisory group in the strategic, steering committee. But on that steering committee we fought hard to get a mix of people because original steering committees were all white male physicians. So ultimately we ended up redoing the steering committee to include minority representation, managed care, business and all kinds of advocacy and services at the community level. Tim McDonald from

General Motors is wonderful. In the beginning days there was issue of, "Gee, what about diabetes standards?" He as an employer person was saying, "I need to know what the standards of care for diabetes are so then when I go and buy health plans for my employees at General Motors, then I know that these services are covered." And then these diabetes organizations were kind of like snipping at each other. I won't name them, but, "I've done standards. My standards are better than your standards." You know, he just kind of slammed his hand on the table and said, "You're telling me you're the experts in this country and you can't agree on standards?" But what he really was pointing out was there is agreement on standards but organizations just can't agree on sharing credit. Through partnerships I've come to really welcome people with different viewpoints. So I would encourage nutritionists to not just talk to nutritionists; talk to all kinds of people out there because they will have an opinion. And if you're going to sell prevention to employers as an investment for cost containment, you have to go out there and talk to employers. If you talk to yourselves and come up with a plan and say, "Here is a great report," it's not going to work because you've got to understand the world from their perspective and then package what you want in their perspective.

I think the other thing is to take risks and bear the heat. As I mentioned, one thing I love about Marion Nestle's book is the controversy she's put out there for discussion about the food industry and the role the food industry in, perhaps contributing in a major way to obesity in this country. By taking the risk of writing the book and having the food industry mad at her, she's raised a debate that's very important. Whether you agree with the specifics or not, she raised the debate that I think is very important. Quite honestly, nothing is done unless someone takes risks. That goes for everyone from surgeon generals to all of you in your day-to-day jobs. Success strategy is important too. Everybody loves a winner, and from the very beginning of working with Anita Owens back, just a couple of years ago, she was always focused on outcomes and the importance of writing objectives, measuring progress and holding yourself accountable. So no matter what you do, set some measurable goals and aim for it. There are a lot of distractions in this world, and it's okay to get distracted here and there, but you should never veer off the main course of achieving your objectives.

Just as an example, one of the first assignments I had in Arizona was to develop computerized data system for surveillance. She wanted to be able to computerize dietary data. So she asked Marissa White at the time, she's Marissa Miller now, to develop a system that could do dietary assessment and then code it in the computer system. Marissa and I worked for weeks on it. We just couldn't figure out how it would work. So one thing you don't do is you don't go to Anita and tell her it didn't work, but we did. Anita sent us back to the drawing board. So Anita, last night when I was referring to I bet you didn't know what Marissa and I were doing over 4th of July weekend in 1974. That's what we were doing. We were sitting on the floor, on the coffee table, it was hot in Phoenix. But we came up with a system called Standard Measuring Units. I have no idea if it's still being used, but there was a really good logic to it that worked for a while. The bottom line being that there is probably some way to get it done if you tried hard enough or were creative enough. It's really important to measure cost effectiveness. The issue here being that when I first started working in

managed care when I was in breast and cervical cancer, every person I met in managed care talked about the issue of what's the return on investment. Tell me what's effective. What evidence is there that this is effective? If you can provide them with evidence that it was effective, they'll listen. If you didn't, they wouldn't listen. So they wanted to know are mammography's effective? What proof do you have that it's effective. When I talked to Tim McDonald at General Motors, the whole issue is what is the return on investment if I as an employer in General Motors started paying for services X, Y and Z and paid $100,000 for it? What is my return for my investment? And General Motors I might add was particularly interested in serving on our steering committee at the time and being very engaged in helping us to develop a document on the business approach to diabetes and the work site diabetes kit that was just launched. It's because they have a huge employee base that are aging employees. So they have a huge retirement population of employees that they still provide health services for and they have a huge aging population of employees that it's in their benefit to make sure that the best preventive care is available in order to help contain costs. But most companies haven't gotten that message yet. We need to brag about successes and do it in their language. What I mean by that is when something works, tell somebody about it. But don't tell them in your language. Who is your audience? Who are you talking to? Package it in a language that they understand and they would value. Otherwise, they won't remember it. Another category I think of success that's really important is having the freedom to make a real difference. One thing I mean by this is don't get pigeonholed in just one program area or one activity area. What I find with a lot of nutritionists is they pigeonhole themselves and then eventually everybody around them pigeonholes them because nobody thinks you can do anything else but X. So when it comes to new challenges that surface in public health or bio-terrorism or whatever, we are the last they think about. I got an e-mail from Bob Gold, who I think Anita knows, who used to be in Detroit. He was asking my help in helping them find a bio-terrorism coordinator for a county in Michigan that he's now the assistant health officer for. I read the duties and I said, "Gee, a nutritionist could do this," because it required assessment skills, planning skills, communication skills, partnership skills. The only thing that changes is the subject matter. And I will tell you from jumping from career to career that subject matter comes if you have the skills there. So don't get pigeon holed in doing just one thing or only looking at things from one view. I think another great example is Margie Tate. She's been so successful in Arizona she's been asked to take on diabetes and chronic diseases, but that's because she's shown that she's effective and she didn't say no. You know, don't be the person that limits. I mean let somebody else say you can't, but don't be the one that says it to yourself. Actually, don't let somebody else say it either. But you've got to get rid of negative talk. "Oh, I can't do that," or "I've never done that before," or "I'm not comfortable taking the lead" or whatever because what I have found over my years is nutritionists have some of the most broad based skills that can be applied to any arena. And it's just a matter of saying, "Hmm, that sounds interesting. Let me give it a try." Because if you have the basic planning, basic assessment, basic communication and partnering and leadership skills, you can probably do it and learn the subject matter along the way. I also think it's real important to reach outside your daily comfort zone because we get so pigeonholed

in doing our day-to-day work that we forget there is a broader world of public health out there and that we need to be supporting some of the environmental causes or the tobacco causes or whatever. But that's all part of public health too and we're part of a public health world. So it's also where if you reach out and help other people with their causes, they'll probably more than likely come back and help you with your causes. But you can't knock on peoples' door when you want something. You have to knock on their door to offer at the same time. And then at the same time that you're reaching out and not being pigeonholed and you're talking to all kinds of people and you're working with all kinds of people we also need to recognize that we as a nutrition community need to stand together as well. I love this phrasing, "United we stand. Divided we fall." Because within nutrition you have all kinds of segments and specialty areas. If we cared only about our own little specialty area and not other areas in nutrition, then as a profession and as an area of public health that needs attention, we will be weak. And we can't do that. So in summary then, I would say that public health nutrition in the 21st Century, one of the important things to do is to look at the trends out there and to say, "How does nutrition fit? How does it affect nutrition?" as opposed to saying, "I'm in nutrition. Let me see what's happening relative to nutrition." You know, start with the big picture and then figure out where you fit as opposed to the other way around. But there are definitely many challenges and there are definitely many untapped opportunities. I would like to invite you to just increase the voice and influence of public health, specifically public health nutritionists by joining APHA and getting involved with the food and nutrition section. The section in the last several years has particularly become more active in the association. Last year they put forward several resolutions that were passed in the nutrition arena, including one on childhood obesity. Cheryl Lee has been working on an action fund through the action board that outlines what APHA should be doing in the obesity area. But it's when we all come together and work together on common causes, no matter what our specialty area is, that I think we're going to get ahead. So with that I conclude. Thank you very much.