WHAT DIFFERENCE DOES EFFECTIVE POLICY MAKE?

AUGUST 2015

Comparing health outcomes to situations *with* and *without* public policy

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THE HEALTH POLICY RESEARCH CONSORTIUM

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Policy can be defined in a number of different ways. For the purposes of this discussion we will use this definition from The Free Online Dictionary – *"a plan or course of action, as of a government, political party, or business, intended to influence and determine decisions, actions, and other matters"*. We are specifically interested in policies that impact the health of Prince George's County residents, whether adopted by the county, the state, or the private sector. Two windows of opportunity to affect health change – one taken, the other lost – are instructive here.

Policy Outcome Lessons from Maryland's Tobacco Use Prevention Efforts

The most effective policies are usually measurable, and data about the effectiveness of a given policy can convey not just how well it worked, but why it worked. Tobacco use prevention in Maryland is one such example. The Division of Environmental Health in the County's Health Department enforces the Maryland Clean Indoor Air Act (CIAA) of 2007, which prohibits smoking in virtually all indoor workplaces. The adoption of this ban overlapped with an increase in the cigarette tax, so the improved health outcomes (or lack thereof) for Marylanders could be attributed to the implementation of either or both policies.

In 2007, when CIAA was adopted, an estimated 41.9% of Maryland adults said they had smoked cigarettes at some point in their lives, and about 58.1% were former smokers[1]. By 2010, those numbers were 39% and 61% respectively[2].

As well, the number of Maryland youth who were taught, in school, about the dangers of tobacco use increased between 2006 and 2010. In 2006, 67.5% of Marylanders attending middle school were exposed to such instruction, and by 2010 that number had increased to 74.7%. Similarly, 44.9% of high school students were exposed to such instruction in 2006, and by 2010 that number had increased to 52%[3].

Compliance with the indoor smoking ban required by CIAA was also impressive. By 2008, compliance among all Maryland adults was measured at 94.6%[4].

In 2011 Prince George's County Health Department estimated the number of adult smokers in the County at 16.9%[5], up from 13.4% in 2010. *(Cigarette smoking among adults in Prince George's County was estimated at 17.2%[6] in 2006, just before CIAA was adopted).*

This trend begs the obvious question – what caused the reversal of fortunes? Why did tobacco use rates, once in steady decline (from 17.2% in 2006 to 13.4% in 2010), begin to trend upward after 2010? Further, and more germane to this discussion - is there a policy explanation? One possible explanation could be survey revisions the state made in 2011, which may have affected the comparability of the numbers. Subsequent data (FY 2013 Biennial Tobacco Study, published in November 2014) show that 14.2%[7] of Prince George's County adults were cigarette smokers in 2012.

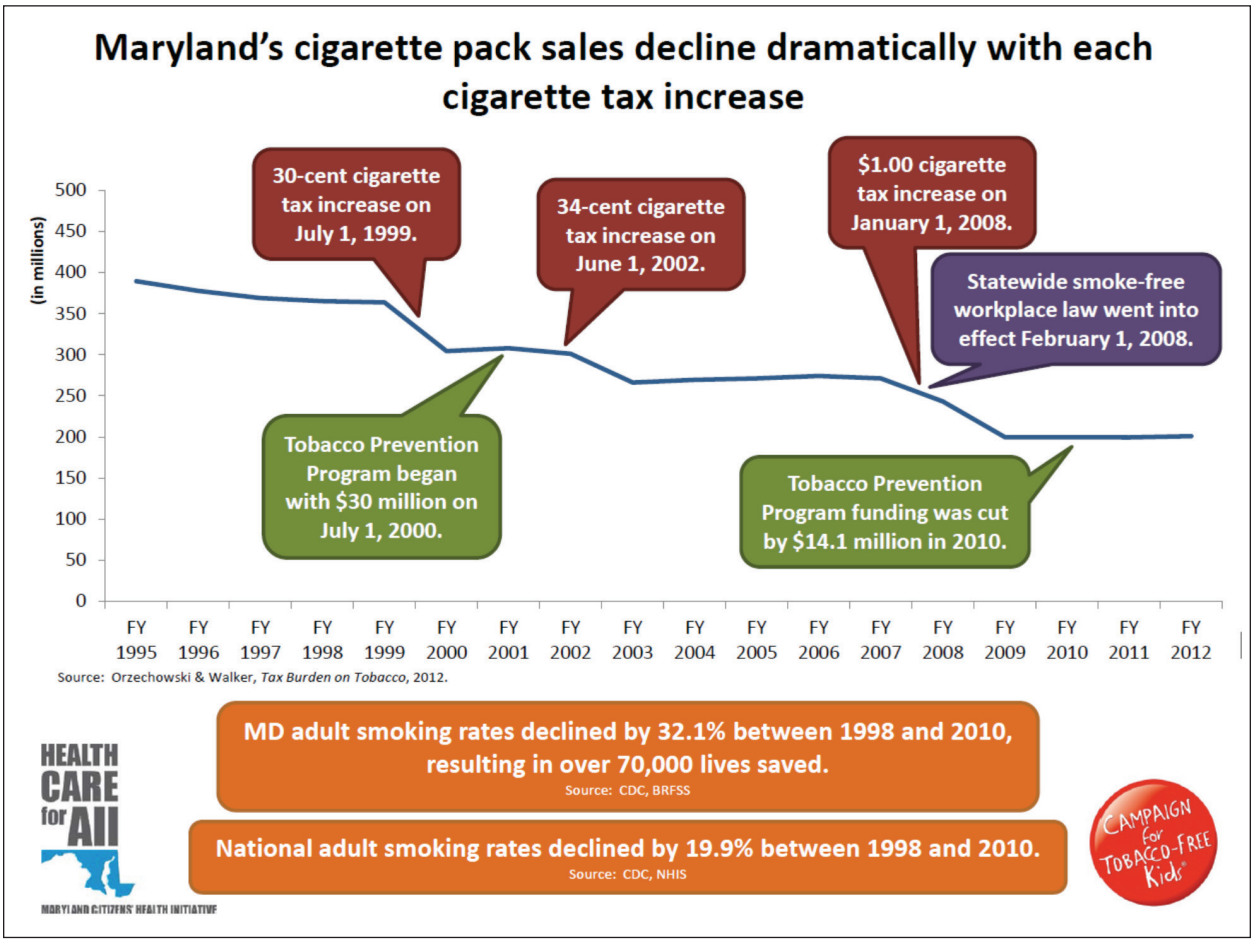
Upon enactment, CIAA appropriated significant funding for implementing the law statewide, including resources for education and awareness of the dangers of smoking, the hazards of secondhand smoke, and the enforcement of the indoor smoking ban. In policy circles, appropriations[8] are often tracked in parallel with implementation efforts. Did the funding situation for tobacco use prevention change in 2010? If so, how? And how did that impact policy and outcomes?

It so happens that the state's Tobacco Prevention Program funding was reduced[9] by $14.1 million in 2010, coinciding with the reversal described in the previous paragraph.

Correlation, as always, does not equal causation, but policymakers in Maryland were intent on implementing policies that worked, so they used multiple approaches. Even though education and outreach had proved successful, the legislature decided to levy per-pack taxes on cigarette sales, which seems to have had the desired effect each time it was implemented (see Figure 1).

Consequently, advocacy efforts are now underway to increase the state's cigarette tax by an extra dollar per pack, for a total of $3 per pack[10]. Advocates were confident that they could secure the votes to get this increase passed by the Maryland General Assembly in the 2015 session, but their efforts proved unsuccessful. Indications are they will try again next session.

Figure 1



Source: Maryland Citizens' Health Initiative

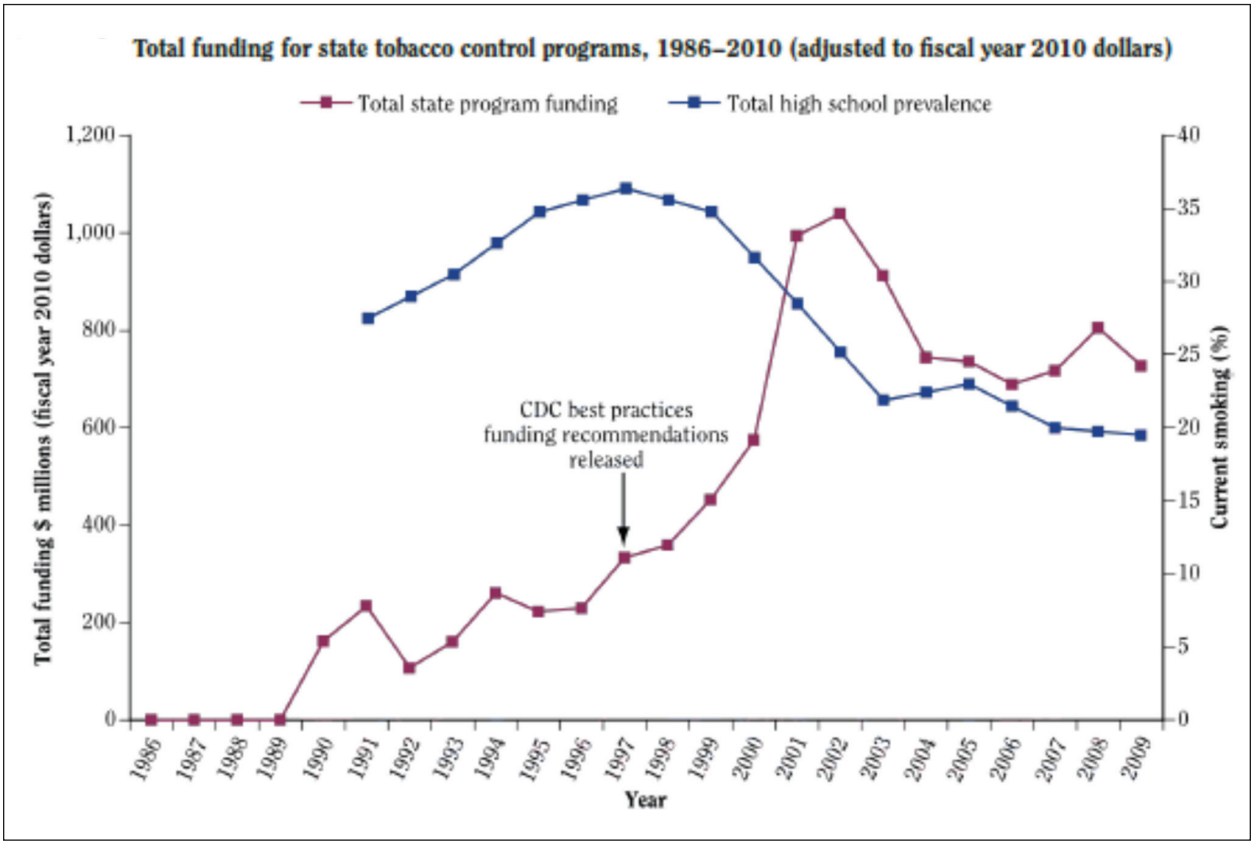
Following the consecutive cigarette tax increases in 1999, 2002, and 2008, there was a 32.1% decrease[11] in smoking rates in Maryland between 1998 and 2010, according to the Campaign for Tobacco Free Kids and the Maryland Citizens' Health Initiative (see Figure 1 below). Citing the Centers for Disease Control and Prevention (CDC), these two groups also report a 19.9% decrease in national adult smoking rates in the same time period, indicating that Maryland's success has significantly outpaced national progress on tobacco use prevention.

Figure 2 below illustrates the impact of increased funding across the nation for tobacco use prevention. As the funding increased, smoking rates among high school students decreased.

The health hazards of tobacco use are legion, and well-documented. According to the CDC[12], smoking harms nearly every organ of the human body, causing a variety of diseases. Quitting smoking, on the other hand, lowers the risk of developing smoking-related diseases, such as lung cancer and chronic obstructive pulmonary disease (COPD). Smoking can exacerbate asthma morbidity – it can trigger an attack or increase its severity.

In spite of all these dangers, robust public policy[13] has made a difference, leading to a drop in the prevalence of youth and adult smoking to less than half of what they were in 1964. Warnings printed on individual cigarette packs, data collection and surveillance, education and outreach, smoking cessation programs, research and public discourse about the hazards of secondhand smoke, indoor smoking bans, tobacco taxes, and regulation of tobacco by the U.S Food and Drug Administration (FDA), were all viable policy options deployed in various combinations over the last half century. Perhaps the most effective has been class action litigation against manufacturers on the grounds that they misled the public over several decades about the dangers of nicotine, not only regarding how toxic it is, but also with respect to how addictive. What is true nationally is also true at the state and local level, as the Maryland and Prince George's County data demonstrate.

Figure 2



Source: The Health Consequences of Smoking – 50 Years of Progress. A Report of the Surgeon General

The takeaway is clear – the presence of sensible policy can improve health outcomes if properly designed and dutifully enforced, especially if effective policies are implemented in tandem. The multiplier effect has a mutually reinforcing benefit for all populations affected – saving lives, reducing morbidity and enhancing quality of life, while saving money by reducing direct and indirect medical costs and improving economic productivity.

Policy Lessons from Prince George's County's Efforts to Reduce Obesity

Unfortunately, there are problems for which sound public policy is lacking, for a variety of reasons. The results may be equally as devastating if bad policies are adopted as if there is no policy at all. For certain, lost opportunities for policy responsiveness can have a deleterious effect on public health.

Prince George's County's food and nutrition policies are therefore worth examining in that light. Food insecurity remains a key contributor to the obesity crisis in the county, given all the food deserts and food swamps. What role does policy play in this crisis?

In collaboration with *Place Matters*, the County has *recently* created a Food Equity Council (FEC), which has just completed a study of food access[14] in the county. Their preliminary findings can be summarized as follows:

- Many residents cannot find nutritious food in their neighborhoods (food deserts);
- Food deserts are more prevalent in low income neighborhoods;
- Some places labelled food deserts by the USDA may not be food deserts;
- Most find healthy food at major supermarkets, and many find healthy food at farmers markets;
- Healthier foods are less affordable and less convenient;
- Many do not know how to prepare healthy foods;
- Unhealthy foods are a lot more convenient, and much more prevalent in low income areas (food swamps).

The FEC's research is ongoing, and they will attempt to understand the connection between good food and good health, the impact of school lunches, and the issues surrounding food insecurity in the county. They will also attempt to learn from the successes of other jurisdictions.

This should yield important insights, some of which will reinforce what we already know. The larger question is – what took the County this long? Are they facing any identifiable barriers to establishing good nutrition policy, and if so, is the county ready to overcome those barriers?

According to the Health Department's 2014 Health Report[15], 68.2% of the county's adult residents have a BMI of 25 or greater, with 30.2% of residents tipping the scales at a BMI of 30 or greater (2011 data). This is an unsustainable state of affairs, given obesity's role as a risk factor for multiple chronic diseases. Obesity puts people at increased risk of cardiovascular disease, diabetes, stroke, and cancer. Childhood obesity makes young people more prone to suffering chronic diseases for a lifetime, and the direct and indirect medical costs are massive.

Accordingly, the County has *recently* convened a Chronic Disease Work Group[16], the objectives of which are to increase the proportion of adults who are at a healthy weight, and to reduce the proportion of children and adolescents who are considered obese. Their strategies to achieve these objectives include increasing access to healthier foods, promoting physical and recreational activity, and increasing public awareness. This work group meets monthly, and is a sub-set of the Prince George's Healthcare Action Coalition (PGHAC)[17], which meets quarterly. PGHAC was created by the county to assist the Health Department in its implementation of the State Health Improvement Process (SHIP)[18].

According to the County's Health Improvement Plan for 2011-2014[19], the number of obese or overweight residents in the County increased by 13% from 1995-2007. By 1997, the County had the highest obesity rate in the state (69%). As previously mentioned, 68.2% of County residents were overweight or obese by 2011, indicating only a very small net decrease in obesity in the last decade and a half. Why is that? Is the

policy situation the same, or similar, with respect to childhood obesity?

In 2005, the Metropolitan Washington Council of Governments (COG) held a regional summit on childhood obesity. Their main finding was that the region lacked useful data on the subject. In 2008, COG released a survey[20] of the region's health and human services officers, which indicated that while Prince George's County exceeded USDA nutrition standards for breakfast and lunch in public schools, it did not collect student BMI data (a pilot program was underway in some elementary schools).

No jurisdictions in the region met the National Association of State Boards of Education standard of 150 minutes of physical education (PE) per week for elementary school students. In addition, Prince George's County had the lowest standard for number of semesters of PE required for high school graduation.

As a result of these findings the COG recommended taking steps to increase retail access to fresh foods in low income areas, and to encourage interaction between elected officials and their communities across all sectors to address youth obesity and its impact on academic performance.

But what happened regarding obesity-reduction policies in Prince George's County between 1997 and 2011?

The County Health Department's website has no archive of such policies within that time period.

Maryland's Department of Health and Mental Hygiene (DHMH) does have obesity information from this time period, ranging from obesity incidence and prevalence data to screening and treatment guidelines. The reasonable assumption would be that providers practicing in Prince George's County followed these guidelines, but there is no indication of a policy strategy as focused and comprehensive as proposals currently under consideration.

In summary, acting upon windows of opportunity for strategic policy implementation is more likely to yield optimal results, particularly in the face of a serious public health challenge. The decline in smoking rates in the county and state supports this assertion. On the other hand, obesity reduction in the county, hampered by policy delay, has not benefitted from the advantages of a responsive, far-sighted policy effort.

APPENDIX A

Tobacco Use in Maryland: Underage Youth Prevalence, Initiation and Cessation (p 75) http://crf.maryland.gov/pdf/HG13-1004-PHPA-Biennial-Tobacco-Study.pdf

Source: Maryland Department of health and Mental Hygiene

APPENDIX B

Tobacco Use in Maryland: Adult Prevalence, Initiation, and Cessation (p 127) http://crf.maryland.gov/pdf/HG13-1004-PHPA-Biennial-Tobacco-Study.pdf

Source: Maryland Department of Health and Mental Hygiene

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Research reported in this publication was supported by the National Institute on Minority Health and Health Disparities of the National Institutes of Health under award number 5U54MD00860802.

The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.