MPHA
Maine Public Health Association

Testimony of Maine Public Health Association In Support of:
LD 1693: An Act To Advance Health Equity, Improve the Well-being of All Maine People and Create a Health Trust

Joint Standing Committee on Health and Human Services
Room 209, Cross State Office Building
Wednesday, February 9, 2022

Good morning, Senator Claxton, Representative Meyer, and distinguished members of the Joint Standing Committee on Health and Human Services. My name is Rebecca Boulos. I am a resident of South Portland and executive director of Maine Public Health Association. MPHA strongly supports LD 1693: "LD 1693: An Act To Advance Health Equity, Improve the Well-being of All Maine People and Create a Health Trust."

MPHA is the state's oldest, largest, and most diverse association for public health professionals. We represent more than 550 individual members and 50 organizations across the state. The mission of MPHA is to improve and sustain the health and well-being of all people in Maine through health promotion, disease prevention, and the advancement of health equity. As a statewide nonprofit association, we advocate, act, and advise on critical public health challenges, aiming to improve the policies, systems, and environments that underlie health inequities – but which also have potential to improve health outcomes for all people in Maine. We are not tied to a national agenda, which means we are responsive to the needs of Maine's communities, and we take that responsibility seriously.

MPHA has a longstanding commitment to protecting and planning public health efforts in Maine, most notably focusing on the Fund for a Healthy Maine (FHM), the repository for the State's Tobacco Settlement monies. We support the 5 major components of this legislation:

1. **Adding Definitions to State Statute:** LD 1693 adds the following terms to state statute: "community health worker," "community resilience," "social determinants of health," "social group," "structural inequity," and "systemic racism."
2. **Protecting the Tobacco Settlement:** LD 1693 secures the tobacco settlement for Maine kids and communities by establishing the Trust for a Healthy Maine, assuring these funds are used as intended – to reduce tobacco addiction and improve the health of Maine youth and adults by funding health equity investments and Maine's state health plan (please see our testimony for LD 1523).
3. **Funding Tobacco Prevention and Control:** This bill ensures full funding for the state's tobacco prevention and control program at the level recommended by the US CDC, through establishing the Trust for a Healthy Maine. LD 1693 also reduces youth tobacco use by ending the sale of all flavored tobacco products and increasing Maine's cigarette excise tax by $2.00/pack (please see our testimonies for LD 1550 and LD 1423).
4. **Strengthening Public Health Infrastructure:** LD 1693 assures an annual investment in systems and infrastructure to improve health equity through the Trust for a Healthy Maine. It establishes baseline funding for public health districts' health improvement plans and establishes in statute an Office of Population Health Equity, including funding for the office's director and data collection and reporting.

5. **Funding Obesity Prevention:** LD 1693 funds a Maine CDC obesity care coordinator and provides funding for obesity prevention programming. It also aligns early care and K-12 nutrition and physical activity standards with national standards and establishes an Obesity Advisory Council to support Maine CDC obesity prevention programming.

I will provide more detail about our support for the obesity prevention provisions in this legislation below.

Obesity Prevention

Obesity is a complex, chronic, relapsing disease in which excess body fat leads to physiological impairments. The disease of obesity increases the risk of developing other chronic diseases and is associated with early mortality and reduced quality of life. Our weight status is determined by multiple, interacting factors, including our health behavior (e.g., diet, physical activity), genetics, environment, and psychosocial wellbeing. Underlying these macro-causes are inequitable access to nutritious, affordable foods, safe places to be physically active, disparities in access to health care which impacts maternal and child health, differential exposures to environmental correlates of obesity, such as PFAS, and chronic stress, which can increase abdominal obesity.

Obesity poses a serious threat to public health and productivity in Maine. According to the Behavioral Risk Factor Surveillance System (2020), 31% of adults in Maine had obesity, and 35% were classified as overweight; in other words, more than two-thirds of Maine adults are either overweight or obese.[1] According to the National Health and Nutrition Examination Survey (2018), 21% of Maine youth ages 12-19 years are obese.[2] Obesity increases the risk for many serious health conditions, including high blood pressure, type II diabetes, and depression. Here in Maine, the disease of obesity is a tremendous economic burden on families and businesses, with direct medical costs alone totaling $450 million every year. Today's generation may be the first to live shorter, less healthy lives than their parents.

Given these considerations, we are supportive of:

- Funding Maine CDC staff & programming: Currently, Maine CDC's obesity prevention programming is primarily done through Maine Prevention Services' contract with *Let's Go!*. We believe at least one full-time staff person in the state health department is needed, and funding for evidence-based prevention programming, education, and reporting is important for impacting population health. This staff member would be well-poised to work with the new Office of Population Health Equity, Permanent Commission on the Status of Racial, Indigenous and Tribal Populations, and other offices, commissions, and local organizations, to identify populations most impacted by obesity, and engage stakeholders to identify and develop strategies to address health inequities and reduce the prevalence of obesity.
- Early Care & K-12 physical activity and nutrition standards – the provisions in this section are well-aligned with the Bipartisan Policy Center's Food and Nutrition Security Task Force's recommendations to improve child nutrition programs (published January 27, 2022).
    - Data show that being physically active is important for healthy growth and development. Physical activity (PA) during childhood is associated with numerous physical and mental health benefits, including obesity prevention, and improved bone health, self-worth, and social engagement. According to the U.S. CDC, engaging in PA may help improve students' academic performance, such as academic achievement and grades, academic behavior (e.g., time on task), and other factors that influence academic achievement (e.g., concentration, memory, and attentiveness in the classroom).
    - According to the 2019 Maine Integrated Youth Health Survey, fewer than 50% of Maine high school students report being physical active for 60 minutes, 5 or more days per week. We see disparities by race, with White students reporting the greatest amount of time spent in PA and Black and Asian students reporting the least (45.0% vs. 33.9% vs 30.0%, respectively). We also see disparities by sexual orientation with heterosexual students reporting the most time spent in PA and gay/lesbian and bisexual students reporting less time (48.0% vs. 27.6% vs. 25.8%,

respectively). Transgender students report even less time spent in PA: 24.4% report being physically active for 60 minutes, 5 days or more per week.
    - We know that sedentary time, including screen-time, is an independent risk factor for obesity.
    - A national study of the school meals programs found that students who participated in the National School Breakfast and Lunch Programs consumed foods of higher nutritional quality than their non-participating peers.[3] More specifically, elementary and middle school students who participate in the National School Breakfast Program consume more fruits and vegetables, whole grains, dairy, fiber, and calcium per day, when compared to students who eat school breakfast less frequently.[4] Students who participate in the National School Lunch Program also have healthier dietary intakes than non-participating peers.[5]
- Obesity Advisory Council: This proposed Council is modeled after the Tobacco Prevention and Control Advisory Council, which serves as an advisory body to the state's tobacco prevention and control program. Given the complexities associated with weight status, existing health disparities – and associated approaches to intervention – and the under-developed state-led program, we believe such an advisory body would be critical for strengthening the state's program quickly and effectively.

I realize there are many parts to this legislation. I am happy to answer any questions or prepare additional materials for the committee in advance of the work session. We strongly support the provisions in this legislation, and respectfully request you to vote LD 1693 "Ought to Pass." Thank you for your consideration.

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[1] U.S. Centers for Disease Control and Prevention. Adult obesity prevalence maps. September 27, 2021. Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion.
[2] Fryar CD, Carroll MD, Afful J. Prevalence of overweight, obesity, and severe obesity among children and adolescents aged 2–19 years: United States, 1963–1965 through 2017–2018. NCHS Health E-Stats. 2020.
[3] Fox MK & Gearan E. (2019). School nutrition and meal cost study: Summary of findings. Alexandria, VA: U.S. Department of Agriculture, Food and Nutrition Service.
[4] Au LE, Gurzo K, Gosliner W, Webb KL, Crawford PB & Ritchie LD. (2018). Eating school meals daily is associated with healthier dietary intakes: The Healthy Communities Study. *Journal of the Academy of Nutrition & Dietetics*;118(8):1474–1481.
[5] Gearan EC, Monzella K, Jennings L, Fox MK. (2020). Differences in diet quality between school lunch participants and nonparticipants in the United States by income and race. *Nutrients*;12(12):3891.