Written Testimony of
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The State of Obesity in America
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Good afternoon. My name is Richard Hamburg, and I am the Director of Government Relations for Trust for America's Health (TFAH), a nonpartisan, nonprofit organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority. I would like to thank the Chairman, the Ranking Member and the members of the Subcommittee for the opportunity to testify on a very serious issue – our nation's obesity epidemic. Today I would like to discuss the scope of obesity in America, the potential factors that may be contributing to it, the health and economic impacts of obesity, and the importance of developing a national strategy to coordinate our response to obesity.

Scope of the Problem

Adult Obesity
Approximately two-thirds of American adults are obese or overweight. To examine obesity trends each year, TFAH publishes a report on obesity entitled "*F as in Fat*: *How Obesity Policies Are Failing in America*." The 2008 report, based on the Centers for Disease Control and Prevention's (CDC's) Behavioral Risk Factor Surveillance Survey (BRFSS) 2005-2007 data, found that adult obesity rates increased in 37 states in the past year. No state saw a decrease. More than 25 percent of adults are obese in 28 states, and more than 20 percent of adults are obese in every state except Colorado. A study published in the July edition of *Obesity* estimates that 86 percent of Americans will be overweight or obese by 2030.

Childhood Obesity

Overall, approximately 23 million children are obese or overweight, and rates of obesity have nearly tripled since 1980, from 6.5 percent to 16.3 percent.[1] Eight of the 10 states with the highest rates of obese children are in the South.[2] According to a recent analysis from the National Health and Nutrition Examination Survey (NHANES), the number of U.S. children who are overweight or obese may have peaked, after years of steady increases. According to researchers from the CDC, there was no statistically significant change in the number of children and adolescents (aged 2 to 19) with high BMI for age between 2003-2004 and 2005-2006.[3] This is the first time the rates have not increased in over 25 years. Scientists and public health officials, however, are unsure if the data reflect the effectiveness of recent public health campaigns to raise awareness about obesity and increased physical activity and healthy eating among children and adolescents, or if this is a statistical abnormality. Scientists expect to know more when the 2007-2008 NHANES data are analyzed. Even if childhood obesity rates have peaked, the number of children with unhealthy BMIs remains unacceptably high, and the public health toll of childhood obesity will continue to grow as the problems related to overweight and obesity in children show up later in life.[4]

Impacts of Obesity

Health Impacts

Obesity and overweight are associated with a number of serious chronic conditions. More than 80 percent of people with type 2 diabetes are overweight. People who are overweight are more likely to suffer from high blood pressure, high levels of blood fats, and high LDL ("bad") cholesterol -- all risk factors for heart disease and stroke. Obesity is a known risk factor for the development and progression of knee osteoarthritis and possibly osteoarthritis of other joints. Obesity may increase adults' risk for dementia and may increase the risk of developing several types of cancer.

The health impacts of obesity can start at a young age. Physical inactivity is tied to heart disease and stroke risk factors in children and adolescents. A number of studies have documented how obesity increases a child's risk for a number of health problems, including the emerging onset of type 2 diabetes, increased cholesterol and hypertension among children, and the danger of eating disorders among obese adolescents.[5] Some

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[1] Ogden, C.L., M.D. Carroll, and K.M. Flegal. "High Body Mass Index for Age among U.S. Children and Adolescents, 2003-2006." *Journal of the American Medical Association* 299, no. 20 (2008): 2401-2405.
[2] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *National Survey of Children's Health 2003*. Rockville, MD: U.S. Department of Health and Human Services, 2005, http://www.mchb.hrsa.gov/overweight/techapp.htm (accessed April 22, 2008).

[3] Ogden, C.L., M.D. Carroll, and K.M. Flegal. "High Body Mass Index for Age among U.S. Children and Adolescents, 2003-2006." *Journal of the American Medical Association* 299, no. 20 (2008): 2401-2405.
[4] U.S. Department of Health and Human Services, National Center for Health Statistics. *Prevalence of Overweight Among Children and Adolescents: United States, 1999.* Hyattsville, MD: National Center for Health Statistics; 2001. http://www.cdc.gov/nchs/products/pubs/pubd/hestats/overwght99.htm..(accessed July 14, 2008).
[5] U.S. Department of Health and Human Services (USDHHS). *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity*. Washington, D.C.: USDHHS, 2001.

studies have shown that obesity and overweight in children also negatively affect children's mental health and school performance.

Economic Impact

These health impacts come at a great cost to our nation. According to the Department of Health and Human Services, obese and overweight adults cost the U.S. anywhere from $69 billion to $117 billion per year.[6] One study found that obese Medicare patients' annual expenditures were 15 percent higher than those of normal or overweight patients. The cost of childhood obesity is also growing. Between 1979 and 1999, obesity-associated hospital costs for children (ages 6 to 17 years) more than tripled, from $35 million to $127 million.[7]

The poor health of Americans of all ages is putting the nation's economic security in jeopardy. More than a quarter of U.S. health care costs are related to physical inactivity, overweight and obesity. Health care costs of obese workers are up to 21 percent higher than non-obese workers. Obese and physically inactive workers also suffer from lower worker productivity, increased absenteeism, and higher workers' compensation claims.

National Security Impact

The problem of obesity and overweight has reduced the number of volunteers for military service who must meet height and weight requirements. At a time when military recruiters are struggling to meet the needs of our armed forces, we are finding more and more volunteers who are overweight and obese. In 1993, 25.6 percent of 18-year-old volunteers were overweight or obese**;** in 2006 that percentage rose to almost 34 percent.[8] This problem continues during active duty. Each year between 3,000 and 5,000 servicemembers are forced to leave the military because they are overweight.[9]

Factors Contributing to Obesity Rates

How did this problem arise? In the simplest of terms, one could argue this is just a matter of physics – Americans today are eating more and moving less, which inevitably leads to increases in weight. That is true, but is only a part of the story.

- We have placed kids in a less nutritious environment – it is not just too much food, but too much unhealthy food that kids are eating, and we have not harnessed the opportunities of the school to compensate for this.

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[6] U.S. Centers for Disease Control and Prevention. "Preventing Obesity and Chronic Diseases Through Good Nutrition and Physical Activity." U.S. Department of Health and Human Services, http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/obesity.htm. (accessed July 14, 2008).

[7] Ibid.

[8] Hsu, L.L., R.L. Nevin, S.K. Tobler, and M.V. Rubertone. "Trends in Overweight and Obesity among 18-Year-Old Applicants to the United States Military, 1993-2006." *The Journal of Adolescent Health* 41, no. 6 (2007): 610-612.

[9] Cable News Network. "Discharged Servicemen Dispute Military Weight Rules." *CNN.com*, September 6, 2000. http://www.cnn.com/2000/HEALTH/09/06/military.obesity/index.html (accessed May 2, 2008).

- We have placed a particular burden on our poor and minority Americans, who are disproportionately overweight and obese, primarily because our poverty programs have not kept up with the rising cost of nutritious food; access to healthy foods is often limited in poor neighborhoods, and physical activity may be limited because of safety concerns or inadequate recreational facilities.
- We have also created a physical environment that reinforces a less active lifestyle, and we have not compensated for this in the level of physical activity we promote in the schools and in the workplace.

The following is a sketch of the scope of the problem and some possible solutions. Our annual report on obesity, *F as in Fat: How Obesity Policies Are Failing in America*, is available at our website, www.healthyamericans.org, and provides a more comprehensive look at these issues. The 2009 edition will be released in a few months.

Nutrition

Many American children are consuming more calories, eating less healthful foods, engaging in less physical activity and instead spending their time engaging in sedentary activities. Overall, "added sugar" consumption for Americans is nearly three times the U.S. Department of Agriculture's (USDA) recommended level,[10] and adolescent females ages 12-15 consumed approximately four percent more calories in 1999-2000 than they did in 1971-1974.[11] In 2003, a USDA report characterized America's per capita fruit consumption as "woefully low" and noted that vegetable consumption "tells the same story."[12] Moreover, since the 1970's, fast food consumption in children has increased five-fold. In the late 1970s, children received approximately two percent of their daily meals from fast food; by the mid-1990s, that increased to 10 percent. Children who consume fast food, as compared with those who do not, have higher caloric intake, more fat and saturated fat, and more added sugar.[13]

Everything from the foods sold in schools to the presence or absence of grocery stores and markets selling fresh fruits and vegetables in communities to the foods that parents serve to their children can influence obesity. What occurs in schools can be critical – given the number of children who depend on school breakfast and lunch for their meals and the patterns that school food access can create for all children. In 2004, the Child Nutrition and WIC Reauthorization Act of 2004 (P.L. 108-265) required the U.S. Secretary of Agriculture to issue school nutrition guidelines that would ensure that American schoolchildren consume foods recommended in the most recent Dietary Guidelines for Americans (DGAs).[14] USDA contracted with the Institute of Medicine

[10] Putnam, J., J. Allshouse, and L. S. Kantor. "U.S. per Capita Food Supply Trends: More Calories, Refined Carbohydrates, and Fats." *Food Review* 25, no. 3 (2002): 1-14.
[11] Briefel, R. R. and C. L. Johnson. "Secular Trends in Dietary Intake in the United States." *Annual Review of Nutrition* 24, (2004): 401-431.
[12] Putnam, J., J. Allshouse, and L. S. Kantor. "U.S. per Capita Food Supply Trends: More Calories, Refined Carbohydrates, and Fats." *Food Review* 25, no. 3 (2002): 1-14.
[13] Asche, K. "Fast Foods May Increase Childhood Obesity Rates." University of Minnesota Extension. (2005). http://www.extension.umn.edu/extensionnews/2005/fastfood.html (accessed July 14, 2008).
[14] U.S. Department of Agriculture (USDA). Incorporating the 2005 Dietary Guidelines for Americans into School Meals. SP 04-2008. Washington, D.C.: USDA, 2007.

(IOM) to convene a panel of experts on child nutrition. The IOM Committee on Nutrition Standards for School Lunch and Breakfast Programs will provide USDA with recommendations for updating the school meal programs' nutrition requirements. Once USDA receives the IOM recommendations, agency officials will then seek to incorporate them into formal USDA guidance. A final rule will take even longer to be issued. This delay is of considerable public health concern. As this process develops, TFAH urges schools to begin to work towards implementation of the most recent DGAs.

Disparities

Unfortunately, as with too many other health problems facing our nation, obesity often disproportionately affects minorities and the poor. African American children are almost twice as likely to be obese[15]. Black and Hispanic adolescents have higher rates of physical inactivity (by 5-6 percentage points).[16]

Equally disturbing, is the apparent relationship between being overweight and poverty. The National Survey on Children's Health (2003) shows that rates of overweight decline as income rises (22.4 percent of kids below 100% of poverty were overweight; only 9.1 percent of kids at 400 percent or more of poverty were overweight). Similarly, rates of physical inactivity are greater for poor children (17% who were under 100 percent of poverty engaged in no vigorous physical activity each week; only 7.8% of those at 400% of poverty fell into that category).

Lack of access to nutritious foods is one obstacle to healthy eating in some low-income communities. Supermarkets are less likely to be accessible in poor neighborhoods, and many families live in communities referred to as "food deserts" because they do not have access to healthy foods and mainstream grocery outlets. To address this problem, innovative organizations such as the Food Trust have been working to increase access to nutritious foods in underserved communities. The Food Trust provided policy recommendations to the Pennsylvania legislature regarding access to supermarkets in low-income communities. As a result, the legislature created the Pennsylvania Fresh Food Financing Initiative, a grant and loan program to encourage supermarket development in underserved neighborhoods throughout the state. The Fresh Food Financing Initiative has committed more that $67 million in funding for 69 supermarket projects in 27 Pennsylvania counties, creating or preserving 3,900 jobs.[17] We must continue to build on this progress by providing financial incentives for supermarkets in low-income neighborhoods with little access to healthy foods; encouraging farmers' markets to accept SNAP Electronic Benefits cards, WIC vouchers and Senior Famers'

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[15] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *National Survey of Children's Health 2003*. Rockville, MD: U.S. Department of Health and Human Services, 2005.

[16] U.S. Centers for Disease Control and Prevention. "Youth Risk Behavior Surveillance -- United States, 2007." *Morbidity and Mortality Weekly Report* 57, no. SS-4 (2008): 1-136.

[17] The Food Trust. "Supermarket Campaign." http://www.thefoodtrust.org/php/programs/super.market.campaign.php

Market Nutrition Program vouchers; and working with schools to improve healthy options through federal meal programs.

Even when healthy foods are readily available, eating healthier can be very expensive, whereas calorie dense foods tend to be less expensive. The current rise in food prices, coupled with the economic recession, raises serious concerns about obesity. For example, a recent study in the UK by Which?, a consumer group, found that 24 percent of UK adults feel healthier eating is now less important, with 56% saying price has overtaken as a priority when choosing food.[18] Similarly, in the U.S. nutritionists are worried that Americans will put on "recession pounds," pointing to studies linking obesity and unhealthy eating habits to low incomes.[19]

To help address this problem, it is important that we provide incentives for Americans to purchase healthy foods. TFAH was pleased with the inclusion of the provision in the Food, Conservation, and Energy Act of 2008 (P.L. 110-246), which provides funding to carry out a point-of-purchase pilot program to encourage households participating in the Supplemental Nutrition Assistance Program (SNAP) to purchase fruits, vegetables or other healthy foods. Further, the American Recovery and Reinvestment Act of 2009 included a 13.6 percent increase in the value of benefits provided through the SNAP. During these difficult economic times, we hope Congress will continue to support the nutrition needs of all Americans, particularly those who are economically disadvantaged.

In particular, as Congress considers Child Nutrition and WIC reauthorization, we hope that Congress will increase reimbursement rates for school meals. As schools are faced with increasing food and energy costs, we must ensure that they are serving healthy meals to America's children and recognize that this requires a higher level of investment in school meal programs. Moreover, TFAH hopes that Congress will consider updating the national nutritional standards for school foods sold outside of the school meal program so that strong nutritional standards based on current science will apply across a school campus. TFAH also hopes that Congress will strengthen requirements for local school wellness policies, strengthen nutrition education, and support the implementation of the new WIC food packages, as well as the technology needs of the WIC program. These actions would help promote access to nutritious foods and increase understanding of the importance of nutrition, which are all necessary to mitigate the obesity epidemic.

An Environment that Discourages Physical Activity

In addition to developing poor dietary habits, many children are becoming less physically active, which is also contributing to obesity and overweight. For example, 30 years ago, nearly half of American children walked or biked to school; today, less than one in five either walk or bike to school.[20] The built environment and community design can have a

[18] BBC News. "Recession Thwarts Healthy Efforts. (March 11, 2009). http://news.bbc.co.uk/1/hi/health/7934242.stm

[19] Reuters. "Will Americans Put on Recession Pounds?" (January 9, 2009). http://www.reuters.com/article/newsOne/idUSTRE50805W20090109

[20] McDonald, N. C. "Active Transportation to School: Trends among U.S. Schoolchildren, 1969-2001." *American Journal of Preventive Medicine* 32, no. 6 (2007): 509-516.

great impact on nutrition and physical activity levels. For children, the placement of schools and access to safe venues for physical activity are particularly important. One study found that the primary reason that children do not walk or bike to school is because their school is too far away. Other concerns included too much traffic, no safe route, fear of abduction, crime in the neighborhood, and lack of convenience.[21] TFAH hopes that Congress considers making improvements to the built environment and promoting non-motorized transit option in upcoming transportation reauthorization legislation.

Furthermore, according to the CDC's latest School Health Policies and Programs Study, only 3.8 percent of elementary schools, 7.9 percent of middle schools and 2.1 percent of high schools provided daily physical education or its equivalent. Some attribute at least part of this decline in physical activity programs to the academic requirements of No Child Left Behind. That is unfortunate as there is growing evidence that fitter more active students perform better academically. When Congress considers reauthorization of No Child Left Behind, TFAH urges Congress to include provisions that promote physical education and physical activity throughout the school day.

Recommendations

It is clear that obesity is a multi-faceted issue with diverse causes and impacts across all sectors of society. Progress can be made by adopting some of the provisions referenced above in various reauthorization bills. However, to truly begin to mitigate and ultimately reverse this epidemic, we will need a sustained commitment over time to investing in population-based prevention strategies and coordinating our efforts to combat obesity.

Strengthening Our Investment in Community Prevention
Real prevention requires changing the communities in which we live and approaching this as a community-wide, not just an individual challenge. It will also be the most cost effective way to mitigate this epidemic. To truly tackle the obesity epidemic, we must make healthy choices easy choices for all Americans, regardless of where they live or what school they attend. We need a cultural shift, one in which healthy environments, physical activity and healthy eating become the norm.

Last July TFAH released *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*, which examines how much the country could save by strategically investing in community disease prevention programs. The report concludes that an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save the country more than $16 billion annually within five years. This is a return of $5.60 for every $1. The economic findings are based on a model developed by researchers at the Urban Institute and a review of evidence-based studies conducted by the New York Academy of Medicine. The researchers found that many effective prevention programs cost less than $10 per person, and that these

[21] U.S. Centers for Disease Control and Prevention (CDC). "Barriers to Children Walking and Biking to School--United States, 1999." *Morbidity and Mortality Weekly Report* 51, no. 32 (2002): 701-704.

programs have delivered results in lowering rates of diseases that are related to physical activity, nutrition, and smoking. The evidence shows that implementing these programs in communities reduces rates of type 2 diabetes and high blood pressure by 5 percent within 2 years; reduces heart disease, kidney disease, and stroke by 5 percent within 5 years; and reduces some forms of cancer, arthritis, and chronic obstructive pulmonary disease by 2.5 percent within 10 to 20 years, which, in turn, can save money through reduced health care costs to Medicare, Medicaid and private payers.

Examples of Successful Interventions
Community and school-based approaches aimed at using reducing obesity in the United States have already shown to be successful. The Child and Adolescent Trial for Cardiovascular Health (CATCH) elementary school program provides education for students, modifications for improvements in school lunches and physical education, and increased education for staff and teachers. Results have shown that students in the program consumed healthier diets and engaged in more physical activity.

The town of Somerville, Massachusetts developed a comprehensive program called "Shape Up Somerville" to curtail childhood obesity rates. The project included partners across the community. Various restaurants started serving low-fat milk and smaller portion sizes; the school district nearly doubled the amount of fresh fruit at lunch and started using whole grain breads; the town expanded a local bike path and repainted crosswalks; and the town targeted crossing guards to areas where children are most likely to walk to school. Researchers evaluated the program after one year and found that children in Somerville gained less weight than children in surrounding communities. (Growing children are expected to gain some weight.)

Another example of a coordinated approach to obesity reduction at the community level is the YMCA's Pioneering Healthier Communities. This project supports local communities in promoting healthy lifestyles. Examples of interventions have included offering fruits and vegetables and encouraging physical activity during after school programs; influencing policymakers to "put physical education back in schools and include physical activity in after school programs"; building or enhancing bicycle and pedestrian trails; and increasing access to fresh produce in communities through community gardens, farmers markets and other activities.

TFAH urges Congress to build upon these successes and to make a sustained investment in population-based disease prevention. If we are serious about combating this epidemic, we must invest in our future by strengthening communities and promoting prevention.

Implementing a National Strategy to Combat Obesity
Clearly, it has taken years for the childhood obesity epidemic to develop, and it will take a coordinated effort over time to begin to mitigate it. At this time, we have no national, coordinated effort to combat obesity. TFAH supports the development of a ***National Strategy to Combat Obesity***. This needs to be a comprehensive, realistic plan that involves every department and agency of the federal government, state and local governments, businesses, communities, schools, families, and individuals. It must outline

clear roles and responsibilities. Our leaders should challenge the entire nation to share in the responsibility and do their part to help improve our nation's health. All levels of government should develop and implement policies to make healthy choices easy choices – by giving Americans the tools they need to make it easier to engage in the recommended levels of physical activity and choose healthy foods, ranging from improving food served and increasing opportunities for physical activity in schools to securing more safe, affordable recreation places for all Americans.

The "National Strategy for Pandemic Influenza Planning" provides a strong example for how this type of effort can be undertaken. With leadership and goals identified by health agencies and experts, every cabinet agency has taken charge of developing and implementing policies and programs in their jurisdiction that all contribute to our nation's preparedness for a pandemic flu outbreak. Similarly, the United Kingdom has announced an anti-obesity strategy to "transform the environment" in which people in England live, including launching a campaign to promote healthy living and healthy towns with bicycle and pedestrian routes.

Conclusion

Our country needs to focus on developing policies that help Americans make healthier choices about nutrition and physical activity. We know that even small changes can make a big difference in people's health – and that individuals don't make decisions in a vacuum. If we want Americans to lead healthy, productive lives, we need a strong partnership from the government, private and nonprofit sectors, as well as parents and teachers, to emphasize wellness and enhance nutrition and physical activity. The challenge is a big one, but we can make a difference together. Thank you again for the opportunity to testify.