Five Big Ideas to Reduce the Burden of Chronic Disease

Introduction

Chronic diseases, generally defined as conditions that last one year or more and require ongoing medical attention or limit daily activities, are the leading causes of death and disability in the United States. Common chronic diseases include hypertension, heart disease, and diabetes. Most chronic diseases cannot be cured, but most can be managed in ways that reduce the daily burden of the disease and/or the likelihood it will progress to more serious symptoms.

More than half of adults ages 18 and older have at least one chronic condition; more than one-quarter have at least two. Eighty-six percent of the nation’s $2.7 trillion annual health care expenditures in 2014 were on behalf of people with chronic diseases and mental health conditions. Seven of the top ten causes of death are associated with chronic diseases including heart disease, cancer, chronic respiratory disease, stroke, Alzheimer’s, diabetes and chronic liver disease.

The Aspen Health Strategy Group selected prevention of chronic disease as its topic for discussion in 2018, its third year. This group of leaders in and outside health care spent three days considering the topic with the assistance of subject matter experts who prepared four background papers to frame the conversation. In our discussions the group quickly came to the conclusion that addressing chronic diseases means taking on obesity – because so many diseases are directly associated with that condition. The group emerged with five big ideas to tackle obesity in order to reduce the burden of chronic disease.
The Aspen Health Strategy Group’s goal is to promote improvements in policy and practice by providing leadership on important and complex health issues. Co-chaired by Kathleen Sebelius and Tommy Thompson, both former governors and former US Secretaries of Health and Human Services, the group is composed of 24 senior leaders across sectors including health, business, media, and technology. (More information about the Aspen Health Strategy Group can be found at www.aspeninstitute.org/health.) This report captures the deliberations of the group, but no specific proposal or statement in the report should be considered to represent the opinion of any individual member of the group.

Background

“Several factors, most of which are outside the traditional health care system, affect chronic disease prevalence, morbidity and mortality rates. These determinants of health include environmental factors, socio-economic status, transportation, genetics, lifestyle and behavioral factors, social services and education,” says Kenneth Thorpe in “Understanding and Preventing Chronic Disease.”

The prevalence of chronic disease and the number of patients with multiple chronic conditions have increased markedly over the past two decades. Compared to 8% in 1995, 18% of adults were treated for five or more chronic diseases in 2015. The costs of treating chronic diseases are also high: As of 2016, chronic diseases accounted for more than $2 trillion in health care spending per year and about six out of every seven dollars spent on health care.
Obesity underlies most chronic diseases. Obesity is a risk factor for type 2 diabetes, hypertension and hyperlipidemia. Nearly 40% of the adult population is now considered obese, a tremendous increase from 15% 30 years ago. The rise in obesity rates, along with increasing intensity of how we treat chronic diseases, accounts for 20% to 30% of the growth in health care spending since 1987.

Chronic disease prevalence varies by race and ethnicity. According to Thorpe: “Non-Hispanic blacks are 55% more likely to be diabetic, 60% more likely to have high blood pressure and 56% more likely to have cerebrovascular disease than non-Hispanic whites.” Some of this difference is associated with different rates of obesity across these population groups. Compared to an obesity rate of 34.5% among non-Hispanic whites in 2014, 48% of non-Hispanic blacks were obese and 43% of Hispanics of any race were obese.

Thorpe calls for preventive approaches to mitigate the growth in behavioral risk factors associated with chronic diseases. In particular, “population-based health programs that integrate social, health care, and other determinants of health could represent the next generation of approaches to reducing the burden of chronic disease.” As an example, he cites positive results from the YMCA’s diabetes prevention program.

In “Investing in Prevention to Address the Burden of Chronic Disease and Mental Health,” Dana Goldman, Seth Seabury, and Sarah Brandon tell us “The United States is becoming a victim of its demographic success. While Americans are living longer, they are not necessarily living healthier. Disability rates have been rising, due in large part to the prevalence of major chronic diseases such as high blood pressure, heart disease, diabetes, cancer, and stroke among our elderly.”

According to Goldman and colleagues, the short-term orientation of the US health care system impedes long-term investment in prevention. Insurance policies last one year and health plans reimburse for a patient in the hospital but don’t pay appropriately to keep them out of one.

The fragmented nature of the US health care system also contributes to increased treatment costs associated with chronic diseases. Poor coordination in diagnosis and care delivery particularly affects those with chronic conditions, who often have multiple care providers and need treatment for multiple comorbidities. Lack of effective communication between primary care providers and specialists contributes to underutilization of effective prevention and makes it harder for patients to manage their chronic conditions. These inefficiencies increase costs and place a burden on patients.
Reducing the Burden of Chronic Disease

Goldman and colleagues report simulation results of the economic and health effects of increasing the use of aspirin¹, preventing heart disease, and delaying the effects of aging. They show significant positive returns to investing in prevention. However, they point out, current payment models discourage innovation in prevention technology and early interventions. This must change in order to realize the benefits of prevention investments: “The key to reaping the fruits of that labor will be our ability as a system to move to a model that rewards positive health outcomes, not health care resource use.”

“Focusing on downstream solutions, such as raising awareness about risk factors, providing access to health care or telling people to change their behavior does little to address the root causes of health inequities,” write Vincent Lafronza and Lisa Tobe in “Models to Prevent Chronic Disease and Create Health in Communities.” Clinical health care accounts for only 20% of modifiable determinants of health; social and economic factors, health behaviors and physical/environmental factors make up the vast majority. Racism, violence, food insecurity and the built environment all have a quantifiable effect on health. Differences in chronic disease incidence account for a large portion of the life expectancy gap between blacks and whites. These disparities are attributable to a number of factors such as socioeconomic status, smoking, diet, and access to care, although even after accounting for these factors unexplained racial differences remain.

Government programs and policies of regulation and taxation designed to promote prevention, healthy eating, active living, and tobacco control could decrease chronic diseases. These policy levers can reach a large share of the population. According to various studies the authors cite, in the first year of implementation, a national sugar sweetened beverage tax would reduce consumption of sweetened beverages by 20%, reduce mean body mass index (BMI) by 0.16, and prevent the loss of more than 100,000 disability-adjusted life years. A 2009 change in the federal Women, Infants and Children (WIC) program encouraged purchases of

¹The simulation was conducted prior to recent evidence that brings into question the value of daily aspirin use.
healthier foods and led to decreased juice purchases and increased fresh fruit and vegetable purchases. Further cigarette tax increases would reduce cigarette consumption. The authors provide eight examples of multisector initiatives underway throughout the United States that address social determinants, reduce disparities, and have multiple partners and funding sources.

Interventions at the community level are also critical to prevent chronic disease. Structural barriers to racial equity must be removed. “Creative placemaking” initiatives allow a community to invest in the design and reinvention of its public space and promote wellbeing for its residents. Community-based efforts can consider the totality of resources and make efforts to allocate them in ways that support residents’ health.

In “Ethical Issues in Responding to Chronic Diseases,” Barbara Redman writes “The health care system’s response to the growing prevalence of chronic disease ... has been inadequate, with excessive reliance upon patient self-management and too little introspection by those in the health care sector regarding the systemic changes needed to orient care to meet these growing needs.” A societal attitude that emphasizes “personal responsibility” places the onus for adopting healthy behaviors on individuals. Recent trends toward “patient activation” continue this push of responsibility to individuals and patients with little regard for their knowledge and ability to effectively monitor and manage their conditions. Despite growing understanding of the importance of social determinants of health, doctors are increasingly held responsible for patient behavior that reflects policies and factors outside their control.

“What we choose to treat or leave untreated, where research dollars are invested and how research subjects are approached, are normative (ethical) decisions,” writes Redman. To address these shortcomings, the health sector must address chronic disease as a health disparity and must redesign care management around a “capability approach” by focusing on what individuals are able to do.
Framing the Issue

Four themes emerged in the group’s discussions that helped guide the development of this year’s big ideas. The themes are:

- The rapid growth in chronic disease is a national crisis.

  The dominant role chronic conditions play in our health care system is now well established. In 2015, 65% of adults had at least one chronic condition and 86% of health care spending was associated with people with chronic conditions.

  It would be gratifying if the growth in chronic conditions were a success story related to growing life expectancy. After all, longer life spans provide more opportunity for chronic conditions to develop. Improved heart attack and stroke care keep people living, often with chronic conditions. A cancer diagnosis, once a death sentence, is now, for many, a manageable life-long condition.

  We could tell ourselves a similar success story about the rising prevalence of multiple chronic conditions. Instead of killing us, a single condition such as diabetes can be managed, giving the body time to develop another chronic condition, such as heart disease. Advances in acute care mean if a single chronic disease leads to an acute episode, such as a heart attack, the person is more likely to survive another day, and live long enough to develop multiple chronic diseases.

  But it turns out this positive story is wrong. While chronic diseases are more prevalent as people age, as the data presented above show, we are now diagnosed with those diseases at earlier and earlier ages. The same is true for multiple chronic conditions.

  Put simply and starkly, people are becoming sick, and becoming increasingly sicker, earlier in life than occurred in the past. And our children are bearing a particularly heavy burden. Life expectancy at birth is falling. Declining life expectancy among those of middle age are thought by some to be “deaths of despair” arising from substance use and depression. But declining life expectancy at birth is primarily associated with the dramatic rise in the early onset of chronic conditions.

  Disparities in the prevalence of chronic conditions are a central element of the racial and ethnic disparities that exist with respect to life expectancy and health status. Responding to the chronic disease crisis is an essential step toward health equity.
As Barbara Redman explains in her paper, much of the health care system has adopted an approach of patient self-management when it comes to chronic conditions. Patients are expected to learn for themselves how to modify their behaviors in response to the onset of a chronic condition. Those that fail to do so are labeled “non-adherent” and may be treated poorly by the health care system. Unlike with acute conditions, worsening of the patient’s condition is often treated as a personal failure, rather than a system failure. This stands in contrast to a shared responsibility approach, in which the health care system engages patients and supports patient capabilities in a non-judgmental manner.

Many chronic diseases bring with them an increase in patient social needs. While parts of the health care system are reorienting toward these needs, the clinical focus of most care leaves those needs largely unmet.

This health crisis brings with it a cost crisis – a crisis that burdens all who pay for health care with a particularly heavy burden on those with chronic conditions. Health spending now comprises 18% of our nation’s GDP, by far the largest share in the world. Our spending continues to grow even as our health declines.

The burden of the crisis is heaviest for those who have chronic diseases. People with chronic conditions are disadvantaged in the health care system relative to people with acute conditions. Much of the disadvantage is unintentional – artifacts of policies or practices that predate the rise of chronic conditions.

For example, an increasing number of people have health insurance plans with high deductibles that must be met each year before coverage kicks in. People with chronic diseases who have ongoing costs -- often medications designed to manage those conditions, such as anti-hypertensives, statins, or insulin -- are likely to run through their deductibles every year. By contrast, someone who has an acute medical episode, even if the associated costs are very high, is likely to face the financial burden of his or her deductible at the time of the episode, but will not experience those costs every year.

Until recently, people with chronic diseases faced the likelihood of being denied health insurance coverage altogether or paying significantly higher insurance premiums if they could obtain coverage. Pre-existing condition exclusions and rating on the basis of health status were routine, particularly in the individual and small group health insurance markets. These practices were abolished by the Patient Protection and Affordable Care Act (ACA), but
recently regulatory action by the Trump Administration will expand the availability of health plans not subject to these rules. How many people will purchase these plans, how well they will meet the needs of people with chronic conditions, and how the expansion of this less-regulated market will affect prices for people seeking to purchase comprehensive coverage, is not yet known.

Health insurance typically covers needed services when recovering from an acute illness. Medicare, for example, pays for rehabilitation and home health care after hospitalization (for a knee replacement, stroke, or heart attack, for example). By contrast, the ongoing needs of someone coping with the challenges associated with diabetes or depression are rarely covered by insurance.

- **We are more willing to spend resources to treat chronic conditions than we are to prevent them.**

  An ounce of prevention may be worth a pound of cure, but, through our actions, we show more willingness to buy pounds than ounces.

  Our orientation toward treating disease rather than preventing it manifests itself in many ways. Health insurance covers all manner of treatment but does not cover forms of primary prevention that address behaviors such as healthy eating or physical activity. Insurance does not typically “reimburse” for non-medical interventions that reduce the likelihood a person will become ill, while payment for medical interventions to treat preventable conditions is the norm. This has yielded tremendous progress in the treatment of chronic conditions, with much less progress when it comes to advancing our understanding of effective primary prevention.

Under the ACA, most health plans must now cover certain screening services (secondary prevention) such as mammography and colonoscopy. Prior to the ACA, such coverage was not typical. Health insurance typically covers pharmaceuticals that help people prevent their chronic conditions from worsening (tertiary prevention), but cost sharing for medications that must be taken regularly can add up and become a barrier to access.
We cannot treat our way out of the burden of chronic diseases. Not only are many treatments quite expensive, and some have undesirable side effects, but they also reduce, rather than eliminate, the health risks associated with chronic conditions. Worse yet, there are often undesirable interaction effects associated with simultaneous treatment of multiple conditions.

The focus of health systems and health system spending on acute conditions has, not surprisingly, led to increased investment in treatment of acute conditions, often with dramatically positive results. As Dana Goldman and colleagues explain, however, this orientation leads to a systematic underinvestment in approaches to reduce the incidence of chronic disease. To put it differently, the orientation of the health system toward acute care, and the funds that flow toward treatment of acute disease, perpetuate our failure to tackle the growing problem of chronic diseases.

Despite the general orientation of the health care system toward treatment, there are notable efforts to shift that orientation toward prevention. The Diabetes Prevention Plan benefit was added to Medicare in 2018, but it is one of the few non-medical interventions that is currently covered. A similar benefit is now being adopted by some private insurers and Medicaid programs.

Another promising step in reorienting the health system to prevention and wellness is the concept of accountable care. In this model, the health care provider keeps a share of the savings it generates if the cost of serving a defined population ends up lower than expected. Such a model creates financial incentives for investments in prevention, although the relatively short time horizon of most accountable care models may limit that incentive. Medicare has adopted a variety of accountable care models; they are proliferating among private insurers and Medicaid programs as well.

It may seem uncontroversial to say that prevention is preferable to treatment. But most of our payment systems reflect the opposite view. If we are serious about reducing the health and financial burdens of chronic diseases, we must reorient our investments toward prevention.

- **Reducing the burden of chronic disease must begin with tackling obesity.**

We entered into our discussions focused on the growing prevalence and burden of chronic diseases – a gradual shift that many Americans are aware of through their own experiences or through media reports. As we learned more about the topic we came to realize the central role obesity plays in this national crisis.
Reducing the Burden of Chronic Disease

The Centers for Disease Control and Prevention defines a chronic disease as one that lasts more than one year and that requires ongoing medical treatment or limits daily activities. By that definition, there are many chronic conditions, and they vary in their origins. Yet, obesity stands out as the root of the fastest growing chronic conditions. Of the ten chronic conditions Ken Thorpe examines, eight of them are positively correlated with obesity. The breadth of conditions correlated with obesity is striking — not just diabetes and hypertension, but arthritis and mental health conditions as well.

Even more dramatic than the association between obesity and individual chronic conditions is its association with the most commonly co-occurring conditions. Obesity brings with it elevated risk for a collection of chronic conditions -- diabetes, hypertension, heart disease -- and people with multiple chronic conditions bear a tremendous health burden and drive the largest share of health care costs.

The correlation between obesity and certain diseases does not prove causation. But the clinical evidence for causation is overwhelming. The etiologies of the fastest growing chronic diseases involve pathways rooted in obesity.

Among children ages 2-19, obesity prevalence was nearly 19% in 2015-2016, according to the Centers for Disease Control and Prevention. Our children are at grave risk of living shorter, less healthy lives. Based on the evidence presented to us, we conclude that the single most consequential step the nation could take to reduce the burden of chronic diseases is to reduce the incidence of obesity.

• The growth in chronic conditions, and the obesity that underlies that growth, arises from multiple causes and systems that need to engage in the solution.

The burden of chronic disease falls disproportionately on those with lower incomes, education, and who are racial and/or ethnic minorities. Those populations are disproportionately burdened by various challenges, including:

> underinvestment in basic infrastructure, such as transportation options and safe public spaces
> the proliferation of unhealthy food options
> a reduction in physical activity among the population
> an inadequate mental health system, and
> the accumulated burdens of stress, including those associated with exposure to violence and the experience of racism
The health care sector did not create the obesity crisis, but it has not responded to it as rapidly as is needed, and it has a unique role to play in responding.

Five Big Ideas to Reduce the Burden of Chronic Disease

There is much we can do to reduce the burden of chronic disease in the United States. The Aspen Health Strategy Group offers five big ideas that will help catalyze this change.

1. **Launch a national initiative against obesity.**

   The nation’s leaders should launch an urgent, sustained, multi-sector national initiative to dramatically reduce obesity akin to previous efforts to reduce tobacco usage and increase seat belt usage. In our work, it quickly became clear that obesity is the primary driver of our chronic disease crisis. The health burden of obesity is so profound that a sustained, high-profile campaign is required.

   Obesity arises from a combination of genetic makeup and behaviors including food consumption and limited physical activity. Individual behaviors occur in the context of the choices available to people, the information they have, and the resulting choices they make. Children’s ability to make healthy choices may be particularly constrained due to neighborhood, school, and family circumstances. And there is growing evidence that behaviors that appear to be choices are actually shaped by environmental factors including stress, exposure to adverse events, and environmental toxins that reshape how people make decisions.

   The government’s appropriate role in achieving behavior change is always a matter of debate. Governments at all levels, along with various private sector actors, have initiated and supported a number of efforts to reduce obesity. We acknowledge the efforts of former First Lady Michelle Obama in her Let’s Move! initiative as well as the Robert Wood Johnson Foundation’s sizeable investment in preventing childhood obesity. These efforts have shown some positive results, but they must be sustained and expanded upon to generate the scale of change that is needed.
With these views in mind, we support a national initiative against obesity with the following elements:

- The initiative must have highly credible, non-partisan leadership.
- The initiative must be sustained over an extended period -- most likely decades -- to build new social norms and to allow time for policy experimentation and evolution.
- The initiative must take a systems approach to individual behavior. It cannot simply be an admonition for people to live healthier lives and make healthier choices. It must address the social context in which people make those choices, giving them better options and addressing the economic and cultural barriers to making healthy choices.
- The initiative must address both sides of the healthy weight equation: food and activity.
- The initiative must have a significant education component, helping people, and especially children, understand the relationship between their present-day decisions and their ability to live a healthy life into the future.
- The initiative must be evidence-based, both in the techniques it uses to effect cultural change, drawing lessons from previous campaigns, and in the relationships among food, activity, obesity, and chronic diseases.

2. **Promote healthy eating.**

The US Government should use the broad array of tools available to it to increase the affordability and availability of healthy foods relative to less healthy foods with the goal of reducing obesity. These tools include taxes, subsidies, education, and a range of programs that provide food to needy families.

Myriad policy choices in multiple domains affect the affordability and availability of different types of foods. A thorough review of these policies should be undertaken. The following topics should be considered as a starting point:

- taxes on products with added sugar and/or sweetened beverages
- agricultural subsidies that affect the price of various commodities
- nutritional guidelines that encourage people to consume various types of food
- food labels that provide information people use to guide their food choices
• food commodities programs that provide foods directly to seniors and schools
• support for markets that provide access to fresh fruits and vegetables
• school meals programs that deliver free and subsidized meals to students
• school policies regarding on-site sales of food and beverages
• policies regarding advertising that promotes the sale of unhealthy foods
• the Supplemental Nutrition Assistance Program (SNAP) that provides funds for people to purchase their own foods

3. Bring all sectors to the table.

The choices people make that lead to obesity arise from myriad policies and behaviors in multiple sectors. These sectors must participate in a comprehensive effort to reduce obesity. Some of the most critical sectors and their roles are:

• The planning and housing communities play a central role in creating the physical infrastructure that can either support or impede healthy behaviors. Communities support healthy habits when people can walk safely to schools, parks, and other community resources. Zoning and related policies affect the availability of fresh foods and the proliferation, or lack thereof, of outlets that primarily sell unhealthy foods. Transportation options play a central role in giving people the time and ability to purchase and prepare healthy foods. Other environmental factors, such as pollution and noise, affect stress and overall wellbeing that are tied to obesity.

• The agricultural sector produces food in accordance with market dynamics and regulations that determine the profitability and viability of producing certain foods. Changes in these policies have the potential to disrupt an important sector of the economy. The creativity of that sector is needed to develop alternative models that produce healthier foods.
while assuring the viability of the agricultural enterprise. A possible model for this engagement is a set of policies that yielded a significant reduction in US tobacco production.

- Policies and practices at schools have a significant effect on children’s healthy behaviors. Schools affect children through the food they serve and the options offered in vending machines and concessions. School policies affect how much physical activity children engage in during the school day, in after-school activities, and in how they get to school.

- Employers play a similar role for adults. Employer choices about where they locate, the food they serve, and opportunities for physical activity directly affect employees. These employees then bring those habits home and to their own communities, yielding a ripple effect that reaches children and other adults.

- The health care sector has a direct role in improving eating habits. Institutions, particularly hospitals and nursing homes, make choices regarding the food provided to their patients and residents. Work schedules and on-site cafeterias also affect the eating options for clinical and non-clinical staff.

- The media affects people’s food choices in both its programming content and advertising. Major social shifts regarding smoking and alcohol consumption have occurred in the context of significant changes in programming and advertising around these two topics. Similar shifts may be necessary to yield changes in food consumption patterns.

4. **Reorient health system financing to reward prevention.**

Public and private health insurance programs need to be redesigned to promote obesity-prevention initiatives. Health insurance, with its risk pooling function, is an ideal place for investment in prevention. The combination of an empowered individual and a motivated health sector would make a real difference in achieving health improvement goals.

We are currently missing many opportunities to build incentives for prevention into insurance programs and our health care financing models. Such incentives could serve as the foundation for unleashing creativity and investment that would yield substantial health improvement. An effective redesign to promote prevention would explore the following options:
• Health insurers, self-insured employers, and health care providers should adopt specific goals and plans to reduce obesity rates and the incidence of chronic diseases that are related to obesity.

• The ACA provision that requires coverage of services determined to be effective by the US Preventive Services Task Force should be expanded to include evidence-based primary prevention, meaning actions that prevent the onset of disease before there are any symptoms.

• Economists, actuaries, and budget analysts should examine the evidence base surrounding prevention, particularly the time horizon for return on investment, to guide policymakers as they consider investments in prevention.

• Pooled funding mechanisms should be created to support community-based efforts that tackle obesity for which the financial benefits accrue to many different parties.

• Policymakers should consider creative ways to encourage health insurance contracts that span multiple years in order to reduce the short-term thinking encouraged by single year insurance contracts. Options could include a risk penalty or reward for insurers based upon degradation or improvement in the health status of their enrollees over an extended period of coverage.

• Policymakers should consider changing regulations and payment policies so Insurers and providers have incentives and opportunities to explore increased use of telehealth and other technologies that can extend the reach of proven models for reducing the incidence of obesity.
• Medicaid, as the largest source of coverage in the nation for pregnant women and children, should build upon the inclusion of children’s weight assessment as a core quality measure to require states, health insurers, and providers to incorporate obesity reduction as a goal.

5. National commitment to support community-based efforts.

The obesity crisis arises from individual behaviors that are framed and made in a social, economic, and cultural context. While state and national policy can and should be deployed to address this crisis, sustainable progress will require engagement at the community level to provide better options and support people in their choices.

The correlation between social and economic disadvantage and obesity, along with the growing understanding of epigenetics, suggests that community-level efforts must include investments that strengthen opportunities and bring resources to historically disadvantaged communities. A national commitment to support community-based efforts should include the following elements:

• Bring public and private investments into communities that help people meet their basic needs of education, employment, housing, food, recreation, and safety and provide them with economic opportunity.

• Prohibit targeting of disadvantaged communities by certain businesses that profit from promoting unhealthy behaviors, such as tobacco and alcohol use, or actions that cause environmental or financial harm to residents.

• Support community efforts to identify racism, whether current, historical or structural (policies embedded in social and political systems that create racial inequities regardless of intent), and reverse its effects in a way that empowers people to overcome barriers to health.
Moving Forward

Growing obesity rates are a demographic time bomb that is slowly exploding with devastating effect for the people affected and for the country as a whole. The Aspen Health Strategy Group, with its multi-sector membership, has developed these ideas to address the crisis of rapidly growing rates of chronic disease. We hope they will serve as catalysts for changes in policy and practice.

We will take our call for a multi-sector response to those we mention in this report. With our focus on health care, we will share this report with officials in the US Department of Health and Human Services, which houses the Centers for Medicare and Medicaid Services, the National Institutes of Health, the Centers for Disease Control and Prevention, the Food and Drug Administration, and other relevant agencies. We will also reach out to other sectors, particularly agriculture and education, both of which have a significant role to play in responding to this crisis.

The Aspen Health Strategy Group members have also committed to examining steps we can take within our own institutions and organizations. We look forward to working with all who share our goal of reducing the burden of chronic diseases.